Agenda

Ref: MA/TH

To the Members of the Board of Directors of Dorset County Hospital NHS Foundation Trust

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **26th May 2020** at **08.30am to 11.05am** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Presentation	Rachel Cookson / Nicky Lucey	Note	8.30-8.50
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	8.50-8.55
	a) Apologies for Absence: Alastair Hutchison, Richard Sim	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 28th April 2021	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**CEO Update**	Enclosure	Patricia Miller	Note	8.55-9.05
4.	**COVID-19 Update**	Verbal	Inese Robotham	Note	9.05-9.15
5.	**Performance Scorecard and Board Sub-Committee Escalation Reports** a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee d) Risk and Audit Committee	Enclosure	Committee Chairs and Executive Leads	Note	9.15-9.35
6.	**Recovery Overview**	Enclosure	Nick Johnson	Discuss	9.35-9.50
Coffee Break 9.50 – 10.00					

7.	**Draft Strategy 2025**	Enclosure	Nick Johnson	Approve	10.00-10.15
8.	**Social Value Action Plan Update**	Enclosure	Simon Pearson / Nick Johnson	Approve	10.15-10.30
9.	**Guardian of Safe Working Report**	Enclosure	Kyle Mitchell	Note	10.30-10.45
10.	**Board Sub-Committees:** • **Effectiveness Reviews** • **Terms of Reference** • **Priorities** • **Cycles of Business**	Enclosures	Trevor Hughes	Discussion	10.45-11.05
	CONSENT SECTION				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
11.	**Annual Statutory Declarations**	Enclosure	Trevor Hughes	Approve	
12.	**NED Committee Membership Proposal**	Enclosure	Trevor Hughes	Note	
13.	**Safeguarding Annual Report** (Quality Committee)	Enclosure	Nicky Lucey	Note	
14.	**Corporate Risk Register** (Risk and Audit Committee)	Enclosure	Nicky Lucey	Note	
15.	**Board Assurance Framework** (Risk and Audit Committee)	Enclosure	Nick Johnson	Note	
16.	**Communications Report October 2020 to March 2021**	Enclosure	Nick Johnson	Note	
17.	**Any Other Business**				
	Nil Notified	Verbal	Mark Addison	Note	
18.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 28th July 2021 via MS Teams / Venue to be confirmed.**				

Minutes of a Meeting of the Board of Directors of Dorset County NHS Foundation Trust Held at 08.30am on 31st March 2021 via MS Teams.

Present:		
Mark Addison	MA	Trust Chair *(Chair)*
Sue Atkinson	SA	Non-Executive Director
Margaret Blankson	MB	Non-Executive Director
Paul Goddard	PG	Chief Financial Officer
Judy Gillow	JG	Non-Executive Director
Nick Johnson	NJ	Deputy Chief Executive
Nicky Lucey	NL	Chief Nursing Officer
Ian Metcalfe	IM	Non-Executive Director
Patricia Miller	PM	Chief Executive Officer
Inese Robotham	IR	Chief Operating Officer
Stephen Slough	SS	Chief Information Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Dr George N Davis	GD	Staff Member – Staff Story *(item BoD20/163)*
Dr Julie Doherty	JD	Deputy Medical Director *(Item BoD20/173)*
Emma Hallett	EH	Deputy Director of Workforce
Dawn Harvey	DH	Incoming Chief People Officer
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*

BoD20/163	**STAFF STORY**	**Action**
	PM introduced GD and invited him to recount his experiences of working in DCH and what could be made to make DCH a 'great place to work.' GD advised that he worked as a Surgical Registrar at DCH and had an interest in the wellbeing of ethnic minority staff. He noted that only two members of the Board were from ethnic minority background; a picture reflected nationally. Promoting staff wellbeing and ensuring that staff felt valued at work was an important contributory factor to delivering high quality care. In GD's experience, staff from ethnic minorities were reluctant to raise concerns at work as they had encountered historic poor responses or felt that they were not listen to or acted upon. Training grade medical staff or those from white backgrounds were afforded greater training and development opportunities than Trust grade staff and were less likely to have a focussed appraisal or training / career progression plan. National statistics indicated that non trainee medical staff also experienced a higher degree of bullying and abuse by senior medical colleagues. GD explained that staff from other countries needed support to better understand the UK health system and culture and that their experience gained in other countries could significantly enhance	

	patient care and experience. GD stated that he felt his skills and experience were valued, and that he was hopeful for the future. He welcomed further opportunities for development and career progression for Trust grade doctors and expressed confidence in the Trust's leadership. Large scale change was now required as there had been little change historically. The Board thanked GD for his frank and honest account and supported the need to embrace diversity in order to recruit and retain good staff. GD advised that DCH provided a good level of care for international recruits but that, in order to be the best, further work was necessary to support recruits adapting to the UK system and culture and to provide development and career opportunities for non-training grade staff. The Board noted that staff did not appear to be using available reporting routes to raise their concerns and enquired how reporting could be improved. The threshold for reporting was noted to be high due to previous poor experiences / responses, making staff afraid to report incidents. A personalised / mentorship approach would be helpful in providing staff confidence to speak up. PM noted a recent external review of the Royal College of Surgeons that highlighted significant disparity and reminded the Board that DCH has developed a charter for non-career grade staff and had assigned a consultant to lead the implementation. She acknowledged the need for further work to ensure consultants undertook appraisals, and supported cultural understanding and development to consultant grade for international staff. The need to deliver the cultural shift was imperative. A report on race disparity had been published that morning which would need further consideration in the context of the Inclusive Leadership Programme and clear messaging from the Trust in response. MA thanked GD for recounting his experience and providing the national context. He acknowledged the need for all staff to be treated with kindness and compassion and the need for international recruits to feel welcome when they arrived. These points would be progressed through the cultural development programme and the Equality, Diversity and Inclusion Group.	
BoD20/164	**FORMALITIES**	
	The Chair declared the meeting open and quorate. He welcomed DH, incoming Chief People Officer, who would commence employment with the Trust the following day. Apologies for	

	absence were received from Alastair Hutchison.	
BoD20/165	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the Agenda.	
BoD20/166	**Minutes of the Meeting held on the 25 November 2020**	
	Members of the Board were reminded that the Minutes of the previous Part 1 meeting of the Board (which was held in November, later meetings had been Part Two only due to the pandemic) were taken and approved at the Part 2 meeting of the Board in January 2021.	
	Resolved: that the Minutes had been previously received and approved.	
BoD20/167	**Matters Arising: Action Log**	
	The Action Log had been considered at the Part 2 meeting of the Board in January 2021. There were no other matters arising.	
	Resolved: that there were no matter arising.	
BoD02/168	**CEO Update**	
	PM noted discussion later on the agenda concerning the Staff Survey, WRES Report, the ICS consultation and the Planning Framework. She highlighted the considerable work completed by the Diagnostic Imaging team and offered congratulations for achieving external accreditation of the service. The first meeting of the ED&I Group had been held and the Inclusive Leadership Programme would commence on 14 June 2021. Letters of thanks from PM and MA on behalf of the Board acknowledging the sacrifices made by staff during the pandemic had been well received. In response to a question about the opportunities for the Trust arising from the planning increase in Apprenticeship payments, the Board noted that the Trust would be participating in the 'Kick Start' programme for 16 -24 year olds providing work placements for 46 people. Further opportunities were being explored to support looked after children. MA offered the Board's congratulations to PM for being amongst the Health Service journal's top 50 Chief Executives.	
	Resolved: that the CEO Update be received and noted.	

BoD20/169	**COVID-19 Update**	
	IR reporting that there were currently no COVID positive patients and that elective activity had been maintained despite increased in urgent and emergency care activity. With an international travel ban persisting, the summer was expected to be a busy period. Nationally, the COVID Incident Level reduced to three meaning regional command and control arrangements were now in place and the DCH Incident Management team continued to meet regularly. The Vaccination Hub had commenced the administration of second doses and PPE and oxygen stocks remained good. The focus of work going forward would be on resuming elective activity and maintaining emergency performance.	
	Resolved: that the COVID-19 Update be noted.	
BoD20/170	**Performance Scorecard and Board Sub-Committee March Escalation Reports**	
	The Non-Executive Chairs of the following committees provided feedback from meetings held the previous week; noting: **Workforce Committee** Discussion of staff and patient safety and the continued education and development opportunities for staff during COVID. A deep dive review of the use of agency. A forensic review of staff who not yet received vaccination in order to further promote access. The committee recommended a further focussed discussion on appraisal processes and performance. **Quality Committee** The review of progress on actions arising from the Ockenden report and wider review of Maternity services performance. Discussion of the Health Inequalities paper and impact on the inequalities agenda. The return to normal operation of the committee arrangements. **Finance and Performance Committee** A number of items discussed at the meeting would be considered in Part 2 of the meeting. The Trust was forecasting a financial break even position at year end. Additional income had been received supporting achievement of this position.	

	Risk and Audit Committee Auditors highlighted the deficit underlying position of the Trust following emergence from the COVID financing regime. The Going Concern Statement would be discussed in Part 2 of the meeting. The year-end preparation of the Annual Report and Accounts. The excellent Risk Report which reflected recent discussions regarding managed and tolerated risks. The Score Card included a large number of red rated indicators and the rationale for these was acknowledged. A significant number of referrals for breast cancer services was noted to have placed considerable pressure on the service and increased activity requiring the provision of mutual aid by UHD. With the additional capacity, it was anticipated that the position would be recovered in May 2021. The Board noted the national move towards all cause deterioration monitoring as opposed to sepsis as a single cause from May 2021. Local audits would continue to monitor sepsis performance.	
	Resolved that: the Performance Scorecard and Board Sub-Committee March Escalation Reports be received and noted.	
BoD20/171	**Health Inequalities**	
	The Board noted previous consideration of the paper by the Quality Committee the previous week which provided an update on the DCH programme of work linked to the approach being taken within the ICS. A DCH programme group had been established to develop the work programme and a clinical lead was to be recruited in April 2021. Reporting to the Quality Committee in future, the programme of work aimed to ensure needs based treatment and equity in outcomes and Governor support and engagement would be sought. The compelling narrative within the Tale of Two Babies would be used to raise awareness of the issues amongst staff. In response to a question regarding community engagement, the Board noted that engagement activity had commenced and would be coordinated at system level. It included discussion of a human and community centred approach. Staff would need support to develop the necessary outwardly focussed skill set and the Board considered their development and support needs in delivering the inequalities agenda also.	

	The recently published Planning Guidance did not fundamentally change the DCH approach which focussed on meeting the assessed needs of the local community. Noting this as a priority for the organisation and the scale of the work programme, for which some additional funding support had been received, the Board noted the need to 'change the lens' and embed the approach into daily aspects of the trust's business. The Quality Committee would maintain oversight of the Health Inequalities Strategy and progress would be reported to the Board. MA summarised that the Board endorsed the approach and noted the value of the Tale of Two Babies and the discussion on community engagement. Publication of the Planning Guidance did not impact on the strategy. A Board Development session to support the inequalities agenda would be considered.	
	Resolved that: discussion of the Health Inequalities update be noted.	
BoD20/172	**Recovery Road Map**	
	NJ noted prior discussion of the road map at the Finance and Performance Committee and sought the Board's comments. The paper set out the recovery principles and aims to utilise business as usual structures and governance as far as possible. Whilst there was a focus on staff support and recovery, there was a need to balance this with patient needs and recovery of activity. The framework would be developed and considered in light of the recent planning guidance released and reporting would be undertaken via business as usual reporting and respective Board committees. Recent advances in the use of technology and innovative approaches to care delivery would need to continue along with maximising the learning that could be applied to service redesign from staff from different cultures, having worked in different systems. The Board noted the recovery trajectory expected by the recently released planning guidance in order to access elective recovery funding and the opportunities for collaboration with acute partners to deliver the recovery for local populations. An Elective Care Recovery Board will review how to progress the innovation and collaboration agenda in order to avoid increasing the level of disadvantage experienced by some communities. Clear messaging about the balance between staff recovery and the service recovery imperative would be needed along with closer system working to deliver efficient and effective emergency care in	

	order to support the service recovery programme. MA summarised that the Board endorsed approach set out in the Recovery Road Map and had noted the need to adapt a pragmatic approach to service models and collaborative system working in order to avoid increasing health inequalities. This would need to be supported by clear messaging about staff recovery and service recovery national expectations and cross system improvements in the emergency admissions regime.	
	Resolved that: discussion of Recovery Road Map be noted.	
BoD20/173	**Learning from Deaths Q3 Report**	
	JD joined the meeting for this item and noted prior discussion of the report by the Quality Committee. JD reported that the Trust had sustained and improvements made in the SHMI position and that triangulation with other mortality indices and indices of care had been included within the report. No significant concerns had been identified. The continued improvements in clinical coding and increasing depth of coding were also noted and included the addition of allergy and medicines information within the Digital Patient Record aiding initial diagnosis. Learning and themes emerging from the data had questioned how decisions regarding resuscitation were made. The Mortality Group was subsequently supporting staff to have these difficult discussions with carers and families. Mandatory Basic Life Support training included discussion of all cause deterioration and decisions regarding resuscitation. JG noted improvements in the position from that a year previously and thanked teams for their hard work. Divisional teams would report on action progress and improvements and identify learning that could be shared. A redacted report ensuring patient anonymity would be published on the internet and only redacted versions of the report would be presented to committees and the Board going forward. MA summarised that the Board were pleased with the sustained progress made on SHMI and thanked JD for the report. JD left the meeting	
	Resolved that: discussion of the Learning from Deaths Q3 Report be noted.	
BoD20/174	**Staff Survey Initial Findings**	
	EH noted prior discussion of the report by the People and Culture	

	Committee the previous week. The findings were positive in comparison to other acute sector providers although scores relating to equality, diversity and inclusion had significantly reduced. Recent encouragement to staff to speak up was thought to have contributed to the result. The overall response rate, although slightly higher than the national response rate, was low despite being undertaken by a third party organisation and staff being able to complete the survey electronically or in hard copy form. Some staff had reported a lack of confidence in the anonymity of the survey. A granular breakdown would facilitate triangulation with other sources of data and enable greater scrutiny as some results had not appeared to change over recent years. The 'Happy App' had enabled staff to provide real time feedback on a day to day basis and there were increasing numbers of staff who would recommend the Trust as a place of work or to receive care. The ambition of the Trust was to be in the upper quartile of organisations providing a positive place to work and the importance of ensuring a systematic approach to listening to staff and engagement in order understand how staff were feeling was noted. Cultural development work commencing in June would help to develop leaders to move from transactional management to building positive relationships. MA summarised the Board's anxiety regarding the low survey response rate and need to positively engage with staff in order to improve this. The planned launch of the Leadership Development Programme would facilitate further positive action and further enquiry was needed in order to better understand the staff perspective in order to interpret some results. The programme of work was endorsed and next steps were approved.	
	Resolved that: the discussion of the Staff Survey Initial Findings be noted.	
BoD20/175	**Committee Risk Framework**	
	The Board noted the proposal for its committees to assume greater responsibility for risk assurance within their respective areas of responsibility. Further discussion was planned at a meeting of committee Chairs the following week and would include top rated corporate risks, strategic risks and escalation of risks from committees where these are not able to be mitigated in order to review the risk appetite. The Board endorsed the approach but were cognisant of the cross cutting nature of strategic risks and the need to balance committee	

	work load priorities. • **Board Assurance Framework (BAF)** The Board noted that the BAF had been discussed at the Risk and Audit Committee the previous week and the need to refresh strategic risks in light of the refreshed strategy. • **Corporate Risk Register** NL reported changes to the report in order to aid Board discussions and the inclusion of managed risks. The financial sustainability and Brexit risks were now considered to be managed. The Board noted the BAF and corporate risk register and acknowledged the inclusion of managed or tolerated risks.	
	Resolved that: the Committee Risk Framework be endorsed and the BAF and Corporate Risk Register be noted.	
BoD20/176	**WRES Update**	
	The Board noted the national report from which organisational level data had been shared in July 2020. Key highlights included: • A low response rate from ethnic minority staff; • DCH was in the lower quartile for staff reporting they had experienced bullying or harassment; • A 10% higher proportion of ethnic minority staff would recommend DCH as a place of work; • DCH being in the upper quartile for ethnic minority staff feeling they have opportunities for development – however this finding did not correlate of soft intelligence available. The NHS overall did not appear to be making progress in addressing the findings and national work to develop the WRES survey was noted. MB questioned whether the national report published that morning would impact the Trust's work and result in a loss of momentum. The Board expressed disappointment in the report's message and was concerned about the potential impact this may have on individual staff. The need to reinforce communications to staff about DCH's approach to equality, diversity and inclusion was emphasised. The Board agreed to develop a statement disagreeing with the report which would preferably be signed by individual Board members.	**MA / PM**
	Resolved that: the WRES Update be received and noted.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions	

	were previously raised by Board members prior to the meeting.	
BoD20/177	**Minor and Technical Changes to Provider License Conditions Proposal**	
	Technical changes were noted along with the proposal to extend requirements of the Fit and Proper Persons Test to include Foundation Trust Governors.	
	Resolved that: the Minor and Technical Changes to Provider License Conditions Proposal be noted.	
BoD20/177	**Declarations of Interest Register**	
	Resolved that: the Register of Interests be noted.	
BoD20/177	**Committee Membership Proposal**	
	Resolved that further discussion of the Committee Membership Proposal be had by Non-Executive Directors at their meeting the following week.	**TH**
BoD20/177	**Delegated Authority Request**	
	Request to Delegate Authority to the Risk And Audit Committee to Approve the Annual Report and Accounts on behalf of the Board be approved.	
BoD20/178	**Any Other Business**	
	Consideration is to be given to using Vespasian House to conduct Board meetings once restrictions are lifted.	**TH**
BoD20/179	**Date and Time of Next Meeting**	
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 26th May 2021** via MS Teams	

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Signed by Chair …….. Date ……..

Action Log – Board of Directors Part 1

Presented on: 26th May 2021

Minute	Item	Action	Owner	Timescale	Outcome	Remove ? Y/N
Meeting Dated: 31st March 2021						
BoD20/176	**WRES Update**	The Board agreed to develop a statement disagreeing with the report on race disparities which would preferably be signed by individual Board members.	**MA / PM**	**April 2021**	**Complete.** Statement published.	Yes
BoD20/177	**Committee Membership Proposal**	Further discussion of the Committee Membership Proposal be had by Non-Executive Directors at their meeting the following week.	**TH**	**April 2021**	**Complete.** Further discussion undertaken at NEDs, and final version included in the May Board papers.	Yes
BoD20/178	**AOB**	Consideration is to be given to using Vespasian House to conduct Board meetings once restrictions are lifted.	**TH**	**May 2021**	Not Due	No
Actions from Committees…(Include Date)						

Title of Meeting	**Board of Directors**
Date of Meeting	**26 May 2021**
Report Title	**Chief Executive's Report**
Author	**Natalie Violet, Corporate Business Manager to the CEO**
Responsible Executive	**Patricia Miller, Chief Executive**

Purpose of Report (e.g. for decision, information)
For information.

Summary
This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also included reflections on how the Trust is performing and the key areas of focus.

The key developments nationally are as follows:

- The publication of the 2021/22 priorities and operating planning guidance setting out the priorities for the NHS for the year ahead from NHS England
- The publication of The Report from the Commission on Race and Ethnic Disparities
- The unfolding COVID situation in India
- The publication of a value proposition for Trusts operating in a rural environment from NHS Providers.

In terms of the organisation and its operational focus during the coming year, the priorities are as follows:

- Improvement trajectories agreed for all areas of operational performance that fall below the standard required.
- Maximising the availability of the Elective Recovery Fund to ensure waits for elective care are substantially reduced.
- Reviewing the Trust's investment plan in the context of the Trust's risk appetite statement and the need to manage risk effectively whilst also delivering a financial break-even position at year end and not increasing the underlying deficit.
- Development and delivery of comprehensive workforce plans
- Progression of the Equality, Diversity, and Inclusion Strategy

From a strategic perspective, the upcoming launch of the Trust Strategy and the need to progress the enabling strategies which will be key to the delivery of the strategic aims:

- Clinical Strategy
- People Strategy
- Digital Strategy
- Long-Term Financial Plan

Finally, there are several other developments worthy of noting:

- The launch of two further staff networks
- The closure and success of our COVID vaccination hub
- The successful recruitment of two Consultant Ophthalmologists

Paper Previously Reviewed By Chief Executive	
Strategic Impact For the Board to operate successfully, it must understand the wider strategic and political context.	
Risk Evaluation Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation. The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed.	
Impact on Care Quality Commission Registration and/or Clinical Quality An understanding of the strategic context is a key feature in strategy development and the Well Led domain. Failure to address significant operational risks could lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators.	
Governance Implications (legal, clinical, equality and diversity or other): Failure to address significant strategic and operational risks could lead to regulatory action and significant deterioration in the Trust's performance against the 'Well Led' domain.	
Financial Implications Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided.

Chief Executives Report

Strategic Update

National Perspective

NHS England Chief Executive

It was announced on 29 April 2021 that Sir Simon Stevens will be stepping down as Chief Executive of the NHS from 31 July 2021. This was not unexpected as he had expressed his desire to step down from the role last year. NHS England have advised they are aiming to appoint a successor before Sir Simon steps down.

India and COVID

The news coverage of the awful situation in India, in terms of COVID, is of concern and we have recognised the importance in ensuring our friends and colleagues who have loved ones in India have some additional support. We have encouraged line managers to check on the welfare of colleagues with family in India and we have arranged several supportive drop-in sessions hosted by a clinical psychologist for anyone who may wish to access them.

In addition, our Critical Care Team have buddied with hospitals in India to provide advice on the management of COVID positive patients as we have best practice information we can share.

From a national perspective once more information is available as to how wide spread the Indian variant is in the UK, there is a possibility this may influence the timing of the lifting of the COVID restrictions in full or indeed a return to more localised public health measures.

Local relevance

NHS Operating Framework 2021/22

On 25 March 2021 NHS England published the *2021/22 priorities and operating planning guidance* setting out the priorities for the NHS for the year ahead:

A) Supporting the health and wellbeing of staff and taking action on recruitment and retention
B) Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
C) Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
D) Expanding primary care capacity to improve access, local health outcomes and address health inequalities
E) Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for emergency department patients and reduce length of stay
F) Working collaboratively across systems to deliver on these priorities

With record numbers of people waiting for hospital treatment, systems are expected to plan for the highest level of activity possible. There is a zero tolerance to patients waiting over 104 weeks and there is an expectation to exception report to NHS England and Improvement those patients waiting beyond 78 weeks for treatment.

The Government has made additional funding of £1bn available through the Elective Recovery Fund. The aim is to allow systems to step activity back up and receive additional funding to support this. Systems that achieve activity levels above the required thresholds and meet specified 'gateway criteria will be able to access the Elective Recovery Fund. The required activity thresholds are 70% of 2019/20 activity, rising by 5 percentage points to 85% from July. The thresholds are based on the value of all elective activity delivered in 2019/20, not on activity numbers. The 'gateway criteria' for acute providers include addressing health inequalities, transformation of outpatient services, implementing system-led elective work, tackling the longest waits, and supporting staff.

Locally, our recovery approach focusses on staff and service recovery whilst looking forward and learning from what has been successfully here and elsewhere. The myriad of wellbeing initiatives remains in place across the Trust and will be in place for a long as our people require them. The long-term effects on the mental wellbeing of our people may not come to the fore for many months.

The Report from the Commission on Race and Ethnic Disparities

On 31 March 2021, The Report from the Commission on Race and Ethnic Disparities was published. As a Trust Board we have published a statement to clearly state we disagree with the conclusions outlined in the report. The report denied the lived experiences of members of ethnic minority communities who face racism and discrimination on a daily basis. Within the NHS there is clear evidence through the National Staff Survey and Workforce Race Equality Standard report staff from ethnic minorities have worse experiences at work.

NHS Providers also published a statement following the publication of The Report disagreeing with the conclusions. Saffron Cordery, Deputy Chief Executive at NHS Providers stated, *'whilst some progress has been made, to pretend that discrimination does not exist is damaging as is denying the link between structural racism and wider health inequalities.*' The full statement can be found using the following link: https://nhsproviders.org/news-blogs/news/to-pretend-discrimination-does-not-exist-is-damaging

On 25 May 2021 I will be participating in an NHS Race and Health Observatory Webinar to debate The Report.

Visa Extensions

On 09 April 2021, the Home Office announced a further twelve-month extension for all regulated healthcare professionals across the NHS and the independent sector, this applies to individuals whose visas expire between 01 April 2021 and 30 September 2021. Those benefitting from the extension are helping to relieve pressure on the NHS and protecting the vulnerable.

National Lockdown

There were significant milestones in the roadmap to releasing national lockdown over the past month with the opening of shops, hairdressers, gyms, outdoor eating, and many more from mid-April. Mid-May saw further glimpses of normality with friends and families being able to meet indoors and the return of indoor eating. Locally, we have seen an increase in non-COVID activity resulting in an increased bed occupancy and patients with a delayed discharge despite being medically fit. It is expected the restrictions in international travel will see Dorset having a busier than normal summer which is expected to increase Emergency Department activity.

NHS Providers – Rural Publication

During April, NHS Providers published a value proposition for Trusts operating in a rural environment. It was a pleasure to be asked to write the foreword for this document which highlights the challenges rural Trust's face as healthcare providers in rural areas. It is important to recognise the difficulties including the differences in population demographics, geographical challenges, workforce constraints, digital limitations, and financial implications. The publication also highlights the vital role rural Trusts have as anchor institutions and the positive social and economic benefits this can bring as well as the importance of addressing health inequalities in an integrated and community-focussed way.

DCH Performance

ICS Restructure

The Trust is actively engaged with our health and social care partners across Dorset to design and implement the new Dorset Integrated Care System. The new organisation will absorb the clinical commissioning responsibilities currently undertaken by the CCG from April 2022 and deliver four strategic objectives:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development

'Kick-off' meetings for the relevant workstreams, the ICS Development Programme Delivery Group and ICS Development Steering Board have taken place this month.

Performance

With the easing of lockdown, activity levels in our Emergency Department are back to near-normal levels in April. The organisation's bed occupancy, delayed discharges and trauma demand have increased over the last month. With some restrictions still in place there are concerns activity numbers will increase further once travel, accommodation, and hospitality sectors fully open putting pressure on the hospital and potentially impacting our recovery of elective services. We continue to work with our health and social care partners to improve patient flow within the hospital.

As the Trust progresses its plan to restart and restore services there are a number of areas that now require focus from an operational perspective:

- Improvement trajectories agreed for all areas of operational performance that fall below the standard required.
- Maximising the availability of the Elective Recovery Fund to ensure waits for elective care are substantially reduced.
- Reviewing the Trust's investment plan in the context of the Trust's risk appetite statement and the need to manage risk effectively whilst also delivering a financial break-even position at year end and not increasing the underlying deficit.
- Development and delivery of comprehensive workforce plans
- Progression of the Equality, Diversity, and Inclusion Strategy

From a strategic perspective as we move to launch the Trust Strategy, a number of enabling pieces of work are now required and it is important that the Board sets a timeframe for these to be completed as they are not only key to the delivery of the Trust's strategic aims but also how the Trust engages with the wider Dorset ICS. The enabling pieces of work include:

- Clinical Strategy
- People Strategy
- Digital Strategy
- Long-term Financial Plan

Ophthalmology Consultant Interviews

On 14 April 2021, we had a very successful interview day for our Ophthalmology consultant vacancies. We appointed two outstanding candidates, both with expertise in occuplastics. This will provide robust cross cover arrangements within the subspecialty. This was a fantastic outcome for the service and the patients we serve. I am looking forward to welcoming both successful candidates to the Trust when they commence in a couple of months' time.

Equality, Diversity, and Inclusion

The key work programmes in our Equality, Diversity and Inclusion agenda are progressing with the launch of our Pro-Equity Leadership Programme communicated, the initial introductory sessions taking place on 04 June for the first four cohorts. The first workshops will be taking place later in June with monthly sessions thereafter until December.

Our work with the Executive Team and members of our Diversity Network to review our policies on recruitment, appraisal and succession planning, and staff conduct and disciplinary matters continues. This month's session included members of our People Team as we move to take action to amend the policies using the information and ideas gathered from previous sessions. A further session is scheduled in June.

During May's Equality, Diversity, and Inclusion Steering Group we had an interactive session looking at the Trust's proposed Equality, Diversity, and Inclusion Strategy. The steering group felt it was more appropriate to use the draft strategy as a framework. This decision was based on the Staff Networks being in their infancy and not yet having the opportunity to contribute and inform the strategy and upcoming refresh of the Trust's People Strategy. Through the People Strategy engagement, we will be able to understand more about the direction of the Equality, Diversity, and Inclusion Strategy.

Staff Networks

Our LGBTQI+ and Disability and Long-Term Health Conditions Networks launched this month with drop-in meetings taking place. Dawn Harvey will be the executive sponsor the Disability and Long-Term Health Conditions Network. The development of formal terms of reference are underway with all three of our Network chairs attending our Equality, Diversity, and Inclusion Steering Group to provide updates and any escalations.

Staff Governor Elections

The Governor Elections 2021 are now open for staff member nominations. We have four staff governor roles, with a term of three-years, who have an important role to play, ensuring that the views and opinions of the staff are represent are heard by the Trust Board and Council of Governors.

Decontamination Services Accreditation

Earlier this month our Decontamination Services underwent an external audit by the Notified Body in order to maintain accreditation. The auditor found zero non-conformities to report and confirmed our processes meet all regulatory requirements. The feedback received from the auditor was very positive, praising our staff and site. I am proud of the team and this recognition demonstrates their dedication and hard work.

Vaccination

On 30 April 2021, the hospital's vaccination hub closed its doors following a successful vaccination programme. We have seen very promising vaccination figures with approximately 25,000 vaccinations delivered to health and care staff from across Dorset. 7,000 of these were to Trust staff with 88% of our staff receiving at least one dose. This would not have been possible without the commitment and dedication of staff who went above and beyond. Vaccinations are now being provided for new staff and any second doses by the Mid-Dorset Primary Care Network who are running a vaccination centre at the Atrium Health Centre in Dorchester.

South West Greener NHS Programme

This month we met with the NHS Regional Director for Public Health England to discuss the South West Greener NHS Programme including Dorset. The Greener NHS Programme aims to work with staff, hospitals, and partners, building on great work being done by Trust's across the country. Sharing ideas on how to reduce the impact on public health and the environment, saving money and reaching net carbon zero. This forms an important part of our social value work, our pledge to be greener and sustainable. We have a vital role in improving our sustainability and contribute to better health and wellbeing of our local community.

Education Quality Review Meeting

On 29 April 2021, the Trust had an Education Quality Review Meeting with Health Education England (HEE) to discuss the current strategic issues affecting both the Trust and HEE and how we can work in partnership. It was a constructive discussion and the feedback received was very positive. This would not have been possible without the hard work and dedication of the teams across the hospital supporting our trainees, particularly the Education Team.

Patricia Miller
Chief Executive
19th May 2021

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**26 May 2021**
Document Title:	**Performance Scorecard and Board Sub-Committee Escalation Reports**
Responsible Director:	**Executive Team**
Author:	**Liz Beardsall, Deputy Trust Secretary**

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee (performance metrics)	18 May 2021	See committee escalations

Purpose of the Paper	To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance Scorecard** Key areas for operational standards in April 2021: The Trust did meet the standard for: • The total waiting list size • All Cancers - 31 Day Diagnosis to First Treatment • All Cancers - 31 Day Subsequent Treatment (Radiotherapy/Other) • All Cancers - 31 Day Subsequent Treatment (Anti-Cancer Drugs) The Trust did not meet the standards for: • Zero 52 week waits • Zero 104 week waits • RTT • Diagnostic Waiting Times • ED, DCH only and Combined with MIU • All Cancers - 62 Day Referral to Treatment following an urgent GP referral • Two week wait from referral to first seen • Breast Symptomatic Two Week Wait from urgent GP referral to first seen • All Cancers - 31 Day Subsequent Treatment (Surgery) Cancer performance for April 2021 will not be confirmed for a further 6 weeks as the shared breaches with external partners will be applied and agreed by NHSE. Looking forward to May 2021, it is anticipated that DCH will: Meet the following standards: • Cancer 31 days (all)							

	DCH will not meet the standard in April for: • RTT • The RTT waiting list size trajectory • Diagnostic Waiting Times • ED – 4 hour standard combined with MIU • Cancer 62 day standard • Cancer two week wait standard • Cancer Breast symptomatic 2 week wait • Zero 52 week waits • Zero 104 week waits **Escalation Reports** The March Board sub-committees met as follows: Monday 17 May: People and Culture Committee Tuesday 18 May: Quality Committee, Finance and Performance Committee, Risk and Audit Committee. The attached reports detail the significant risks and issues for escalation to Board for action, key issues discussed, decisions made, implications for the Corporate Risk Register and Board Assurance Framework (BAF), and items for referral to other committees, arising from each of the Board sub-committee meetings.
Action recommended	The Board of Directors is requested to: 1. **NOTE** the performance data 2. **NOTE** the escalations from the Board sub-committees.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	N	
Impacts Strategic Objectives?	Y	Operational performance and corporate governance underpins all aspects of the Trust's strategic objectives.
Risk?	Y	Implications for the Corporate Risk Register or the Board Assurance Framework (BAF) are outlined in the escalation reports.
Decision to be made?	N	Details of decisions made are outlined in the committee escalation reports.
Impacts CQC Standards?	Y	Operational performance and governance underpins all aspects of the CQC standards.
Impacts Social Value ambitions?	Y	Operational performance and corporate governance underpins all aspects of the Trust's social value ambitions.
Equality Impact Assessment?	N	N/A
Quality Impact Assessment?	N	N/A

Metric	Threshold/ Standard	Type of Standard	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Movement on Previous Period	12 Month Trend
Safe											
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	**1 (0.1)**	0 (0.0)	↑	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	Contractual (National Quality Requirement) 2019/20	0 (0.0)	3 (0.4)	2 (0.3)	1 (0.1)	2 (0.3)	4 (0.5)	**3 (0.4)**	↑	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	2	0	0	0	2	0	0	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	1	0	0	0	0	0	0	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	**N/A**	
NRLS - Number of patient safety risk events reported resulting in severe harm or death	**10% reduction 2016/17 = 21.6 (1.8 per mth)**	Local Plan	0	0	**4**	**2**	**2**	1	**2**	↓	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	**1 (0.1)**	**1 (0.1)**	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	2 (0.3)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	↔	
Emergency caesarean section rate			16.4%	27.5%	20.5%	19.5%	20.9%	22.3%	20.1%	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**88.9%**	90.0%	100%	100%	96.0%	95.1%	N/A	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	97.1%	90.0%	96.4%	**82.1%**	95.7%	95.7%	95.8%	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**68.0%**	91.3%	**75.0%**	**77.3%**	**57.9%**	**82.1%**	N/A	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	92.9%	96.3%	95.8%	**85.7%**	**84.2%**	94.6%	**84.2%**	↓	
Effective											
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	2	2	2	N/A	N/A	N/A	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.14 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	1.10	1.10	1.12	N/A	N/A	N/A	N/A	↓	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**105.9**	**104.3**	**107.8**	**115.7**	N/A	N/A	N/A	↓	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**108.4**	**105.6**	**110.2**	**114.9**	N/A	N/A	N/A	↓	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	**49.8%**	**42.0%**	**57.7%**	**65.9%**	**70.5%**	**54.5%**	**59.8%**	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	**89.5%**	100.0%	100.0%	100.0%	97.5%	100.0%	↑	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	Contractual (Local Quality Requirement)	**86.1%**	**73.3%**	**83.3%**	**75.0%**	**88.0%**	**60.6%**	**83.3%**	↑	
Caring											
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	27	34	33	18	22	38	21	↑	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	**94.2%**	**94.9%**	**89.1%**	96.9%	**94.6%**	**94.9%**	**94.5%**	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	89.1%	89.9%	87.8%	95.7%	89.7%	90.1%	88.0%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**93.1%**	95.2%	**93.6%**	94.8%	**93.3%**	**94.6%**	**93.0%**	↓	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**5**	**9**	**6**	N/A	N/A	N/A	N/A	↓	

Metric	Threshold/ Standard	Type of Standard	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Movement on Previous Period	12 Month Trend
Responsive											
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position)	**92%**	Contractual (National Operational Standard)	**49.4%**	**52.1%**	**53.3%**	**51.3%**	**50.5%**	**50.9%**	**51.5%**	↑	
RTT Incomplete Pathway Waiting List size	**17,274**		15,659	16,038	16,251	16,110	16,162	16,853	17,194	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**57.2%**	**65.4%**	**73.1%**	**61.7%**	**76.0%**	**79.1%**	**68.5%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**14.3%**	**9.1%**	**0.0%**	**21.4%**	**27.5%**	**29.3%**	**0.0%**	↓	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	98.7%	98.2%	97.9%	97.9%	**93.1%**	97.7%	96.5%	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**71.4%**	100.0%	**77.8%**	100.0%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	100.0%	-	-	-	-	-	100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**73.0%**	**76.1%**	**71.4%**	**75.7%**	**67.7%**	**83.9%**	**82.5%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**57.1%**	**33.3%**	100.0%	**76.9%**	100.0%	**71.4%**	**60.0%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**66.1%**	**72.8%**	**73.6%**	**75.9%**	**82.5%**	**79.9%**	**80.0%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**86.2%**	**90.6%**	**84.2%**	**78.8%**	**79.2%**	**81.0%**	**80.7%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	Contractual (National Operational Standard)	**91.8%**	**94.1%**	**90.2%**	**87.3%**	**88.5%**	**90.3%**	**86.6%**	↓	
Well Led											
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	**3.55%**	**3.50%**	**3.29%**	**4.89%**	**4.03%**	**3.13%**	N/A	↑	
Appraisal rate	**90%**	Internal Standard reported to FPC	**74%**	**76%**	**77%**	**76%**	**76%**	**76%**	**77%**	↑	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.85%	8.6%	8.4%	8.23%	7.7%	7.7%	7.7%	↑	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,599.7	2,663.5	2630.9	2,644.2	2,720.6	2,781.5	2,798.5	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**7.2%**	**6.4%**	**6.4%**	**6.4%**	**5.7%**	**6.4%**	**6.6%**	↓	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**10,338.4**	**10,628.8**	**10,415.30**	**10,703.0**	**10,978.2**	**18,872.1**	**11,215.1**	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	0	0	0	↔	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**87%**	**87%**	**88%**	**87%**	**87%**	**88%**	**87%**	↓	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,135**	**2,212**	**2,149**	**1,904**	**1,865**	**2,434**	**2,010**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£1,985,199**	**£2,108,025**	**£2,004,285**	**£1,524,140**	**£1,468,667**	**£2,207,635**	**£1,902,370**	↓	
Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M1 = Breakeven**	Local Plan	(999)	(891)	(1,901)	(2,055)	(805)	387	(502)	**N/A**	**N/A**
Cash Balance	**2021/22 - M1 =**		24,590	24,589	24,134	25,648	29,286	17,698	17,900	↑	
CIP - year to date (aggressive cost reduction plans)	**No target for the first qtr of the year**	Local Plan	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	N/A	**N/A**	**N/A**
Agency spend YTD	**2021/22 = No Annual value YTD M1 = 1,031**		**5,458**	6,358	7,199	8,117	8,985	**1,398**	**1,031**	**N/A**	**N/A**
Agency % of pay expenditure			**6.4%**	**6.6%**	6.6%	6.7%	6.7%	6.7%	7.9%	↓	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Mar-21	Apr-21
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	**0**	**1 (0.1)**	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	**50% reduction by 2023**	2 (0.3)	3 (0.4)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	**4 (0.5)**	**3 (0.4)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	1	0
	SHMI - Rolling 12 months, 4 months in arrears (Oct-19 to Sep-20)	**<1.14**	1.12	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Nov-19 to Oct-20)	**100**	**115.7**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**50.9%**	**51.5%**
	RTT Incomplete Pathway Waiting List size	**17,274**	16,853	17,194
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**83.9%**	**82.5%**
	Maximum 6 week wait for diagnostic tests	**99%**	**79.9%**	**80.0%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**90.3%**	**86.6%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,207,635**	**1,902,370**
	Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M1 = Breakeven**	387	**(502)**
	CIP - year to date (aggressive cost reduction plans)	**No target for the first qtr of the year**	Yet to be decided	N/A
	Agency spend YTD	**2021/22 = No Annual value YTD M1 = 1,031**	**1,398**	**1,031**

Rating Key

Escalation Report

Executive / Committee: People and Culture Committee (formerly Workforce Committee)

Date of Meeting: 17th May 2021

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• A very positive report had been received from Health Education England following their annual review • The Equality, Diversity and Inclusion Strategy would be presented at a later point in the year Autumn) in order to enable greater input from the newly established staff networks and alignment with the developing People and Clinical strategies.
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • Workforce Performance Report • Appraisal and Succession Planning • Education Bi-monthly Update • Divisional Bi-monthly Update – Urgent and Integrated Care Division • Estates and facilities Quarterly Update • Quarterly Freedom to Speak Up Report • Maternity Safe Staffing Bid and changes to the bid • There were no 'Red Flag' safe staffing incidents
Decisions made by the Committee	The Committee approved the • Terms of Reference and Work Plan noting that further work was in process to develop these further in line with the developing People and Equality, Diversity and Inclusion strategies
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None
Items / issues for referral to other Committees	• None

Escalation Report

Committee: Quality Committee

Date of Meeting: 18th May 2021

Presented by: Judy Gillow/Nicky Lucey

Significant risks / issues for escalation to Committee / Board for action	• Stroke unit capacity impacted by increasing stroke prevalence and social distancing requirements. • Mental health capacity for adults and young people; particularly tier 4 • Mortality Report noting the outlying position of the Trust in respect to pressure ulcers in Dr Foster data

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting
	  ○ Changing profile of the waiting list and forecast
	• Maternity Safety Update and Ockenden action plan.
	• Divisional Exceptions
	  ○ Urgent and Integrated Care Division
	  ○ Family and Surgical Services Division
	• Learning from Deaths Quarter 4 Report
	• Transformation and Improvement Quarterly Report noting significant support to various work streams
	• Sub-Committee Minutes and Escalation Reports
	  ○ Safeguarding Group including Annual Report

Decisions made by the Committee	The committee approved; • Terms of Reference • Priorities • Work Plan
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None
Items / issues for referral to other Committees	• None

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 18th May 2021

Presented by: Stephen Tilton

Significant risks / issues for escalation to Board for action	• Increasing numbers of patients with 'no reason to reside' was noted • The changing profile of the waiting list with a high proportion of patients waiting over 52 weeks for treatment predicted

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• COVID Performance Update
	• Performance Report noting the issues above
	• COVID finance Update
	• Elective Recovery Plan three programmes of work
	  ○ Patient contact validation
	  ○ Effective use of resources: returning to business as usual
	  ○ Outpatient Reset and Digitisation
	• Finance Report including H1 Plan
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care
	  ○ Family Services and Surgical
	• ED15 Bi-monthly Update
	• DCH Subco Quarter 4 Report

Decisions made by the Committee	The following items were approved by the committee: • DCH Subco Q4 Report • Climate Change Adaptation Plan • Committee Terms of Reference, Priorities and Work Plan
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Risks to the delivery of activity volumes in order to access Elective Recovery Fund – outpatient and theatre capacity and reliance on third party capacity • Lack of contingency regarding 2021/22 Capital programme
Items / issues for referral to other Committees	• Joint oversight of the waiting list with Quality Committee

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 18th May 2021

Presented by: Ian Metcalfe

Significant risks / issues for escalation to Board for action	• Inclusion of an increasing number of delayed discharge of complex paediatric patients on the Corporate Risk Register • Limited Internal Audit assurance on validation of the waiting list Internal Audit • Head of Internal Audit Opinion on the overall systems of Internal Control provided Moderate Assurance. • Health inequalities to be included in the future scope of internal audits.
Key issues / other matters discussed by the Committee	The committee received and noted the following reports: • Internal Audit Progress Report • Internal Audit report - Clinical Validation of the Waiting List • Internal Audit Annual Report • Head of Internal Audit Opinion • Corporate Risk Register • Board Assurance Framework • Clinical Audit Assurance Report • SIRO report 2020/21

Decisions made by the Committee	• The committee approved the following:
	• Draft DCHFT Annual Report and Audited Accounts 2020/21 including
	  ○ Annual Governance Statement
	  ○ Accounting Officer's Statement of Responsibility
	  ○ Draft External Auditors opinion
	  ○ External Auditors' Audit Letter of Representation and ISO 260 Report
	• Losses and Special Payments
	• Committee Terms of Reference, Priorities and Work Plan

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Further planned review of the Board Assurance Framework and alignment to the refreshed strategy was noted.
Items / issues for referral to other Committees	• Monitoring progress of clinical audit • To note the actions required in the Internal Audit Report regarding the validation of waiting lists.

Meeting Title:	Board of Directors
Date of Meeting:	26 May 2021
Document Title:	**Recovery Overview**
Responsible Director:	Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships
Author:	Natalie Violet, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Patricia Miller, Chief Executive		
Dawn Harvey, Chief People Officer		
Inese Robotham, Chief Operating Officer		

Purpose of the Paper	The purpose of the report is to provide the Trust Board with an overview and seek approval of the proposed approach to recovery following the COVID-19 pandemic. Following approval by the Board trajectories will be provided at the next meeting. Monitoring will take place through the integrated performance report and the reporting presented to the sub-committees.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The organisations recovery priority is twofold – our NHS people and clinical services. The approach is in line with the national 2021/22 Priorities and Operational Planning Guidance, published on 25 March 2021. The key objectives of the recovery programme are: Our NHS People • To establish and embed a range of offers which will provide ongoing recovery and wellbeing support to staff which prioritise retention • To manage the balance between staff recovery and wellbeing and service recovery to meet both staff and patient needs Clinical Services • To do as much as we can with what we have and by working with system partners • To minimise harm and prioritise care based on clinical need • To embed equity in health outcomes into restart processes • To take the innovations from Covid and use them as platform for service delivery going forward and to share and spread learning and best practice Following approval by the Board trajectories will be provided at the next Trust Board meeting. Monitoring will take place through the integrate performance report and the reporting presented to the sub-committees.							
Action recommended	The Trust Board is recommended to **approve** the proposed approach to recovery following the COVID-19 pandemic.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to produce a robust recovery framework could result in further deterioration of standards and impact the achievement of ERF. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus.
Financial	Y	Failure to produce a robust recovery framework could result in further deterioration of standards and impact the achievement of ERF. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus.
Impacts Strategic Objectives?	Y	Delivery of outstanding care. Significant impact on patient and staff experience and reputation of poor performance with commissioners, regulators, and the public.
Risk?	Y	The clinical impact of COVID-19 on planned care and patients that are not clinically urgent is not understood yet, but a clinical risk stratification programme is in development, which follows the nationally published guidelines. Harm cannot be determined until the patient is seen.
Decision to be made?	Y	To seek approval of the proposed approach to recovery following the COVID-19 pandemic. Following approval by the Board trajectories will be provided at the next Trust Board meeting. Monitoring will take place through the integrated performance report and the reporting presented to the sub-committees.
Impacts CQC Standards?	Y	Ensuring a robust recovery framework is produce links with the CQC well-led domain.
Impacts Social Value ambitions?	N	N/A
Equality Impact Assessment?	N	N/A
Quality Impact Assessment?	N	N/A

Recovery Overview

1.0 Purpose

The purpose of the report is to provide the Trust Board with an overview and seek approval of the proposed approach to recovery following the COVID-19 pandemic. Following approval by the Board trajectories will be provided at the next Trust Board meeting. Monitoring will take place through the integrated performance report and the reporting presented to the sub-committees.

2.0 Recovery Framework

The organisation's priority following the COVID-19 pandemic is the recovery and wellbeing of its people. The priority is twofold, our NHS people and clinical services. The approach focuses on staff and service recovery whilst looking forward and learning from the innovations implemented during the pandemic and also recognising full recovery will be a long-term process. Staff and services experienced different pandemics and therefore recovery must be variable across the organisation. For staff in particular the emotional and psychological recovery will be a very individual experience and their needs may not become apparent for some time.

With regard to clinical services, the principle aim is to ensure that recovery is delivered in a sustainable way. This will require an understanding of what element of the current backlog relates solely to COVID and what element relates to recurrent increases in demand.

The key objectives of the recovery programme are:

Our NHS People

- To establish and embed a range of offers which will provide ongoing recovery and wellbeing support to staff which prioritise retention
- To manage the balance between staff recovery and wellbeing and service recovery to meet both staff and patient needs

Clinical Services

- To do as much as we can with what we have and by working with system partners
- To minimise harm and prioritise care based on clinical need
- To embed equity in health outcomes into restart processes
- To take the innovations from Covid and use them as platform for service delivery going forward and to share and spread learning and best practice

The organisation's Recovery Framework is in line with the 2021/22 Priorities and Operational Planning Guidance, published on 25 March 2021. The national priorities are:

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
F. Working collaboratively across systems to deliver these priorities

3.0 Operational Focus

The organisation's operational priorities for 2021/22 should focus on the following:

- Improvement trajectories agreed for all areas of operational performance that fall below the standard required
- Maximising the availability of the Elective Recovery Fund to ensure waits for elective care are substantially reduced
- Reviewing the Trust's investment plan in the context of the Trust's risk appetite statement and the need to manage risk effectively whilst also delivering a financial break-even position at year end and not increasing the underlying deficit
- Development and delivery of comprehensive workforce plans
- Progression of the Equality, Diversity, and Inclusion Strategy

4.0 Performance

The organisation's Operational Recovery for Elective Care was launched this month, with a fortnightly Elective Performance Management Group (EPMG) meeting and supporting workstreams. The supporting workstreams include Patient Contact Validation, Effective Management of Resources: Returning to Business as Normal and Outpatient Reset and Digitalisation.

EPMG will be responsible for elective recovery oversight, performance monitoring and management, activity management and recovery (ERF), waiting list oversight and performance management and addressing waiting list health inequalities, with a particular focus on ethnicity and deprivation. From a governance and assurance point of view EPMG will report into the Finance and Performance Committee.

A presentation detailing this structure was presented to the Committee this month. The presentation can be found in Appendix A.

5.0 People Recovery

The organisation is working towards a triangulated and people centred approach to its people reporting to the People and Culture Committee. This will see the organisation move away from its traditional transactional approach.

From July onwards the measures included in reports will be 'softer' which will demonstrate and allow understanding of organisational culture, what it is like to work within the organisation, to be able to understand the mood and themes around experience; to act as a 'cultural barometer'. Included in this reporting will be metrics showing how the workforce is recovering from the effects and how the impact of the pandemic to be monitored.

As part of this work the Divisional reporting will also be reviewed to move away from transactional reporting. This review will include how the Divisions are monitored from a people perspective at the monthly Divisional performance meetings and the introduction of quarterly trajectories of improvement.

It is important to note, from quarter 2 all Trusts are expected to recommence the quarterly staff survey. The approach of this survey will be focused on three dimensions of engagement; motivation, involvement, and advocacy. The test will encompass nine questions:

Motivation:

1. I often/always look forward to going to work
2. I am often/always enthusiastic about my job
3. Time often/always passes quickly when I am working

Involvement:

4. There are frequent opportunities for me to show initiative in my role

5. I am able to make suggestions to improve the work of my team/department
6. I am able to make improvements happen in my area of work

Advocacy:

7. Care of patients/service users is my organisation's top priority
8. I would recommend my organisation as a place to work
9. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

This quarterly staff survey will support our new approach to reporting and results and themes will be reported to the People and Culture Committee.

6.0 Conclusion and Next Steps

It is clear there is work underway to deliver significant transformation and innovation to deliver services differently and achieve our recovery objectives.

Following approval by the Board trajectories will be provided at the next Trust Board meeting. Monitoring will take place through the integrate performance report and the reporting presented to the sub-committees.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Operational Recovery- Elective care at DCH

Financial year 2021/22

Outstanding care for people in ways which matter to them

Programme Governance

DCH: Finance and Performance Committee (Sub-Board committee)
System: ECOG, SLT, OFRG

Governance reporting direction

Elective Performance Management Group (EPMG), meets fortnightly

- Elective recovery oversight
- Performance monitoring and management
- Activity management and recovery (ERF)
- Waiting list oversight and performance management
- DM01, Cancer and RTT performance KPIs
- Address waiting list health inequalities, with a particular focus on ethnicity and deprivation

EPMG

Exec sponsor: Chief Operating Officer

Chair: Associate Director of Performance

Work streams

1) Patient Contact Validation

- Clinically led validation of all W/L
- Contacting all patients to confirm place on W/L
- Shared decision making with patient and clinician about next steps
- Effective & regular communication with patients
- Robust technical validation processes- refresh

2) Effective management of resources: Returning to BAU

- PTL management
- Theatre efficiency and 6-4-2
- Move to a 3 theatre list day
- Clinic utilisation, incl. PAU
- Patient Access training
- Clinic room utilisation
- Workforce resource analysis
- Outsourcing & Insourcing

3) Outpatient Reset and Digitalisation

- Online referral management
- Increasing A&G via e-RS
- PIFU
- Virtual offer and reporting activity
- Digital clinic outcome forms
- Speech recognition
- Centralisation of follow up booking
- Move to a 3 clinic session day

2021/22 priorities and operational planning guidance

The 2021/22 priorities and operational planning guidance, sets out a number of key actions. Where these actions are for providers to individually complete, they are included within this recovery plan.

2021/22 priorities and operational planning guidance- Section C1, C2 and ERF gateways (where operational)	Work streams
Prioritise the clinically most urgent patients, e.g. for cancer and P1/P2 surgical treatments	2
Incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk (drawing on both primary and secondary care)	1
Include actions to maintain effective communication with patients including proactively reaching out to those who are clinically vulnerable. Shared decision making and treatment reviews between patients and clinicians, keeping waiting patients informed of next steps in their treatment, including discussion of alternative treatment options	1
Maintaining waiting list data quality, detailed validation of the weekly Waiting List Minimum Dataset (MDS) uploads, to ensure waiting list data are complete and accurate	1
Address the longest waiters and ensure health Inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation	EPMG
Return to pre-COVID activity levels and beyond. Thresholds, as a percentage of the value of the 2019/20 activity: • 70% for April 2021 • 75% for May 2021 • 80% for June 2021 • then 85% from July to September 2021	2
Recovery of diagnostic activity volumes to the highest possible levels; particularly to support elective recovery	2

2021/22 priorities and operational planning guidance

The 2021/22 priorities and operational planning guidance, sets out a number of key actions. Where these actions are for providers to individually complete, they are included within this recovery plan.

2021/22 priorities and operational planning guidance- Section C1, C2 and ERF gateways (where operational)	Work streams
Return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower)	2
Meet the new Faster Diagnosis Standard from Q3, to be introduced initially at a level of 75%.	2
Avoid outpatient attendances of low clinical value. Increased mobilisation of Advice & Guidance and Patient Initiated Follow Up services. Where outpatient attendances are clinically necessary, at least 25% should be delivered remotely by telephone or video consultation (equivalent to c.40% of outpatient appointments that don't involve a procedure	3
Introducing Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider; including personalised stratified follow up for cancer patients, avoiding unnecessary follow up attendances, and providing faster access to follow up appointments where clinically necessary	3
Collaborating across primary and secondary care to treat more patients without the need for an onward referral, including increasing the uptake of Advice and Guidance or other measures such as referral triage to avoid unnecessary first attendances	3
Create clear accountability for elective recovery	EPMG
Evidence of common tracking of waiting lists; clinical review and prioritisation; dynamic planning of elective capacity and shared capacity, demand and monitoring data	2

ERF forecast- finance

ERF is based is calculated at HRG level to ensure case mix is comparable to 2019/20 and not volume of activity.

Income type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
IP	1,989,478	2,452,078	2,347,278	2,776,878	2,672,078	3,101,678
OP Procs	285,840	271,548	314,425	314,425	314,425	314,425
OPS	1,840,987	1,758,938	2,035,086	2,055,086	2,059,086	2,059,086
Total	4,116,305	4,482,564	4,696,789	5,146,389	5,045,589	5,475,189
% delivered Vs 2019/20	86%	96%	85%	100%	107%	108%
ERF premium payment @ 100%	719,286	466,596	251,295	-	-	-
ERF premium payment @ 120%	48,421	619,799	-	929,573	1,227,619	1,383,594
Total ERF premium forecast	**767,707**	**1,086,395**	**251,295**	**929,573**	**1,227,619**	**1,383,594**

Total additonal income via ERF	**5,646,183**

ERF forecast- activity

ERF is based is calculated at HRG level to ensure case mix is comparable to 2019/20 and not volume of activity. To ensure we monitor the impact on waiting lists, DCH will also be monitoring activity levels.

ERF Monitoring - actuals											
						NHSI Plan					
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Day Case	2,025	2,149	2,063	2,141	1,846	2,079	2,140	2,296	1,858	2,152	1,879
Elective	239	286	282	255	254	245	288	272	203	233	280
Outpatient Procedures	2,764	3,091	2,777	3,321	2,711	2,849	3,191	2,712	2,817	3,006	2,756
OPs	18,254	19,637	18,502	20,738	18,473	18,728	20,542	19,094	15,830	19,831	17,893
						Actuals					
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Day Case	1,805										
Elective	205										
Outpatient Procedures	2,216										
OPs	18,392										
	22,618	-	-	-	-	-	-	-	-	-	-
Day Case	89%										
Elective	86%										
Outpatient Procedures	80%										
OPs	101%										

ERF forecast includes

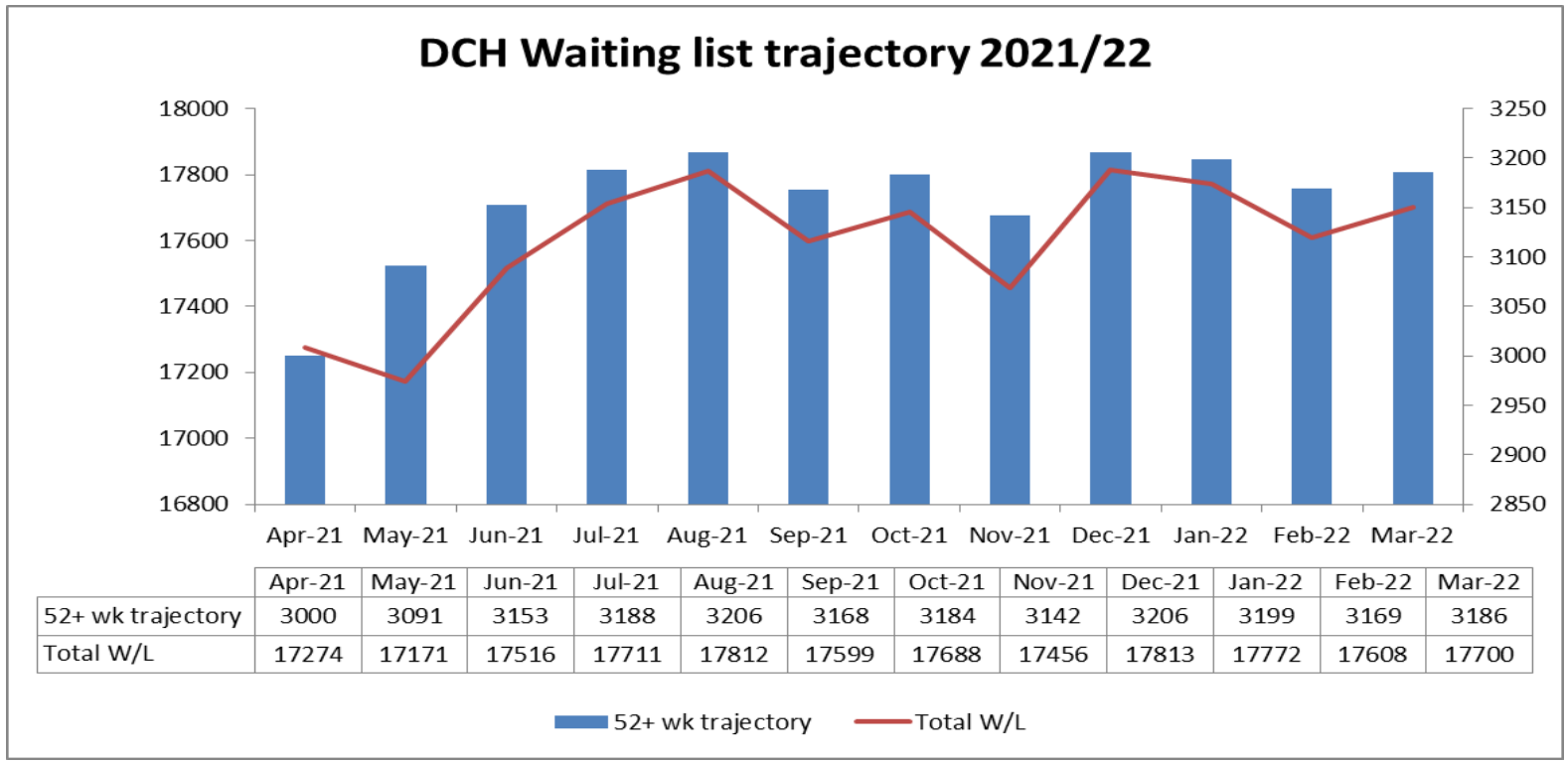
The ERF Forecast is inclusive of all outsourcing and insourcing plans, where the activity is counted by DCH. This includes the following, April to September:

- Orthopaedic activity sub-contracted to New Hall
- Orthopaedic insourcing
- Gynaecology insourcing
- Urology insourcing
- OMF insourcing
- ENT insourcing
- Ophthalmology

Outsourcing activity, via inter-provider transfer is not counted as DCH activity and is therefore not in the ERF forecasts. This includes:

- Outsourcing orthopaedic activity to Circle (Winterbourne) and Ramsay (New Hall). There are two contracts for Ramsey, one that is owned by the CCG and non DCH counted activity and a sub-contract that is owned by DCH.

Waiting list performance



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
52+ wk trajectory	3000	3091	3153	3188	3206	3168	3184	3142	3206	3199	3169	3186
Total W/L	17274	17171	17516	17711	17812	17599	17688	17456	17813	17772	17608	17700

Achievement of the 2021/22 planning guidance will not deliver a reduction in 52+ week waiters or a reduction in waiting list size.

Risks to delivery

- Prevalence of COVID and future waves
- H2 financial regime
- Staffing levels
- Non-elective demand
- Reliance of third party providers (insourcing and outsourcing)
- Outpatient clinic room capacity

Meeting Title:	Trust Board Meeting
Date of Meeting:	26th May 2021
Document Title:	**Strategy Refresh: Your Future Hospital - 2025**
Responsible Director:	Nick Johnson – Deputy CEO
Author:	Ciara Darley – Transformation Programme Manager

Confidentiality:	Not Confidential
Publishable under FOI?	Yes/~~No~~

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Various iterations at EMT, SMT, DMT and other forums	Nov 20 – May 21	

Purpose of the Paper								
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The Trust Strategy has been refreshed following a comprehensive engagement approach consisting of three stages; Discover, Design and Develop. It describes the journey DCH must take to providing outstanding care for people in ways which matter to them and is based on the recognition that improvements must be made to provide the very best care for local communities. Currently demand is outweighing capacity, and this is felt by staff, patients and the local population. Now is the right time to refresh the strategic focus to guide the Trust's priorities and decisions over the next five years. The Strategy proposes three Strategic themes: People: This theme will see us putting our people first to make DCH a great place to work and receive care. Place: The Place theme will see us delivering outstanding care by building a better and healthier place for our patients and population. Partnership: Partnership is about working together to ensure outstanding services, accessible to our patients and population. Approval of the Strategy will allow detailed planning to commence, including further engagement with departments to help embed the strategy. Approval will also trigger the reinstatement of the Transformation Senior Management Team Meeting (SMT) to oversee and monitor implementation. In addition, work within the Communications Team will start to develop designed Strategy materials to be circulated with staff and published on the Trust website.							
Action recommended	The Committee is recommended to **APPROVE** the update.							

Governance and Compliance Obligations

Legal / Regulatory	~~Y~~/N	
Financial	~~Y~~/N	*Not directly*
Impacts Strategic Objectives?	Y/~~N~~	Proposal to update current Strategic Objectives as part of the refresh. Positive impact to reflect future direction of Trust.
Risk?	~~Y~~/N	*Not directly – strategic risks will be developed as part of refreshed BAF*
Decision to be made?	~~Y~~/N	
Impacts CQC Standards?	~~Y~~/N	*Not directly*
Impacts Social Value ambitions?	~~Y~~/N	*Embeds SV ambitions as part of Trust Strategy and aligns to SV Pledge*
Equality Impact Assessment?	~~Y~~/N	*EIAs for any key strategic programmes and initiatives arising*
Quality Impact Assessment?	~~Y~~/N	*QIA for any key strategic programmes and initiatives arising from the strategy*

Your Future Hospital

Dorset County Hospital NHS FT

Trust Strategy 2025

1. Introduction

Who are we?

At Dorset County Hospital, it is our staff who make our Trust - we are 3,500 individuals from over 80 different countries, working together for one common purpose; to provide outstanding, compassionate care for our local population.

We are a relatively small hospital with under 400 beds, but our significance to the local community is great. We are the main provider of high quality acute and specialist services for approximately 250,000 people residing towards the west of Dorset. We provide a range of district general services including urgent and emergency care, planned and specialist care, maternity and paediatric services and care for long-term conditions, frailty and end of life care.

In the pages that follow, this Strategy explains that the context we are working within is changing and therefore we must change too. NHS England have set out their long term vision for tacking the top health challenges within the country and encourages local systems and organisations to now come up with their own strategies to outline what this means locally. We know things must change in Dorset, currently demand is outweighing capacity and this is felt by our staff, patients and local population. Now is the right time to refresh our strategic focus to guide our priorities and decisions over the next five years.

How have we engaged?

Refreshing the Strategy brought forward an opportunity to gain the views from people stretching across the organisation to find out what is important, what our Trust should look like in future and how we might achieve this. The goal was to develop an ambitious, but realistic strategy that is meaningful and sets the course for the improvement of health services for our local population.

The engagement approach consisted of three key stages:

1. **Discover**

   The purpose of this stage was information gathering to ask as many people as possible what the future of DCH should look like

2. **Design**

   This stage allowed us to review the findings from the Discover phase and ask the question, how can we make this happen?

3. **Develop**

   Following the first two stages it was then important to test and refine the emerging strategy to see if there were opportunities for further improvement.

Engagement opportunities included multiple open staff sessions and presentations to key groups for discussion and feedback, including our Patient and Public Engagement Group, Senior Medics, the Council of Governors, the Senior Management Team, Finance Teams, the Board of Directors and consultation with representatives from wider groups such as Age UK.

What will the Strategy do?

The refreshed strategy will provide the people of Dorset County Hospital with a framework to build on over the coming years to help us achieve the ambitions set out within this document. It is purposefully flexible and not a detailed plan to provide the answers, but a guide to capture and set out the future strategic direction. Teams and individuals are invited to use this strategy as a basis for their own departmental strategies and planning so that together, we can become a hospital fit for the future.

2. Context and Challenges

Whilst most people in west Dorset report having good or very good health, the number of residents aged 65 or over is above the national average. Across Dorset this number is expected to grow by 50% in the next 25 years[1], meaning pressure on services will increase.

Having a higher proportion of elderly residents often means that the acuity of illness can be higher; in turn this can lead to increased lengths of stay in hospital. Demand for beds already outweighs capacity and over the last five years we have seen an average increase of 2-3% in activity.

This demand can be exacerbated in the summer months as we experience an increase in visitors enjoying 142 kilometres of coastline, stretching from Lyme Regis in the west to Highcliffe in the east.

The cost of living in west Dorset is generally higher than average, including house prices. This means it can be difficult to attract and house key workers in the area and recruitment and retention of staff can be a challenge, currently across the Trust there are 77 unfilled nursing vacancies. In contrast, there are also pockets of deprivation which have an influence on wellbeing. In terms of life expectancy there is an average difference of 6.3 years for men and 5.3 years for women[2] between the least and most deprived areas.

Many of the complexities outlined above have been further exacerbated by the Covid19 pandemic, with services reconfigured and long waiting lists for patients.

Finally, the NHS in Dorset is facing a significant financial deficit.

Wider Strategic Context

The Dorset system is not unique in the challenges it faces. In 2019 the NHS published its Long Term Plan to address some of the greatest health challenges that are being faced nationally and set out its ambitions for improving care for patients. If these ambitions are successfully adopted within local systems, over the next 10 years the NHS will:

- Boost 'out of hospital' care, dissolving the divide between primary and community health services
- Reduce pressure on emergency hospital services
- Provide more personalised care whilst supporting people to take control over their own health
- Support digitally-enabled primary and outpatient care to go mainstream across the NHS
- Increase the focus on population health via Integrated Care Systems

[1] Dorset Council https://www.dorsetcouncil.gov.uk/your-community/statistics-and-census-information/statistics-and-census.aspx
[2] Dorset Insight https://apps.geowessex.com/insights/Topics/Topic/Deprivation

Our Dorset Integrated Care System

Locally, our Integrated Care System named 'Our Dorset' represents a partnership of health and care providers including two councils, NHS services, the community and the voluntary sector, all working together to address local health, wellbeing, quality and financial challenges. Dorset was initially selected as one of 14 early implementer systems, building on the work of the Sustainability and Transformation Plan.

Further proposals from NHS England and NHS Improvement to put Integrated Care Systems on a statutory footing have been put forward following publication of the next steps for building strong and effective integrated care systems across England. This would see statutory Integrated Care Systems replace Clinical Commissioning Groups by April 2022. Whilst Our Dorset ICS has made much progress, there is recognition that there is still more to do. An ICS Transformation Next Steps Programme is now in development to support the evolution of the ICS in line with the proposed legislative changes.

The overarching objective of the programme is to ensure that collectively, partners create the right environment for transformation of care and services to deliver maximum benefits for patients and the population.

This will lead to achievement of the four key aims:

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development.

This strategy is aligned to both the NHS Long Term Plan and the next steps for our ICS, whilst acknowledging that it must also be unique to the needs and requirements of our hospital, staff, patients and population.

Consultation and Engagement

Engagement was initiated in November 2020, using the three-stage model: Discover, Design and Develop.

Different approaches to engagement were used to try and reach as many people as possible, these included formal facilitated sessions with a presentation and breakout groups, and more informal open sessions.

Right at the core of our future direction sits the Trust vision and mission statements:

Support was found for the continuation of both the statements, with feedback suggesting that we are still on the journey to completing our mission and realising our vision.

There was widespread support for the Trust to continue to fulfil the recommendations following the Clinical Services Review[3] and continue to be a 24/7 emergency and planed hospital with consultant led maternity and paediatric services for west Dorset. There was also support for the Long Term Plan and for the Trust to continue to work with our ICS in fulfilling the aspirations of increased out of hospital care, reduced pressure on emergency services, more personalised care, digitally-enabled primary and outpatient care and a focus on population health.

Emerging Themes

Through capturing and analysing feedback from engagement, several key themes were identified.

In summary it was felt that what makes Dorset County Hospital indispensable is our provision of acute emergency care for our local communities. It was felt that it is important to recognise the role of population health and the opportunities to drive this agenda from within the Trust. Further key themes included a need to focus on long term care and health inequalities and the role that personalised care can have. Many people discussed the need to work more closely with our colleagues in primary and community care to help place us at the heart of our local communities. It was also felt that we should maximise our virtual offer to spread across more services, with an agreed operating model that allows staff to do their job well. Further, we should train and support our staff to help fill workforce gaps – this should be joined up and properly funded as part of the Trust's responsibility to the community social value.

Alongside these themes, several challenges were also raised, including a lack of workforce availability and staff burnout. The increase in elderly, unhealthy and acutely unwell patients and growing waiting lists. The increasing pressure on patient

[3] Clinical Services Review https://www.dorsetsvision.nhs.uk/about/csr/

discharge and flow, growing waiting lists, demand outside of our control and stretched social care capacity were all also raised. As well as public behaviour and expectations, our role within the ICS and limited finances.

3. Guiding Principles

A number of key principles have been identified which underpin the strategic themes and should help guide decision making when embedding the strategy.

Dorset County Hospital and the way we work will not be the same in future. Our people are our greatest asset and we want to do more to ensure that they remain at the heart of what we do, our staff must feel valued and best able to support our patients and populations now and in future.

We need to be here for our communities and place more focus on population health to prevent illness and support people in managing their own health, closer to home where possible and using digital technology to support where we can.

Our decisions must also represent our commitment to reducing health inequalities and ensuring equal access to all, but we cannot do this alone. The choices we make must support the Integrated Care System and our role in making it successful. To achieve the above, we should be prepared to organise ourselves differently, be more outward facing and work with our communities to co design the services which will be of most benefit to them.

Guiding principles:

1 DCH People are our greatest strength	**2** We will always be here for our local communties	**3** We continuously strive to achieve outstanding clinical excellence	**4** We support people to be healthier
We will look after our people and make DCH a great place to work. In turn, our workforce will be in the best possible place to offer the highest standards of care to our patients.	Our local communities need us. We need to use the information we have and adopt better use of digital data to ensure that we can meet the needs of our population now and in the future.	We aspire to deliver outstanding care, every time. We will get the basics right and encourage innovation in our ambition to achieve and recognise excellence.	We will support people to live healthier lives and take control of their own health, preventing illness and reducing the need for secondary care.
5 We recognise people's differing needs	**6** We will work towards creating an effective ICS	**7** We will have to change as an organisation	**8** We will work with others to meet these principles
We know that avoidable health inequalities exist within our communities. With our system partners, we must put measures in place to reduce health inequalities and address unwanted variation in care.	We are committed to our role within the Dorset Integrated Care System and will support its ongoing development to improve the health outcomes for our people.	In recognising that the way we deliver care has to change, we must also be prepared to organise ourselves differently and work in new ways to ensure we meet the needs of our patients and partners.	We will work with anyone who can help us achieve our strategy; from working better across organisations, to listening more to our staff and ensuring the patient voice is heard.

4. What we Will Look Like in Future

Dorset County Hospital is the 24/7 Major Planned and Emergency Hospital serving mid and west Dorset. On site we have 360 beds and an emergency department, but the way we work and organise ourselves is different.

We have strived to ensure our hospital is a great place to work, staff are recognised for their individual contributions and are encouraged to learn and use quality improvement approaches to make a difference within their teams; they feel invested in and like their voice matters. Staff from all professional disciplines, including our Allied Health Professionals and Support Services, are considered equally and included within decision making.

The Integrated Care System is thriving, we work far more closely with our system partners, for example with our local acute partners to deliver safe and effective services. We encourage our community partners to work with us on site via our Integrated Service Hub. Our emergency department and intensive care unit have also been refurbished and designed with staff to provide for patients in need of the most urgent care.

We focus more on the overall health of our population and not just the patients within our hospital. Through working with the community, patients are now taking more responsibility for their own health and wellbeing. Furthermore, we actively engage with our population and design services with them.

More people are receiving care closer to home, this is especially important for our elderly and vulnerable population. Where it is appropriate, we are also using more digital technology to avoid the need for our patients to travel. As a result, we are starting to see a positive impact in demand for our services.

To bring our future hospital to life, part of the deliver plan will include working with our patient community to develop some case studies and vignettes to help showcase the difference that these changes could make.

5. Vision, Mission and Values

Our vision is that *Dorset County Hospital, working with our health and social care partners, will be at the heart of improving the wellbeing of our communities.*

Our mission is to provide *outstanding care for people in ways which matter to them.*

Underpinning everything we do are our values:

6. Strategic Themes

To achieve the mission and realise our vision, we will focus on three strategic themes: **People, Place and Partnership.**

These themes have been created out of the learning from engagement, acknowledgement of local challenges and we believe they capture the ambitions that we know we want to achieve as a Trust. They are guided by the national context and ambitions of the Long Term Plan whilst ultimately providing the blueprint for our trust for the future.

Themes:

People

This theme will see us putting our people first to make DCH a great place to work and receive care.

Place

The Place theme will see us delivering outstanding care by building a better and healthier place for our patients and population.

Partnership

Partnership is about working together to ensure outstanding services, accessible to our patients and population.

The following sections will outline each theme in more detail.

7. People

The first strategic theme focuses on our people. They are the cog that keeps this organisation going and our goals here are clear:

- We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes
- We will create an environment where everyone feels they belong, they matter and their voice is heard
- We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves
- We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge and respect

There are some key actions that must take place to achieve the above, therefore we will:

- Develop the DCH People Plan, establishing new clinical roles, creating career development pathway and partnerships to attract and retain staff.
- Recognise the equal importance of all professional disciplines and ensure meaningful representation of AHPs and clinical Support Services within decision-making processes
- Develop recruitment and retention approaches to ensure we are a local employer of choice, attract out of area and overseas staff and build a staff experience that supports people to stay
- Build on and sustain our staff wellbeing offer and put wellbeing and development conversations at the heart of appraisal
- Through the Equality, Diversity and Inclusion Strategy develop managers to build team effectiveness by supporting racial equality, inclusion and a culture where people feel free to express their knowledge, skills, perspectives, needs and potential
- Review HR policies and procedures to align with a just and learning culture and ensure ‘human’ is at the heart of HR
- Through the Quality Improvement Strategy, Research Strategy and Innovation Hub support people to research, innovate and improve the quality of their services
- Increase psychological safety by developing managers ability to listen to and respond effectively to concerns

8. Place

Where we work is so important, we want it to be the best place for our staff, patients and partners. Our goals are for DCH to be a place where:

- We will deliver safe, effective, quality, equitable care for every patient
- We listen to our communities and recognise their different needs to give everyone an opportunity to improve their health and well-being
- Digital technology enables and empowers people, improving productivity, enabling virtual care and helps us work with our partners to join-up care
- We build on our first-class same day emergency care offer and a dynamic seamless urgent and emergency care pathway gets people to the right place
- To proactively provide a personalised approach to the management of long-term conditions focussing on what matters to the individual
- We build sustainable infrastructure to meet the changing needs of the population
- We positively contribute to the economic, social and environmental health of our local communities; increasing local employment and working towards net carbon zero

We will achieve this by:

- Revising our Quality Strategy and supporting systems and processes
- Utilising our Digital Strategy which focuses on meeting basic delivery needs, developing decision-support tools, increasing remote monitoring and helps us work with our partners
- Creation of an integrated, dynamic, UEC Pathway through the UEC Delivery Board and ED15 and New Hospital Project
- Creation of a DCH Population Health Management Roll-Out Programme to create integrated LTC pathways and embed PHM into DCH clinical delivery
- Strategic Estates Development Programme to ensure the right capacity is available in the right place with the right partners and to deliver the new ED, ICU and Integrated Services Hub
- Outpatient Transformation Programme to increase productivity and increase remote delivery
- Following the Clinical Strategy create a DCH Centres of Excellence Programme which invests in and sustains our key anchor services, expands our Acute Hospital at Home Service, develops a Stroke Hyper Acute Unit and builds integrated rehab pathways across Stroke, CVD and Trauma

- Health Inequalities Programme, including our Social Value Pledge, to improve outcomes and improve health and well-being

9. Partnership

In order to become an organisation that is sustainable and able to deliver outstanding care, we must achieve the following goals, by working in collaboration:

- With our patients to ensure our services meet their needs
- To reduce clinical variation across Dorset to provide equity of outcomes for all
- To increase the capacity and resilience of diagnostics, planned and elective care by working in provider collaboratives and networks
- To increase the capacity and resilience of our clinical and non-clinical support services through provider collaboratives and networks
- To contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the Dorset population
- To ensure that we are efficient and achieving best value for the population in all we do and to work towards adequate funding for healthcare for rural communities
- Create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in an innovative and cost-effective way

We will achieve this by:

- Expanding the Patient Voice Group and embed co-design principles in all we do through our QI Strategy
- Developing a Clinical Strategy which sets a broad direction for each of our services and which seeks to develop our services around places, communities and Primary Care Networks
- Through the Dorset Planned Care Oversight Board expand Provider Collaboratives which maintain access to quality services for our population.
- Actively support the Integrated Care System Development Programme to launch a statutory ICS by April 2022
- Expand day surgery and maximise theatre capacity to optimise efficiency through our Theatre Efficiency Programme
- Through our Better Value Better Care Board continue to deliver stretching Cost Improvements and develop and embed a new value-based measurements and outcomes
- Develop a Commercial Partnering Strategy and Plan

10. How will we measure success?

Following approval of the strategy, work will commence to gain the detailed metrics that will form a balanced scorecard which will be used to monitor progress against the strategy.

We will work with key people to gain the correct metrics, ensuring an iterative process, allowing the opportunity to review and amend our metrics as delivery of the Strategy progresses.

It is likely that the balanced scorecard will include a blend of:

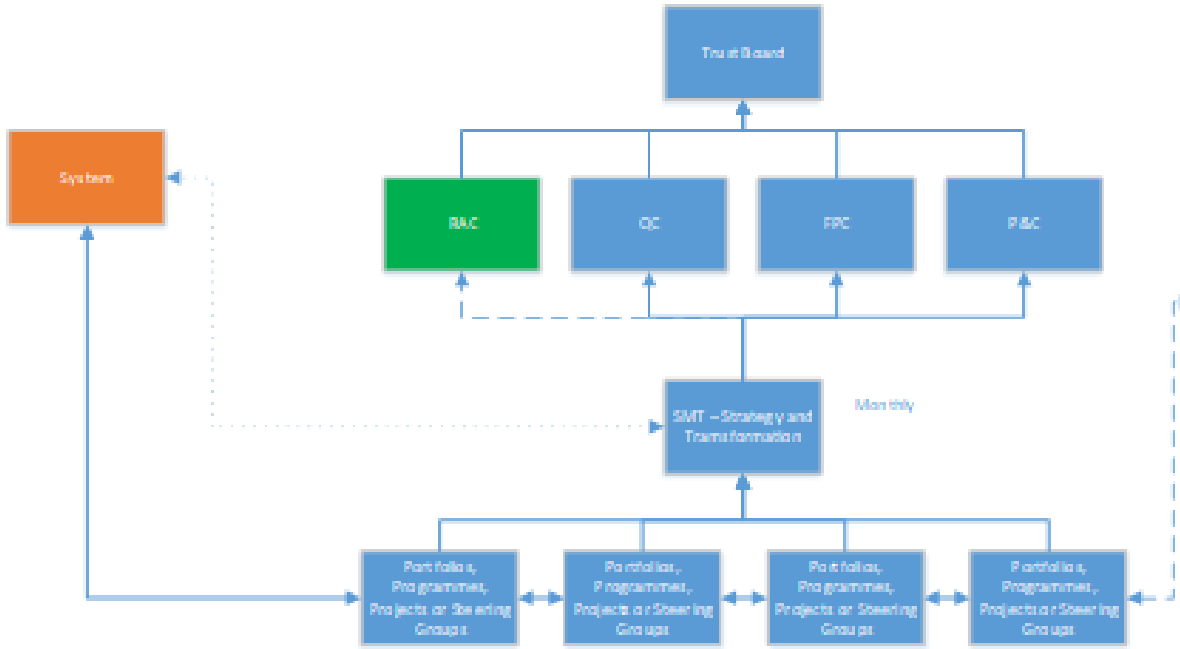
- Outcome driven metrics
- Quality metrics
- Wider social value data
- Patient experience data

11. Governance and Monitoring

The following Governance and Oversight Framework has been outlined. Of note, the Strategy and Transformation Senior Management Team (SMT) meeting will be reinstated and will be the key group for monitoring implementation. A dynamic review process will be put in place, including six monthly reporting to the Trust Board to review the strategic measures via the strategy dashboard. An annual review process will also be decreed, with updated annual and three-year delivery plans.

Governance and Oversight

NHS
Dorset County Hospital
NHS Foundation Trust



Core purpose of Strategy and Transformation SMT

- Strategy monitoring and oversight – e.g. measures and metrics
- New Trust Strategies for check and approval*
- New multi year business case check and approval*
- Knowledge sharing and learning
- Oversight on progress and escalation/decision making on key System and Organisational Strategic and Transformation activity
- *within existing governance and SFIs

12. Next Steps

Once approved, it is crucial that the strategy is embedded within the organisation. This will include further engagement to make the strategic themes feel real for our staff.

Once approved the strategy will:

- Become the basis for strategic planning discussions with divisions and departments
- Form the basis for Clinical Strategies
- Inform business planning activity
- Be embedded as a common framework in governance and performance management across the Trust

Key Milestones:

	May	Jun	Jul	Aug	Sep
Deliver Strategy to Trust Board					
Prepare Strategy Materials for Trust					
Re-establish Transformation SMT					
Strategic Delivery Plan (3 year rolling and 21/22)					
Strategy Dashboard					
Engagement to embed in Clinical Strategies					
Develop case studies and vignettes					
Launch					

Meeting Title:	DCHFT Board
Date of Meeting:	26th May 2021
Document Title:	**DCH Social Value Programme – Progress Report**
Responsible Director:	Nicholas Johnson, Deputy Chief Executive
Author:	Simon Pearson, Head of Charity & Social Value

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Trust Board Senior Management Team	25.11.20 12.5.21	Board requested 6 month progress report on DCH Social Value programme.

Purpose of the Paper								
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The enclosed report presents an update on key activities relating to development of the DCH Social Value programme; following Trust Board's approval on 25.11.20 of the DCH Social Value Pledge commitments. The **DCH Social Value Action Plan** has been developed with the Social Value Programme Group. The plan details the current operational activities and measures for delivering DCH's social value commitments as an anchor institution.							
Action recommended	The Trust Board is recommended to: 1. **NOTE** progress to date and plans for further development of the DCH Social Value programme 2. **APPROVE** the DCH Social Value Action Plan 2021-25							

Governance and Compliance Obligations

Legal / Regulatory	Y	The Public Services (Social Value) Act 2012
Financial	N	
Impacts Strategic Objectives?	Y	DCH Social Value commitments to be embedded through DCHFT strategic objectives and activities.
Risk?	N	
Decision to be made?	Y	To approve the DCH Social Value Action Plan.
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	Purpose of the Social Value programme is to deliver DCH social value commitments as per DCHFT Social Value Pledge.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DCH Social Value Programme: Progress Report (May 2021)

Our Social Value Pledge
Dorset County Hospital Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an Acute Trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community.

This 6 month report presents an overview of our progress to date in developing our Social Value programme, as requested by Trust Board on 25.11.20. The key elements of our programme development are summarised as follows:

- **DCHFT Social Value Pledge:** our social value commitments as an anchor institution were approved by Trust Board on 25.11.20. These provide the foundations and objectives for Dorset County Hospital's delivery of social value. This is available on the DCHFT website https://www.dchft.nhs.uk/about-us/social-value/ and sharepoint here: http://sharepoint/departments/DCH-Social-Value/SitePages/Home.aspx

- **DCHFT Social Value Policy:** was approved by Senior Management Team on 3.2.21. This is available on sharepoint here: http://sharepointapps/clinguide/CGdocs1/2055-Social-value-policy.pdf

- **Social Value Programme Group:** the group's role is to develop, manage, evaluate and report on DCHFT's social value commitments and the impact we have as an anchor institution. Meetings are held monthly to progress the Trust's social value programme development and implementation.

  The Chair will report quarterly to the Health Inequalities Group on progress in line with the DCH Social Value Action Plan. Programme Group leads will report quarterly, through the appropriate Trust Committee, on social value activities as part of their service area's overall progress reporting aligned to delivery of the Trust Annual Plan/Strategy. The Programme Group will report through the Health Inequalities Group, to inform the Quality Committee of any matters for escalation; or which require resolution by the Board.

  The Programme Group will provide six-monthly progress reports to the Board.

- **DCHFT Social Value Action Plan:** our current operational plan is presented with this report for approval. The plan comprises key workstreams which reflect our social value commitments and objectives. Development of the plan will also align with the

new Trust Strategy and Annual Plan, integrating social value in to the Trust's business planning and operational activities as we move forward.

- **Social Value Dashboard:** we are working with DCH Business Intelligence team to develop our management information dashboard, aligned to our Social Value Action Plan. This will present our key social value metrics, comprising both quantitative and qualitative information. Combined with a Social Value Maturity Index this will enable us to monitor and manage progression of our social value programme activities. Once implemented, we will present a social value dashboard summary with our six-monthly reports to the Board.

- **Social Value Impact Assessment:** we have developed a Social Value Impact Assessment template to integrate social value across the Trust's operational activities. An assessment of social value impact will be embedded in Trust policies, business planning and key corporate documents. The process for implementing this in Trust policies is currently under consideration.

  Corporate report templates: (ie. Board reports) now include a specific section for social value impact consideration.

- **Communications:**

  DCH Social Value communications: as we develop our programme we will communicate our social value ambition and delivery (internally and externally)**.**

  Our DCH Social Value Pledge is now publicised on posters and pull-up banners across the hospital; on the DCH intranet; staff comms and the new DCHFT website – please see Social Value page here: https://www.dchft.nhs.uk/about-us/social-value/ External communications will be developed using media, social media and other publications. Current DCH projects and activities delivering social value will be publicised including – Willmott Dixon's social value evaluation of the MSCP development, delivering c£4M social return on investment, to be covered in their Residents newsletter; and the Kickstart scheme which seeks to provide work placements for young people age 16-24 who are not currently in employment or education.

  Health Foundation: DCH contributed to the Health Foundation's roundtable for Dorset ICS aimed at considering the role of anchor institutions during and beyond the pandemic. The Health Foundation's 'Anchors in a storm' Covid report (Feb 2021) may be viewed here: https://www.health.org.uk/publications/long-reads/anchors-in-a-storm

Health Anchors Learning Network: 'Anchors in a Storm' webinar (17.5.21) This event included a presentation on DCH's role in delivering social value as a Health Anchor.

- **Funding:** we will capitalise on external funding opportunities to support our social value programme.

  NHS Charities Together: DCH Charity is leading on the NHS Charities Together Covid Appeal Community Partnerships grants for Dorset ICS. Dorset region has been allocated £356K and the Dorset programme will focus on addressing health inequalities. DCH will submit a bid for c£50K for project/s which contribute to our work on addressing health inequalities.

  NHSCT Covid Appeal Recovery grants have also been announced and DCH has been allocated £65K for which we need to apply, for projects supporting long term health and recovery of NHS staff, patients and volunteers impacted by Covid 19.

- **DCHFT Annual Report 2020/21**: the Trust's Annual Report will reflect our social value commitments across our operational activities. From 21/22 we will plan to report key metrics and qualitative information to convey the Trust's social value impact on the community we serve.

- **Memberships**:

  Social Value UK (https://socialvalueuk.org/**)**: Annual membership

  Health Anchors Learning Network (HALN) https://haln.org.uk/ **):** Launched in March 2021, HALN is a new, UK-wide network for people responsible for, or interested in, anchor approaches in health. The network is supported by the Health Foundation and NHS England.

Simon Pearson MCIOF
Head of Charity & Social Value

Dorset County Hospital NHS
NHS Foundation Trust

Social Value Action Plan 2021-25

Our Commitments as an Anchor Institution

Outstanding care for people in ways which matter to them.

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Social Value Workstreams: ➢ Develop Anchor Networks - Dorset System ➢ Maximise Local Investment ➢ Increase Local Employment ➢ Recognised as a Good Employer ➢ Champion Equality, Diversity & Inclusion ➢ Greener & Sustainable ➢ Promote Civic Partnerships ➢ Involve our Community ➢ Monitor & Report	See SV Workstream sections below.
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DCHFT Social Value Action Plan ***(align to new Trust Strategy (PPP)/Annual Plan)***

This plan outlines Dorset County Hospital NHS Foundation Trust's commitment to delivering social value and how we deliver, measure and communicate the social value we create for the community we serve.

What is Social Value?

Increasingly, organisations are considering their activities holistically, taking account of the wider economic, social and environmental effects of their actions.

Social Value serves as an umbrella term for these broader effects, and organisations which make a conscious effort to ensure that these effects are positive can be seen as adding social value by contributing to the long-term wellbeing and resilience of individuals, communities and society in general.

DCHFT & Social Value

As an Anchor Institution our commitment is to maximise the positive social impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the wider community. For the purposes of measuring and monitoring our social value programme 'local' is defined as the whole of Dorset. Specific reference will be given to localities within the DCH catchment area in our analysis and reporting.

Social Value Act

Dorset County Hospital NHS Foundation Trust will be compliant with the requirements of The Public Services (Social Value) Act 2012 which will be used to support how we can derive social value from our activities. The Act requires public authorities to have regard to economic, social and environmental wellbeing in connection with public services contracts.
An introductory guide to the Social Value Act can be found here:
https://www.gov.uk/government/publications/social-value-act-introductory-guide

Our Social Value Pledge

Dorset County Hospital commits, through its approach to delivering social value, to reduce avoidable inequalities and improve health and wellbeing across its community. Please see DCHFT Social Value Pledge here: https://www.dchft.nhs.uk/about-us/social-value/

Our Social Value Principles

- Working together, across DCH and with our Dorset system partners, to improve health and well-being and reduce avoidable inequalities across our community – linked to the Marmot Principles:
  - Giving every child the best start in life;

- Enabling all children, young people and adults to maximise their capabilities and have control over their lives;
- Creating fair employment and good work for all;
- Ensuring a healthy standard of living for all; throughout the life course;
- Creating and developing sustainable places and communities;
- Strengthening the role and impact of ill-health prevention;
- Protecting health and social care services for future generations.

- Social Value will be embedded as core practice, behaviours and the way that we operate across DCH.
- Our delivery of Social Value will be embedded in DCHFT strategic priorities.
- Our Social Value approach will create a lasting social impact and legacy for the community we serve.

Social Value Maturity Index

The Social Value Maturity Index (SVMI) has been developed by Social Value Portal (www.socialvalueportal.com) to allow both public sector organisations and their suppliers to assess where they are on their journey of embedding social value and provide a step by step guide on how to embed social value as an effective way of delivering better outcomes for communities. We have adapted the SVMI scoring criteria to meet DCHFT activities and requirements for monitoring our social value progress. The DCHFT Social Value commitments will be delivered through specific workstreams as detailed in sections below. Progress in terms of social value 'maturity' will be recorded and monitored based on our maturity score index as follows:

SV Maturity Score	Maturity Stage
1	Minimum
2	Developing
3	Maturing
4	Mature
5	Innovating

The DCHFT Social Value maturity index will enable monitoring at an organisation-level and for specific social value commitments and activities.

NHS Long Term Plan

As described by the Health Foundation's report on the NHS as 'anchor institutions' there is an increasing policy focus on prevention & population health and the move towards 'place based' models of care focusing on communities and populations. There is growing synergy between the place-based lens of the NHS and broader policy emphasising localism in shaping the environments where we live. Dorset County Hospital NHS Foundation Trust commits to build social value objectives into its planning for the delivery of the LTP as a Trust and in partnership across the Dorset system.

DCHFT Social Value Action Plan

Our Social Value Commitments

We commit to delivering social value as an anchor institution through the provision of our services, contributing to reducing avoidable inequalities and improving the social, economic and environmental well-being of the community we serve. We will achieve this through the following commitments:

- Develop Anchor Networks across the Dorset System
- Maximise Local Investment
- Increase Local Employment
- Recognised as a Good Employer
- Champion Equality, Diversity & Inclusion
- Greener & Sustainable
- Promote Civic Partnerships
- Involve Our Community
- Monitor & Report

Our Social Value Action Plan outlines how we will work to deliver these commitments during the period 2021-25.

DCHFT Social Value Action Plan

Workstream: Develop Anchor Networks across the Dorset System

Objective Dorset County Hospital NHS Foundation Trust commits as an anchor institution to build social value objectives into its planning for the delivery of the NHS Long Term Plan; and in partnership across the Dorset ICS system. With our system partners, we will develop Our Dorset's social value vision and pledge in order to maximise our contribution to the wider health and well-being of our local communities.		**Project Lead:** Nicholas Johnson, Deputy Chief Executive				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	With our system partners, we will develop Our Dorset's social value vision and pledge in order to maximise our contribution to the wider health and well-being of our local communities.	See Leeds Anchors Framework See Barts AI Framework (Andrew Attfield, Dir Public Health)	SV/AI pledge via HIG in place	Sept 21	2	NJ
	Working with Dorset Council, NHS Trusts, CCG, Large Education Providers, VCSE sector, Arts and Cultural organisations and Business and Industry to deliver our social value ambition.	Actions arising from SV/AI pledge and HIG			2	NJ
	To address avoidable inequalities across the Dorset system; with particular reference to the	As per ICS HIG Strategy and			2	NJ

	objectives of the Dorset ICS Health Inequalities Group.	Plan				

DCHFT Social Value Action Plan

Workstream: Maximise Local Investment

Objective We commit to maximise local investment which is financially generative to the local economy, retaining and recirculating wealth locally. We will take account of the social, economic and environmental impacts of buying locally when procuring goods and services.		**Project Lead:** Louise Brereton, Head of Procurement				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	Our major local investment is in our local workforce. Support the local economy by choosing suppliers close to the point of service delivery, where possible. Increase accessibility and improve opportunities for local businesses and social enterprises to bid for contracts throughout the supply chain. Develop local supply chains which will impact on local economic growth for the longer term.	Calculate current local staff annual payroll; monitor in line with commitment to increase local employment. Review spend data to determine how much non-pay spend is currently local (DT postcode) with how many suppliers, with a focus on catering and estates & facilities. Develop our internet website and specifically the procurement pages to suggest upcoming projects and allow suppliers to contact us though a link.	Value £ p/a Value £ p/a No. of suppliers	Annual check Annual check Annual check	2 1	

	Commit to sourcing our raw materials locally, where possible. Commit to sourcing local services, where possible. All suppliers to have SV/Sus statement/policy (incl to Living wage)	Use the Government SV Model to ensure SV is evaluated in tender opportunities. Local catering suppliers ie. Milk (Craigs farm); County Farms initiative tbc et al Estates & Facilities using local builders, grounds maintenance, window cleaners et al Request evidence of SV/Sus statement from current suppliers. Do not duplicate the work that NHS SupplyChain is doing with suppliers that we use, e.g. SV statements around use of child labour, evidence of sustainable supply chains etc			1 2 2 1 1	
	Ensure our major capital infrastructure investments deliver measurable social value. Recognise and communicate these social value benefits.	SV evaluation reports from major contractors (ie. Wilmott Dixon MCSP)	SV valuations per project SROI		3 / 4 dependent on project	

	Work with third sector organisations to deliver services and contracts, where appropriate.	Partnerships with local charities ie. Macmillan; Freewheelers	No. local VCSEs			

DCHFT Social Value Action Plan

Workstream: Increase Local Employment

Objective We commit to increase employment and training opportunities for local people, especially from areas of high deprivation and unemployment; supporting people into work and work experience placements.		**Project Lead:** Emma Hallett, Deputy Director of Workforce				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	Commit to create employment and training opportunities for local residents; including opportunities which contribute to improved social mobility and enable career progression. Promoting improvement and provision of local employment and training opportunities	Implement Kickstart Programme (to facilitate high quality training opportunities for young people aged 16 to 24 who are in receipt of Universal	No. 'local' employees Fill all placements Ensure all participants complete programme Ensure at least 80% of participants	46 DCH placements identified. First Cohort to join in June 2021.	3	Sara Collinson

		Credit and at risk of long term unemployment)	secure permanent employment			
		Implement a 'guaranteed interview' scheme for those leaving care in the local area and for those who have completed the DCH Kickstart scheme.		Aim to launch this scheme by September 2021	1	Hilary Harrold
		Continue to advertise roles and training opportunities locally so as to attract local people to apply	80% of those recruited into permanent and training roles will be from within the Dorset area.	Ongoing	3	Hilary Harrold

		Promote creation of apprenticeships as part of workforce and succession planning embracing new apprenticeship frameworks (e.g. OT and Physio and Facilities)	Increase level of apprenticeships offered to those living locally to the Trust	Ongoing	2	Sara Collinson
	Seek opportunities to work with education and training providers to help ensure young people are equipped with the right skills to match the requirements of the NHS labour market.	Expand the 'access to' programme which is currently delivered to local schoolchildren to promote careers within the NHS	Continue to deliver access to; Nursing Medicine Midwifery Extend programme to include AHP, Science and	Expand offering throughout 21/22	2	Elaine Hartley

			EFM careers			
	Seek to provide employment opportunities for all ages including those older age groups and those seeking a late stage career change.	Collaborate with local job centres and DWP to target those who are not eligible for the Kickstart and apprenticeship routes.	Recruitment metrics (TRAC) 80% of those recruited into permanent and training roles will be from within the Dorset area.	Aim to launch this scheme by September 2021	1	Hilary Harrold
	Support the local economy to create jobs and apprenticeships, by adopting procurement strategies that remove barriers to local businesses.	Publicise the existing successful volunteer network within the local community. Capture and promote the number of volunteers who progress into	No. volunteers entering employment		3	Hannah Robinson

		employment.				
	Work with local third sector organisations to ensure people facing barriers to employment are supported.	Implement Kickstart Programme (to facilitate high quality training opportunities for young people aged 16 to 24 who are in receipt of Universal Credit) Implement a 'guaranteed interview' scheme for those leaving care in the local area. Continue to advertise roles and training opportunities	Fill all placements Ensure all participants complete programme Ensure 80% of participants secure permanent employment 80% of those recruited into permanent and training roles will be from within the Dorset area.	46 DCH placements identified. First Cohort to join in May 2021. Aim to launch this scheme by September 2021 Ongoing	2 1	Sara Collinson Hilary Harrold Hilary Harrold

		locally so as to attract local people to apply				
	Support volunteering to provide routes into employment.	Publicise the existing successful volunteer network within the local community. Capture and promote the number of volunteers who progress into employment.	Resume projects with Voluntary Sector as part of Voluntary Service COVID recovery plan and increase activity to promote volunteering at DCH New volunteer management software currently being procured as part of ICS will support effective reporting of numbers. We will work with	From April 2021 – continual programme of community engagement From June 2021	3 2	Hannah Robinson

		Capture and promote the number of young volunteers who move onto further study with an ambition to return to a career in health and social care	Comms to case study success stories Case studies to promote those who have progressed on and promotion of opportunities for young volunteers in the NHS post study.	From June 2021	2	

DCHFT Social Value Action Plan

Workstream: Recognised as a Good Employer

Objective To provide outstanding careers, ensuring our employees have a positive and fulfilling experience, through opportunities to develop skills and further their careers. Committed to working together in line with our Trust values – Integrity, Respect, Teamwork and Excellence - empowering our staff to deliver outstanding services, sustainably, everyday.		**Project Lead** Emma Hallett, Deputy Director of Workforce				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	Comply with working hours legislation and sector standards. To support fair employment by considering/providing a range of employment contracts. To support flexible working by considering/providing a range of flexible working options.	Our revised People Plan will reflect the NHS People Plan and the commitments within it.	Improved Staff Survey scores in relation to engagement and recommending the Trust as an employer	Staff Survey undertaken in October 2021 – results shared in February 2022	2	Dawn Harvey
	Work towards paying the Living Wage, within the context of Agenda for Change. Ensure zero hours contracts do not discriminate or disadvantage individuals in the	Working Hours are monitored to ensure compliance	Improved Staff Survey scores in relation to satisfaction	Staff Survey undertaken in October 2021 – results	3	Emma Hallett

	workplace/market.	with the WTD and NHS contracts. A wide range of employment contract and flexible working practices are available but need to be publicised to existing staff and potential recruits.	with working hours and opportunity for flexible working.	shared in February 2022		
	We will provide in-work training opportunities for our people to develop skills and further their careers.	Produce a report for the People and Culture Committee regarding the implications (financial, moral etc.) of introducing the	No./% employees paid Living Wage or above Improved Staff Survey scores in relation to satisfaction with working	Report completed and considered by PCC and Board by the end of December 2021	2	Emma Hallett

		Living Wage. The HR Team have previously undertaken ad-hoc checks of those working regularly under zero hour contracts to see if they would like to swap to a permanent contract. This will become a regular process.	hours and pay.	Review of zero hour contracts undertaken quarterly by the HR team from May 2021 onwards	3	
	Understand the different needs of our workforce and implement policies that support their health and wellbeing.	Promote opportunities and facilitate more staff to undertake in-work training.	Improved Staff Survey scores in relation to accessing training and development.	Staff Survey undertaken in October 2021 – results shared in February 2022	3	Elaine Hartley

	Foster a loyal and motivated workforce. Work to ensure recruitment practices for new applicants and opportunities for career progression are inclusive of all. Ensure that equality strands are supported through transparent and fair employment processes.	A specific section relating to Health and Wellbeing will be included in the revised People Plan			2	Julie Barber
	Ensure we are a Leaderful organisation, recognising that leaders exist at all levels contributing to the success of our hospital.	A specific section relating to Recruitment and Career Progression will be included in the revised People Plan			2	Hilary Harrold/Emma Hallett
	Develop workforce volunteering programmes.	An Inclusive Leadership Programme is being launched shortly. There is a Management Toolkit available for	Improved scores in relevant sections of annual Staff Survey	Launching June 2021 A re-vamped Toolkit is to be launched by	3	Julie Barber

		anyone in a management or leadership role.		the end of May 21 as the new 'go to' resource for Line Managers. The Toolkit will be expanded and improved throughout 2021-22.		
	Commitment to the NHS People Plan promise that the NHS is best place to work for all – where we are part of one team that brings out the very best in each other.	Publicise the existing successful volunteer network within the local community.	Measure recruitment of volunteers for both response roles and the young volunteer programme. Recommence events to publicise volunteering in and across the community. Measure	From April 2021	3	Hannah Robinson

		Increase opportunity for volunteers to gain nationally recognised certificate in volunteers. Work with departments across DCH to be able to offer opportunities for Young Volunteers to learn about different roles within the NHS Recommence plans pre-COVID to work alongside youth organisations as part of the	number of volunteers who take part in the HEE pilot for the national volunteer certificate and numbers achieved. Young Volunteers provided with opportunities to speak to different staff and learn about their role. Delivery of the projects originally	Pilot runs Mar 21 – Mar 22. Roll out to DCH volunteers from Apr 21 From July 2021 From July	3 2 2	

		Pears iWill commitment	planned	2021		
		Our revised People Plan will reflect the NHS People Plan and the commitments within it.	Improved Staff Survey scores in relation to engagement and recommending the Trust as an employer	Staff Survey undertaken in October 2021 – results shared in February 2022	2	Dawn Harvey

DCHFT Social Value Action Plan

Workstream: Champion Equality, Diversity and Inclusion

Objective Dorset County Hospital NHS Foundation Trust is committed to becoming a truly inclusive organisation. We recognise that we must value the contribution of people of all backgrounds, abilities and experiences in order to deliver outstanding services. We will work to ensure that our organisation is a place where all our staff and patients feel safe, listened to, and that they belong.		**Project Lead:** Emma Hallett, Deputy Director of Workforce				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	We will work closely with local partners and community organisations to ensure that all voices are heard and every member of DCH and our wider community has equitable access to the benefits that our Social Value programme will bring.	The Trust has staff networks in place for Diversity, LGBTQ+, and Disability/Long Term Health Condition (LTHC). These need to be developed and	Embed and promote the networks as part of BAU at DCH. Improved scores in annual Staff Survey, WDES, WRES, SFFT – Workforce	Assess initial output of networks via Network Governance Checklist due in September 2021	3	Julie Barber

		supported.	Demographics by Pay Band (increased representation from minority groups at 8a & above)			
	Our overarching EDI goals include: ➢ Better Health Outcomes for All ➢ Improved Patient Access and Experience ➢ Empowered, Engaged and Well Supported Staff ➢ Inclusive Leadership at All Levels Our objectives for achieving these goals are detailed in our Equality, Diversity & Inclusion Action Plan 2019 – 2021.	Launch of new Trust EDI strategy Implementation of mandatory Inclusive Leadership Programme for band 7+	Improved Staff Survey scores in relation to satisfaction, engagement and WRES and WDES questions. Improved scores on Staff, Friends & Family Test quarterly.	Due to be completed in May 2021 First four cohorts launching in June 2021	3	Julie Barber Julie Barber

DCHFT Social Value Action Plan

Workstream: Greener & Sustainable

Objective We commit to our DCH Green Plan (SDMP) to deliver long term improvements to the sustainability performance of the hospital. We recognise the impact we have on the environment and our responsibility to improve our sustainability and contribute to better health and well-being of our local community. We will work towards the Greener NHS Net-Zero objectives committing to protecting the environment, minimising waste, water and energy consumption and using other resources efficiently within our organisation and supply chains.	**Project Lead:** Don Taylor, Head of Estates & Facilities

Ref	Commitments	Actions	Key Metrics	Timeline	Progress (SV Maturity Score 1-5)	Lead
	In line with 'Delivering a 'Net Zero' National Health Service' (1 October 2020) UK Government and DCHFT are committed to reaching net zero by 2050. For the emissions controlled directly by the NHS Carbon Footprint plans are to reach net zero by 2040, with an ambition to reach an	DCH have this year changed a large proportion of our lighting over to the much more efficient LED systems. This uses much	Carbon tonnage/volume £Bills £Investment	Annual Check	3	DJT

	80% reduction by 2028 to 2032. DCHFT will be assessing and promoting to staff and general public how as a partnership we can reduce our Carbon Footprint. For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.	less electricity and thus reduces our carbon footprint. Our plant is a combined heat and power system.			4	
	Plans continue for reduction of our energy and water consumption. (NB. due to Covid-19 and the guidance for staff, patients and visitors 'Wash Your Hands' is anticipated to raise the use of water consumption.)	LED lighting has been installed, and we plan to change over further areas as funding allows. Most areas fitted with PIR detectors and timers to minimise lighting electricity costs.	£Bills £Investment	Annual Check	3 4	DJT
	Eliminate unnecessary waste by continuing to "reduce, reuse, recycle" and improve the infrastructure to enable people to do so.	DCH is constantly looking at ways to reduce waste, and increase the proportion that we recycle.	Tonnage	Annual Check	3	DJT

	With sources of NHS carbon footprint highlighting Medicines, Medical Equipment and other Supply Chain as the highest ratio to address, DCHFT is now addressing Anaesthetics, Medical Devices, Nursing and Pharmacy to be included in the new Green Plan.					??
	Promote the DCH Green Travel Plan for sustainable transport (public transport/electric vehicles/cycling/walking/car share)	DCH have provided a number of electric vehicle charging points, and ordered some electric vehicles to add to our transport fleet. The new multi-storey car park will also provide further electric vehicle charging points. We are also investigating the potential for electric transportation	Numbers of vehicle charging points Numbers of people car sharing Numbers cycling/walking	Annual Check	3 2 1	DJT

		from outlying nurses accommodation, where they can't be housed locally, rather than conventional mini-buses.				
	Improve green areas (e.g. biodiversity, visual attractiveness)	DCH have initiated a Gardening Club, involving volunteers and staff in the improvement of our green areas. This will promote diversity of both flora and fauna, attracting bees, birds and other wildlife to our grounds.	Visual check of species	Annual Check	2	DJT
	Ensure that sustainability is thoroughly communicated throughout the Trust and ensure that appropriate employees receive relevant training as part of induction.	Sustainability is a key message in our induction process, and all new employees are trained and	Numbers of inductees	Annual Check	3	DJT

		encouraged to think sustainably, in all their duties.				
	To work in partnership with local groups and key stakeholders in order to support sustainable development within our community.	Local volunteers are active on our site, specifically with the grounds upkeep and improvement, but also with sustainable transportation	Numbers of Volunteers	Annual Check	3	DJT
	Contributing to a sustainable local economy.	Employment of local people and purchasing goods and materials from local suppliers and contractors not only reduces the distance materials travel when supplied, but also cuts down on the commute for staff.	Procurement and employment metrics	Annual Check	3	DJT

DCHFT Social Value Action Plan

Workstream: Promote Civic Partnerships

Objective To build on and coordinate effective partnerships between DCH and our civic community including VCSE organisations, supporters, arts and culture sector, schools/colleges, religious organisations and other civic bodies. To develop joint initiatives and programmes, and implement local activities which contribute to reducing inequalities and improving health and well-being for all.		**Project Lead:** Simon Pearson, Head of Charity & Social Value				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	DCH Charity builds relationships with supporters across our community including patients, families and organisations; delivering funding which enhances patient care and staff welfare at DCH.	As detailed in DCH Charity Strategy/Business Plan 2021-25	£Income No. supporters No. Community Orgs	As per Strategy/Annual Plan	4	SP
	Friends of DCH coordinate DCH Volunteer services and raise funds to support the hospital.	As per DCH Friends annual activities plan	No. Volunteers £Income	Annual check	4	DCHF

	DCH Volunteers provide valued and essential services for our hospital; in addition to the social, skills and other benefits achieved from volunteering. The DCH Young Volunteers programme also exemplifies this approach.	As per DCH Volunteers programme	No. Volunteers £Value WTE No. Young Vols.	Annual check Volunteering Impact reports	4	HRobinson
	DCH Arts in Hospital programme engages with local artists and arts/cultural organisations from our local community. Research demonstrates the benefit arts deliver in contributing to people's well-being, particularly mental health.	As per Arts in Hospital Annual Plan	No. Arts exhibitions/projects Patient/Staff feedback		4	SRushbrook
	Through existing and new partnerships with local civic bodies we will develop initiatives which contribute to improving our community's social, economic and environmental well-being, particularly as our local community works to recover from the Covid pandemic.	Develop partnership working with civic bodies/community orgs ie. Rotary Spring Clean	No. Civic Partnerships/initiatives Social value impact assessment		3	SP

DCHFT Social Value Action Plan

Workstream: Involve our Community

Objective A key principle of delivering social value is engagement with our stakeholders. We will play an active role in engaging with our local community by listening to them, involving them and acknowledging their contributions to our social value commitments		**Project Lead:** Alison Male, Patient Experience & Engagement Lead				
Ref	**Commitments**	**Actions**	**Key Metrics**	**Timeline**	**Progress (SV Maturity Score 1-5)**	**Lead**
	Engage with local residents and service users.	DCH is part of the ICS Engagement leads Network in partnership with local authority, health organisations, Healthwatch and the voluntary sector to engage with residents of Dorset DCH is part of the Dorset Carers Development Group and Pan Dorset Carers Steering Group which Carers on the group.			4 3	Alison Male, Patient Experience & Engagement Lead

		Future opportunities (post Covid) for the Your Voice group to engage with the public alongside promoting the Trust Membership and linking with the Governor Membership committee. Work alongside the Voluntary sector to support community engagement. Work with local schools and youth organisations to encourage Youth Voice through Volunteering opportunities.	No. Trust members/new members No. Young Volunteers	Annual check Annual check	2 2 2	
	To promote opportunities for gathering views, including those not heard or voiced.	Part of ICS Engagement leads Network in partnership with local authority, health organisations, Schools and Youth organisations and the voluntary sector to engage with residents of			3	Alison Male, Patient Experience & Engagement Lead

		Dorset to discuss opportunities to gather views of seldom heard people in Dorset using the established support networks in place. Views are gathered from Carers as part of the Pan Dorset Steering group to inform the future Carers strategy in Dorset.	See Carers Strategy		2	
	To provide feedback to the local community so they can see the results of their involvement. Ensure communities receive timely and appropriate information and communication.	DCH contributed (via the ICS Engagement Network) to a SW survey of the impact of COVID and the results were published via the CCG across Dorset	See Survey report		4	Alison Male, Patient Experience & Engagement Lead

DCHFT Social Value Action Plan

Key Element: Monitor & Report

Objective We will monitor and demonstrate our commitment to delivering social value by implementing recognised procedures for measuring and reporting our Social Value outcomes and Social Return on Investment.		**Project Lead:** Mark Lovett, Financial Controller			
Ref	**Commitments**	**Actions**	**SV Measurement Tools**	**Timeline**	**Responsibility**
	Implementing recognised procedures for measuring and reporting on our Social Value outcomes and Social Return on Investment.	DCH SV baseline evaluation (review) SV Dashboard SV Maturity Index Measure Social Return on Investment (SROI) Triple Bottom Line (TBL) analysis	 DCH data sources DCHFT SV maturity scoring index SV toolkit calculator National SV TOMs (Themes/Outcomes/Measures) -see SV Portal website	2019 6 month review Annual	ML/SP/DCH BI
	Embedding tools for monitoring, measuring and reporting on social value outcomes as part of our organisational processes.	Social Value Impact Assessment framework (for all Trust policies)		As per Policy review/All new Policies	TH/SP
	Reporting on our Social Value commitments	DCHFT Annual Report DCHFT Social Value Impact Report (tbd)		Annual	TH/SPa

DCHFT Social Value Action Plan

Workstream: SV Communications

Objective Communicate our Social Value commitments and outcomes internally and externally.		**Project Lead:** Susie Palmer, Head of Communications		
Ref	**Key Comms**	**Actions**	**Timeline**	**Responsibility**
	Internal communications: SV strapline (one-liner) SV Pledge summary/display Staff comms Provide advertising and promotional opportunities (free of charge) on site for appropriate local businesses.	Launch pledge via internal comms channels (Staff Bulletin/Staff App/CEO Brief) Link intranet to Social Value website page Install advertising noticeboard near main reception	April 2021	SVPG SP SPa

	External communications:			
	DCHFT Website (new)	Social Value page	April 2021	SPa
	Social media posts	Link community impact/involvement with #SocialValue	Ongoing	MH
	Media stories			SPa
	Social Impact Report	MSCP SV impact – residents newsletter to feature social value feature		SVPG/SPa
	Kickstart and apprenticeship schemes		April 2021	SPa/MH
		Promote Kickstart/apprenticeship schemes – case studies of young people working at DCH, encouraging expansion of Kickstart/apprenticeship opportunities	June 2021	
	Health Foundation – Anchors/C-19 report		Feb 2021	NJ/SP
	Health Anchors Learning Network	DCH 'case study' – delivering social value as an Health Anchor	17 May 2021	SP

DCHFT Social Value Action Plan

Key Element: Governance

Objective Governance		**Project Lead:** Trevor Hughes, Head of Governance	
Ref	**Action**	**Timeline**	**Responsibility**
	SV Terms of Reference	May 2021	TH/SP
	SVPG reporting Trust Board	See SVPG ToR Board (6 monthly)	NJ/Programme Group leads NJ
	SV Policy approval/review	Feb 2021 (approved) Annual review (SVPG) Jan 2024 (full review)	SP/SMT SVPG SVPG/SMT
	SV Action Plan approval (DCHFT Board) SV Action Plan review	May 2021 6 monthly	NJ/SP
	Develop Trust Corporate templates to include Social Value Impact Assessment: - Board reporting templates - Business planning templates	Ongoing	NJ/TH/SP
	Trust Policies: - Add SV Impact Assessment	All Trust Policies	KL/TH/SP

DCHFT Social Value Action Plan

Key Element: Policies

Objective		Project Lead Simon Pearson, Head of Charity & Social Value	
Ref	**Policy**	**Timeline**	**Responsibility**
	Social Value Policy	Feb 2021 (approved)	SP
	Social Value Impact Assessment	SVPG (19/5) for approval	SP
	Sustainable Procurement Policy		LB

DCHFT Social Value Action Plan

Key Element: SV Budget

Objective SV budget (operational budget to be developed / project-specific budgets tba as required)		**Project Lead** Nicholas Johnson, Deputy Chief Executive
Ref	**Budget Item**	**Budget**
	DCH Social Value Lead	0.2 WTE Band 8b
	DCH HI/SV post	tbc
	Comms (design/print)	Initial SV designs/publicity (NHS Creative) c£1200
	SV training courses	Primarily online (tbc)
	SVUK Membership (Annual)	£60

DCH Social Value Action Plan

Key Information *(Appendices to be added)*

Key Element	Key Information	Appendix
Governance	SVPG Terms of Reference	Appendix X
Policies/Key Documents	Social Value Policy Social Value Pledge Sustainable Procurement Policy DCH Green Plan (SDMP)	Link: http://sharepoint/departments/DCH-Social-Value/SitePages/Home.aspx Link: https://www.dchft.nhs.uk/about-us/social-value/ Appendix X/link Appendix X/link
Reporting	DCHFT Annual Report 2020/21 DCHFT Social Value Impact Report 2021/22	Appendix X Appendix X
DCH SV baseline evaluation	Initial SV evaluation analysis data (2019) Social Value Dashboard	See file Link: https://bireports.dchft.nhs.uk/reports/powerbi/Test/DCH004%20-%20Social%20Value%20Dashboard
Strategy/System	DCHFT Strategy 2020-25 (Refresh) Dorset ICS LTP NHS People Plan/DCH People Strategy	Appendix X Appendix X Appendices X/X
QI (Sustainable Quality Improvement)	Centre for Sustainable Healthcare - SusSchool	See SusQI course information
Volunteering **PALS**	Impact Report Patient Engagement – 'Your Voice'	Appendix X Appendix X
Charity/Community Partnerships	DCHC Annual Report	Appendix X
External Advisors	Health Foundation (reports) Prof. David Pencheon (ex NHS SDU)	Appendix X
Professional Bodies/Membership	SVUK Health Anchors Learning Network	Annual Membership https://haln.org.uk/

Role Identification

Role	Name	Contact
Executive Lead	**Nicholas Johnson**	**Nicholas.johnson@dchft.nhs.uk**
Social Value Lead	**Simon Pearson**	**Simon.pearson@dchft.nhs.uk**

Meeting Title:	Trust Board
Date of Meeting:	26 May 2021
Document Title:	**Guardian of Safe Working Annual Report**
Responsible Director:	Alastair Hutchison, Chief Medical Officer
Author:	Kyle Mitchell, Guardian of Safe Working

Confidentiality:	N/A
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
N/A		

Purpose of the Paper	The purpose of this monthly report is to provide the People and Culture committee a monthly overview on key workforce measures. This report is for information.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	Junior doctors have made an incredible contribution throughout the pandemic. The Trust has increased the establishment of junior doctors and reduced vacancies and this has been associated with a reduction in Exception Reports. The easing of Covid-19 related restrictions may challenge these successes.							
Action recommended	The Trust Board is asked to note the annual Guardian of Safe Working report.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Junior Doctor Contract 2016
Financial	Y	The report contains details of locum spend at a Doctors in Training grade level.
Impacts Strategic Objectives?	Y	Doctors in training provide important care for our patients. Despite being in training, they are still subject to regulation by the General Medical Council (GMC). Pressure may exist to work beyond their contractual commitments because of an overarching commitment to provide safe patient care as outlined by the GMC's Duties of a Doctor. In recognition of this potential conflict, the role of Guardian of Safe Working exists to ensure a focus, at trust level, on ensuring an environment in which doctors in training can work safely. Exception reports (breaches of the Junior Doctor contract) are highlighted which, if not effectively addressed, could present a risk to the Trust's contractual requirements.
Risk?	Y	As above.
Decision to be made?	N	N/A
Impacts CQC Standards?	Y	Safe. Well-lead.
Impacts Social Value ambitions?	N	N/A
Equality Impact Assessment?	N	N/A
Quality Impact Assessment?	N	N/A

Title of Meeting	**Trust Board**
Date of Meeting	**26 May 2021**
Report Title	**Annual Guardian Report of Safe Working report: Doctors in Training (April 2020 – March 2021)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

1.1 Junior doctors are a vital part of the workforce at Dorset County Hospital, providing round the clock care for sick patients and their contribution has continued without interruption throughout the Covid-19 pandemic.

1.2 All work schedules provided to doctors in training within the Dorset County Hospital NHS Foundation Trust ("the Trust") between April 2020 and March 2021 complied with contractual commitments under the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract").

1.3 All eligible doctors in training at the Trust between April 2020 and March 2021 were working under the 2016 Contract and all had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW).

1.4 Educational and Named Clinical Supervisors continue to play a key role in reviewing and overseeing resolution of Exception Reports. There continues to be a high level of engagement and most Exception Reports are resolved within 7 days of submission.

1.5 Facilities for Exception Reporting at the Trust continued throughout the period of the Covid-19 pandemic without interruption.

1.6 Exception Reporting has been at a reduced rate during the Covid-19 pandemic, with less than half as many reports submitted as during 2019/20 (see appendix 7).

1.7 The average total number of junior doctors employed by the trust has increased by 15 on year 2019/20 and the annual average vacancy rate for junior doctor posts has been at the lowest level since the post of GoSW was created. The enlarged pool of junior doctors available for employment is in part a consequence of the pandemic, and cannot be assumed to represent a permanent solution.

1.8 During the Covid-19 pandemic, the GoSW extended the use of the Exception Reporting to provide a method of escalating wider concerns of doctors in training regarding the safety of their workplace, including, for example, availability of PPE. No Exception Reports we generated regarding lack of PPE or "service support" more generally.

1.9 Some junior doctor rotas have been changed as a result of the scrutiny of Exception Reports.

1.10 The Junior Doctor Forum (JDF) has continued to meet at regular intervals during the Covid-19 pandemic, run by our Chief Registrar, with reliable participation from a small core of BMA representatives, and active engagement from HR, the divisions and Trust management. Inevitably, distanced working has hampered the less formal aspects of the JDF and in the opinion of the GoSW, the JDF should not remain "virtual" longer than epidemiologically necessary.

1.11 This is the fourth Annual Report to the Board by the GoSW. The report is based on a National Template and provides information about rota gaps, vacancies and issues relevant to the provision of a safe working environment doctors in training.

2. Introduction

2.1 This is the **annual** report covering the period of April 2020 – March 2021.

3. High level data

Number of doctors / dentists in training posts (total):	166	(154 in 2019/20)
Number of doctors in training post (total):	156.5	(141 in 2019/20)
Annual average vacancy rate among this staff group:	12.03	(7.2% vs.13% in 2019/20)

4. Annual data summary

4.1 Section 5 is the annual aggregate data on vacancies in junior doctor posts within in the Trust. This refers to all vacancies among the medical training grades (including trust doctors) during the previous year split by specialty, rota and grade. A more detailed breakdown as featured in the quarterly reports can be found in appendix 6.

Trainee Vacancies within the Trust

Speciality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Gaps Average WTE
Paediatrics	ST3	0	0.3	1.0	0.8	0.5
Paediatrics	ST4+	1.1	0.9	0.6	0.8	0.9
O&G	ST1	0	0.0	0.0	0.0	0.0
O&G	ST3+	0.4	0.4	1.6	0.6	0.8
ED	ST3+	0	0.0	0.0	0.0	0.0
Surgery	CT1	0	0.0	0.0	0.0	0.0
Surgery	CT2	0	0.0	0.0	0.0	0.0
Surgery	ST3+	1	1.0	1.0	1.0	1.0
Orthopaedics	ST3+	0	0.0	1.0	0.7	0.4
Anaesthetics	CT1/2	1	1.0	1.0	1.1	1.0
Anaesthetics	ST3+	1	0.7	0.5	0.3	0.7
Medicine	CT1/2	0	1.3	2.0	2.0	1.3
Medicine COE	ST3+	0	0.0	0.0	0.0	0.0
Medicine Diab/Endo	ST3+	0	0.0	0.0	0.0	0.0
Medicine Gastro	ST3+	0	0.0	0.0	0.0	0.0
Medicine Resp	ST3+	0.2	0.7	1.0	0.0	0.5
Medicine Cardio	ST3+	0	0.0	0.0	0.0	0.0
Medicine Renal	ST3+	0	0.1	0.1	0.1	0.1
Heamatology	ST3+	0	0.0	0.0	0.0	0.0
Med/Surg	FY1	0	0.0	0.0	0.0	0.0
Med/Surg	FY2	0	0.0	0.0	0.0	0.0
GPVTS	ST1	1	1.7	2.0	1.0	1.4
GPVTS	ST2	2.2	2.3	2.3	3.5	2.6
GPVTS	ST3	0	0.0	0.0	0.0	0.0
Orthodontics	ST3	1	1.0	1.0	0.7	0.9
Total		**8.9**	**11.57**	**15.1**	**12.53**	**12.03**

Trainee vacancies outside the Trust overseen by the LET guardian:

Speciality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Gaps Average WTE
General Practice	GPVTS	1	2.3	3	3.4	2.4
Public health trainees	FY1/2	0	0	0	0	0
Total		1	2.3	3	3.4	2.4

5. Key issues arising

5.1 Uncertain engagement with exception reporting - Exception Reports provide a useful tool not only for ensuring fair remuneration for doctors but also for identifying those clinical areas that are relatively understaffed or that lack resilience and as such may represent a clinical risk. Underreporting compromises the usefulness of this tool. The reduction in Exception Reports in 2020/21 may reflect an increased junior doctor establishment and the reduced vacancy rate and increased flexibility in general working but it remains important to be vigilant that this could reflect reduced engagement with reporting rather than fewer breaches. Restricted face-to-face interactions with large groups of junior doctors further hampers discussion of the role of Exception Reporting generally and addressing specific concerns of junior doctors.

5.2 Mismatch between clinical need and medical staffing

5.2.1 Specific clinical areas - As previously observed, clusters of Exception Reports have continued to appear from specific clinical areas when other areas reported few or no exceptions. This suggests a mismatch in resources.

5.2.2 Specific time periods - Exception Reports have highlight challenges at handover periods, with junior doctors preparing information for handover or ward rounds whilst still providing clinical care for patients.

5.3 "Rebound" problems may follow pandemic working patterns - The previous Annual Guardian's Reports have highlighted the association between vacancies and exceptions. In 2020/21, vacancies in doctor in training post are the lowest in recent years and fewer Exception Reports have been submitted. Numerous posts have been fortuitously filled by doctors whose plans for onward, often international, movement have been shelved by Covid-19 related restrictions.

6 Action taken to resolve issues

6.1 Uncertain engagement with exception reporting - The GoSW, supported by the Medical Director, has continued to promote the role of Exception Reporting at induction and JDF.

6.2 Mismatch between clinical need and medical staffing

6.2.1 Specific clinical areas - Temporary clusters of Exception Reports were identified within several clinical areas. Meetings were held with junior doctors supported by Program Directors. Outcomes have included changes to the FY1 and FY2/CT rota in Trauma & Orthopaedics; an extension to the General Surgical FY1 On-Call working day; and a redesign of the model of care for medical patients outlying on surgical wards.

6.2.2 Specific time periods - Changes have been made to rotas in General Surgery and Trauma & Orthopaedic to permit a longer overlap between day and night teams to avoid short but repeated breaches of working hours.

6.3 "Rebound" problems may follow pandemic working patterns - Restrictions to overseas travel for junior doctors cannot be considered to be a long term staffing solution. The anticipated easing of restrictions my result in a greater than usual exodus of junior doctors.

Previously, HR identified specific strategies to improve recruitment and retention including deliberate over-recruitment in areas with chronic under filling such as the Emergency Dept and these efforts should be supported despite the ongoing uncertainty regarding the ongoing pandemic and the apparent adequacy of medical staffing.

The GoSW Annual Report 2019/20 identified challenges associated with staffing over the Christmas/ New Year period and a post-holiday surge in Exception Reporting. The GoSW and Medical Director highlighted the importance of specific planning to ensure adequate staffing at this time. There was no apparent increase in Exception Reporting associated with the holidays this year, perhaps consistent with there being no significant holidays this year. It is vital to ensure that the memory of pre-pandemic problems endures long enough to guide post-pandemic action.

7 Other Information:

7.1 Resilience of junior doctors during the Covid-19 pandemic - The impact of the Covid-19 pandemic has been felt very acutely by our junior doctors. Most are on rotational attachments, away from family, living in temporary accommodation or with long commutes. Most are on temporary contracts with repeated competitive selection to gain training opportunities necessary to achieve their desired specialty. Most face arduous and expensive examinations and many hope to spend time in specialist centres, often abroad, to gain skills and experience. Few have robust local support networks and many have family at a distance. All have had to live with uncertainty regarding how this will affect their training and career progression.

The efforts of junior doctors working in this Trust throughout the Covid-19 pandemic have been astounding. The GoSW has observed commitment, dedication, calmness, maturity, positivity, helpfulness, cheerfulness, optimism and bravery amongst junior doctors that was almost overwhelming. Despite the challenges of working through the pandemic, junior doctors still took time to Exception Report when necessary and review/ resolve these with their supervisors.

7.2 Application of temporary contractual arrangements for pandemic working - In March 2020, The BMA and NHS Employers issued a joint statement providing

guidance for circumstances when an employer is unable to meet its obligations to provide safe and appropriate cover within the terms and conditions of the 2016 Contract. This recognised the potential need to remove the limit on the frequency of weekends worked; increasing maximum average weekly hours from 48 to 56; and increasing the maximum number of consecutive shifts and long day shifts reduced from 8 and 5 respectively. Rotas for junior doctors working in Anaesthesia, Paediatrics, Emergency Medicine and Medical and Surgical Specialties were temporarily modified in line with this guidance, usually to provide for uniform delivery of care across the 7-day week. By July 2020, The BMA withdrew support for this statement in view of the obvious reduction in hospital cases of Covid-19. Since August 2020, Junior Doctor rotas within the Trust have complied fully with the standard 2016 Contract.

7.3 **Extension of exception reporting to locally employed doctors working outside the 2016 Contract -** Locally Employed Doctors (LEDs) are not automatically allocated educational supervisors and are not contractually entitled to access to Exception Reporting. However, many LEDs work in a similar way to doctors in training employed under to 2016 Contract. The Trust's Medical Education Committee has declared its intention to support the career development of our LEDs and, as need and capacity allow, provide educational supervision for LEDs. The GoSW has extended access to Exception Reporting to LEDs who have a nominated supervisor and to review and act on these Reports in the same way as Reports generated by junior doctors working on the 2016 Contract.

7.4 **Support for junior doctors (fatigue and facilities charter) -** The Department of Health announced in May 2019 that a one off payment of £30,000 per trust would be made to improve rest facilities for doctors in training. A JDF subcommittee took oversight of this budget and prior to the pandemic a proportion of monies were spent or committed to improve on-call rooms, the junior doctor's mess and hospital accommodation common areas. The reality of pandemic working has delayed completion of some aspects of this project but work is ongoing and continues to be delivered by junior doctors with support from the Director of Medical Education, the Chief Executive and the GoSW.

7.5 **Guardian's Fines -** Whilst Exception Reports recognize demands inherent to the role of being a junior doctor and provide a mechanism for fair remuneration, Guardian's fines represent a failure on the part of the employer to provide safe and adequate staffing and should act as a deterrent. The Trust has, to date, avoided any Guardian's fines.

8 Conclusion

It is a privilege to work for the junior doctors in our Trust as Guardian of Safe Working.

Doctors in training, Educational Supervisors and the Trust continue to engage with the Exception Reporting process.

The resilience of our junior doctors during the Covid-19 pandemic is obvious. Due to the ongoing restrictions to normal life, some junior doctors on fixed-term and rotational employment have extended their time in the Trust. This has facilitated retention and increased our junior doctor workforce.

The Trust has increased its junior doctor establishment in line with anticipated demands.

The increased establishment and reduced vacancy rate matches a period of reduced Exception Reporting. The GoSW concludes that the Trust prioritizes, and complies with, the safeguarding aspects of the 2016 Junior Doctor Contract.

Maintenance of an adequate junior doctor workforce beyond the pandemic will be essential to ensure sustained resilience. The opening up of opportunities for travel may cause post-pandemic challenges.

ANNUAL GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

Appendix 1 – Exception Reports by department, grade and rota

Exception reports by department					
Specialty	No. exceptions carried over from last report Apr 2019 - Mar 2020	No. exceptions carried over from last report that remain open Apr 2019 - Mar 2020	No. exceptions raised Apr 2020 - Mar 2021	No. exceptions closed Apr 2020 - Mar 2021	No. exceptions outstanding Apr 2020 - Mar 2021
A&E	0	0	0	0	0
Acute Medicine	0	0	5	5	0
Adult Psychiatry	0	0	0	0	0
Anaesthetics	0	0	0	0	0
Anaesthetics ICU	0	0	0	0	0
Cardiology	1	0	6	7	0
Clinical Oncology	0	0	3	3	0
Colorectal	0	0	0	0	0
Diabetes & Endocrinology	0	0	0	0	0
Elderly Care	0	0	15	15	0
Gastroenterology	0	0	23	22	1
General Medicine	0	0	18	18	0
General Practice	0	0	0	0	0
General Psychiatry	0	0	0	0	0
General Surgery (inc Breast, Upper GI, Vascular, ENT, Colorectal)	0	0	24	24	0
Haematology	0	0	1	1	0
Histopathology	0	0	0	0	0
Obstetrics & Gynaecology	0	0	9	9	0
Ophthalmology	0	0	0	0	0
Orthodontics	0	0	0	0	0
Orthopaedics	1	0	4	5	0
Paediatrics	0	0	0	0	0
Renal	0	0	0	0	0
Respiratory	0	0	7	7	0
Urology	0	0	2	2	0
Total	**2**	**0**	**117**	**118**	**1**

Exception Reports by grade					
Specialty	No. exceptions carried over from last report Apr 2019 – Mar 2020	No. exceptions carried over from last report that remain open Apr 2019 – Mar 2020	No. exceptions raised Apr 2020 -Mar 2021	No. exceptions closed Apr 2020-Mar 2021	No. exceptions outstanding Apr 2020-Mar 2021
F1	1	0	87	88	0
F2	1	0	5	5	1
CT1-2/ST1-2	0	0	23	23	0
ST3-8	0	0	2	2	0
Total	2	0	117	118	1

Exception Reports by rota					
Specialty	No. exceptions carried over from last report Apr 2019-Mar 2020	No. exceptions carried over from last report that remain open Apr 2019-Mar 2020	No. exceptions raised Apr 2020-Mar 2021	No. exceptions closed Apr 2020-Mar 2021	No. exceptions outstanding Apr 2020-Mar 2021
CMT/GPVTS Cardiology	0	0	0	0	0
CMT/GPVTS Haematology	0	0	0	0	0
CMT/GPVTS Respiratory	0	0	0	0	0
CT1 Acute Medicine	0	0	1	1	0
CT1 Clinical Oncology	0	0	3	3	0
CT1 Geriatric Medicine	0	0	4	4	0
CT1 Haematology	0	0	1	1	0
CT1-2 Anaesthetics	0	0	0	0	0
CT1-2 Anaesthetics ICU	0	0	0	0	0
FY1 Acute Internal Medicine	0	0	4	4	0
FY1 Adult Psychiatry (Surgical on call)	0	0	0	0	0
FY1 Breast/Vascular	0	0	0	0	0
FY1 CAMHS (Gen Adult)	0	0	0	0	0
FY1 Cardiology	1	0	6	7	0
FY1 Child & Adolescent Psychiatry (Orthopaedic On call)	0	0	0	0	0
FY1 Colorectal/UGI	0	0	0	0	0
FY1 Colorectal/Urology/ENT	0	0	0	0	0
FY1 ENT	0	0	0	0	0
FY1 Gastroenterology	0	0	18	18	0

FY1 General Medicine	0	0	11	11	0
FY1 General Surgery	0	0	24	24	0
FY1 Geriatric/Stroke	0	0	10	10	0
FY1 O&G	0	0	1	1	0
FY1 Orthopaedic	0	0	4	4	0
FY1 Paediatric	0	0	0	0	0
FY1 Renal	0	0	0	0	0
FY1 Respiratory	0	0	7	7	0
FY1 Urology (with Ortho & Surgical on call)	0	0	2	2	0
FY2 AHAH	0	0	0	0	0
FY2 Anaesthetics ICM	0	0	0	0	0
FY2 Gastroenterology	0	0	3	2	1
FY2 General Practice (AHAH – Med On Call)	0	0	0	0	0
FY2 GP – Med On Call	0	0	0	0	0
FY2/CMT Cardiology	0	0	0	0	0
FY2/CMT Medical Oncology	0	0	0	0	0
FY2/CMT Renal Medicine	0	0	0	0	0
FY2/CMT Respiratory Medicine	0	0	0	0	0
FY2/CT1/2/GPVTS - ENT	0	0	0	0	0
FY2/CT1/2/GPVTS - General Surgery	0	0	0	0	0
FY2/CT1/2/GPVTS - Orthopaedic	1	0	0	1	0
FY2/CT1/2/GPVTS General Medicine	0	0	7	7	0
FY2/GPVTS A&E	0	0	0	0	0
FY2/GPVTS Paediatrics	0	0	0	0	0
FY2/ST1-2 Obstetrics & Gynaecology	0	0	8	8	0
GPVTS – GP	0	0	0	0	0
GPVTS- Community Geriatric Medicine	0	0	1	1	0
GPVTS Palliative Care	0	0	0	0	0
ST1-2 Histopathology	0	0	0	0	0
ST3+ Cardiology	0	0	0	0	0
ST3-8 Anaesthetics	0	0	0	0	0
ST3-8 Gastroenterology	0	0	2	2	0
ST3-8 General Medicine	0	0	0	0	0
ST3-8 General Surgery	0	0	0	0	0
ST3-8 Haematology	0	0	0	0	0
ST3-8 Orthopaedics	0	0	0	0	0

ST3-8 Paediatrics	0	0	0	0	0
ST3-8+ Obstetrics & Gynaecology	0	0	0	0	0
WAST Trainee Medical Rota	0	0	0	0	0
Total	**2**	**0**	**117**	**118**	**1**

Standard Exception Reports - response time Apr 2020 – Mar 2021			
	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	46	41	0
F2	3	1	1
CT1-2 / ST1-2	18	5	0
ST3-8	0	2	0
Total	67	49	1

Exception Reports - Immediate safety Concern - response time Apr 2020 – Mar 2021				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	1	1	2	0
F2	0	0	0	0
CT1-2 / ST1-2	0	1	0	0
ST3-8	0	0	0	0
Total	1	2	2	**0**

Appendix 2 – Work schedule reviews by grade and department

Work schedule reviews by grade Apr 2020 - Mar 2021	
F1	22
F2	3
CT1-2 / ST1-2	4
ST3+	0

Work schedule reviews by department Apr 2020 – Mar 2021	
A&E	0
Acute Medicine	0
Adult Psychiatry	0
Anaesthetics	0
Anaesthetics ICU	0
Cardiology	0
Clinical Oncology	3
Colorectal	1
Diabetes & Endocrinology	0
Elderly Care	2
Gastroenterology	16
General Medicine	0
General Practice	0
General Psychiatry	0
General Surgery (inc Breast, Upper GI, Vascular, ENT)	0
Haematology	0
Histopathology	0
Obstetrics & Gynaecology	2
Ophthalmology	0
Orthodontics	0
Orthopaedics	4
Paediatrics	0
Renal	0
Respiratory	1
Urology	0
Total	29

Appendix 3 - Locum agency bookings and bank usage

The following table sets out spend for each department and grade; this is indicative of the amount of bank activity in each area.

	Q1	Q2	Q3	Q4	YEAR
DIVISION A	**£312,880.11**	**£322,397.10**	**£352,763.67**	**£264,954.23**	**£1,252,995.11**
CONSULTANT BANK	**£514.22**	**£20,172.36**	**£21,903.43**	**£11,156.98**	**£53,746.99**
VASCULAR SURGERY	£0.00	£0.00	£0.00	£10,813.54	£10,813.54
EMERGENCY MEDICINE	£615.24	£1,277.92	£0.00	£615.24	£2,508.40
HISTOPATHOLOGY	£0.00	£11,786.02	£9,000.00	-£9,000.00	£11,786.02
MEDICAL MICROBIOLOGY	-£101.02	£7,108.42	£12,903.43	£8,728.20	£28,639.03
SPECIALTY DOCTOR BANK	**£37,166.34**	**£15,658.96**	**£34,104.55**	**£31,694.05**	**£118,623.90**
GENERAL (INTERNAL) MEDICINE	£8,445.61	£6,710.19	£13,418.76	£11,005.55	£39,580.11
EMERGENCY MEDICINE	£21,460.92	£2,806.27	£15,802.62	£8,843.72	£48,913.53
CARDIOLOGY	£0.00	£0.00	£0.00	£5,393.16	£5,393.16
PALLIATIVE MEDICINE	£7,259.81	£6,142.50	£4,883.17	£6,451.62	£24,737.10
GENERAL PRACTITIONERS BANK	**£244,669.18**	**£209,083.64**	**£218,148.47**	**£129,303.79**	**£801,205.08**
DORSET HEALTHCARE NHS FT	£0.00	£0.00	£49,784.09	£12,673.82	£62,457.91
GP DOCTORS IN TRAINING	£197,286.56	£161,781.77	£180,548.11	£27,612.94	£567,229.38
GENERAL MEDICAL PRACTITIONER	£47,382.62	£47,301.87	£37,600.36	£89,017.03	£221,301.88
UNIVERSITY HOSPITALS DORSET NH	£0.00	£0.00	-£49,784.09	£0.00	-£49,784.09
SPECIALTY TRAINEE BANK	**£27,958.90**	**£60,680.10**	**£70,247.93**	**£71,760.90**	**£230,647.83**
GENERAL (INTERNAL) MEDICINE	£27,651.29	£48,663.98	£50,305.36	£52,454.32	£179,074.95
EMERGENCY MEDICINE	£307.61	£2,821.58	£5,132.27	£4,509.44	£12,770.90
CARDIOLOGY	£0.00	£9,194.54	£14,810.30	£14,797.14	£38,801.98
FOUNDATION YEAR 2 BANK	**£2,571.47**	**£16,802.04**	**£8,359.29**	**£21,038.51**	**£48,771.31**
GENERAL (INTERNAL) MEDICINE	£2,571.47	£11,595.00	£5,655.55	£5,178.18	£25,000.20
EMERGENCY MEDICINE	£0.00	£5,207.04	£2,703.74	£15,860.33	£23,771.11

	Q1	Q2	Q3	Q4	YEAR
DIVISION B	**£211,988.67**	**£194,076.29**	**£227,190.54**	**£243,625.32**	**£876,880.82**
CONSULTANT BANK	**£85,513.63**	**£113,823.03**	**£123,172.39**	**£137,691.02**	**£460,200.07**
ANAESTHETICS	£10,253.20	£20,512.52	£4,852.17	£12,872.54	£48,490.43
OPHTHALMOLOGY	£0.00	£0.00	£5,021.28	£0.00	£5,021.28
TRAUMA AND ORTHOPAEDIC SURGERY	£643.44	£0.00	£0.00	£0.00	£643.44
PAEDIATRICS	£18,000.00	£20,751.09	£12,508.71	-£101.02	£51,158.78
CLINICAL NEUROPHYSIOLOGY	£602.40	£2,731.20	£1,968.00	£3,854.94	£9,156.54
LOCUM CLINICAL RADIOLOGY	£28,518.25	£28,451.38	£28,359.15	£18,439.14	£103,767.92
YEOVIL DISTRICT HOSP NHS FT	£9,938.00	£9,940.00	£9,939.00	£1,266.00	£31,083.00
LOCUM OTOLARYNGOLOGY	£0.00	£0.00	£0.00	£9,004.49	£9,004.49
LOCUM ANAESTHETICS	£17,558.34	£31,436.84	£60,524.08	£92,354.93	£201,874.19
SPECIALTY DOCTOR BANK	**£25,245.23**	**£19,935.66**	**£35,885.18**	**£52,417.02**	**£133,483.09**
ANAESTHETICS	£18,979.93	£11,297.27	£26,484.66	£39,698.43	£96,460.29
GENERAL SURGERY	£2,592.21	£0.00	£2,233.12	£967.30	£5,792.63
OBSTETRICS AND GYNAECOLOGY	£3,673.09	£8,638.39	£7,167.40	£11,751.29	£31,230.17
SPECIALTY TRAINEE BANK	**£97,923.01**	**£60,317.60**	**£64,980.71**	**£50,507.27**	**£273,728.59**
GENERAL (INTERNAL) MEDICINE	£0.00	£154.90	£0.00	£0.00	£154.90
ANAESTHETICS	£14,491.11	£6,407.80	£8,237.79	£16,182.04	£45,318.74
GENERAL SURGERY	£57,060.47	£35,524.16	£36,704.20	£21,947.02	£151,235.85
TRAUMA AND ORTHOPAEDIC SURGERY	£26,371.43	£9,185.12	£1,748.23	£2,233.12	£39,537.90
PAEDIATRICS	£0.00	£1,889.66	£0.00	£2,008.57	£3,898.23
OBSTETRICS AND GYNAECOLOGY	£0.00	£7,155.96	£9,680.29	£2,233.12	£19,069.37
DERMATOLOGY	£0.00	£0.00	£8,610.20	£5,903.40	£14,513.60
FOUNDATION YEAR 2 BANK	**£3,306.80**	**£0.00**	**£3,152.26**	**£3,010.01**	**£9,469.07**
TRAUMA AND ORTHOPAEDIC SURGERY	£3,306.80	£0.00	£3,152.26	£3,010.01	£9,469.07

Appendix 5 – Fines levied by Department and Cumulative Total

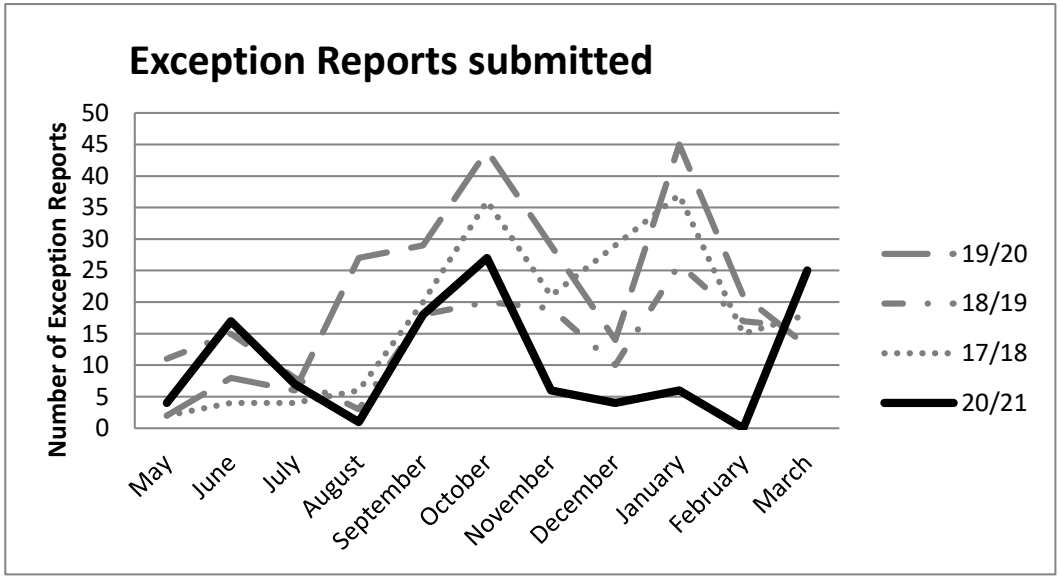
Fines by department		
Department	Number of fines levied	Value of fines levied
Paediatrics	0	0
Obstetrics & Gynaecology	0	0
ENT	0	0
Urology	0	0
Vascular	0	0
Breast	0	0
Upper GI	0	0
Colorectal	0	0
Orthopaedics	0	0
Anaesthetics	0	0
Anaesthetics ICU	0	0
Orthodontics	0	0
Ophthalmology	0	0
Haematology	0	0
Histopathology	0	0
A&E	0	0
Acute Medicine	0	0
Elderly Care	0	0
Stoke	0	0
Clinical Oncology	0	0
Cardiology	0	0
Respiratory	0	0
Renal	0	0
Gastroenterology	0	0
Diabetes & Endocrinology	0	0
Adult Psychiatry	0	0
General Psychiatry	0	0
General Practice	0	0

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
0	0	0	0

Appendix 6 – Medical training grade vacancies

		Q1				Q2				Q3				Q4				
Specialty	**Grade**	**Apr**	**May**	**June**	**Average Q1**	**July**	**August**	**Sept**	**Average Q2**	**Oct**	**Nov**	**Dec**	**Average Q3**	**Jan**	**Feb**	**Mar**	**Average Q4**	**Annual Average WTE**
Paediatrics	ST3	0	0	0	0	0	0	1	0.3	1	1	1	1.0	1	1	0.3	0.8	0.5
Paediatrics	ST4+	1.1	1.1	1.1	1.1	1.1	1.1	0.6	0.9	0.6	0.6	0.6	0.6	0.6	0.6	1.2	0.8	0.9
O&G	ST1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
O&G	ST3+	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.6	1.6	1.6	1.6	0.6	0.6	0.6	0.6	0.8
ED	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	CT1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	CT2	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	ST3+	1	1	1	1	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	1.0
Orthopaedics	ST3+	0	0	0	0	0	0	0	0.0	1	1	1	1.0	1	1	0	0.7	0.4
Anaesthetics	CT1/2	1	1	1	1	1	1	1	1.0	1	1	1	1.0	1	1.2	1.2	1.1	1.0
Anaesthetics	ST3+	1	1	1	1	1	0.6	0.6	0.7	0.6	0.6	0.4	0.5	0.2	0.4	0.4	0.3	0.7
Medicine	CT1/2	0	0	0	0	0	2	2	1.3	2	2	2	2.0	2	2	2	2.0	1.3
Medicine COE	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Diab/Endo	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Gastro	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Resp	ST3+	0.2	0.2	0.2	0.2	0.2	1	1	0.7	1	1	1	1.0	0	0	0	0.0	0.5
Medicine Cardio	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Renal	ST3+	0	0	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Heamatology	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Med/Surg	FY1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Med/Surg	FY2	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
GPVTS	ST1	1	1	1	1	1	2	2	1.7	2	2	2	2.0	2	4	4	1.0	1.4
GPVTS	ST2	2.2	2.2	2.2	2.2	2.2	2.4	2.4	2.3	2.4	2.4	2	2.3	2.4	4	4	3.5	2.6
GPVTS	ST3	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Orthodontics	ST3	1	1	1	1	1	1	1	1.0	1	1	1	1.0	1	1	0	0.7	0.9
Total		**8.9**	**8.9**	**8.9**	**8.9**	**9**	**12.6**	**13.1**	**11.57**	**15.3**	**15.3**	**14.7**	**15.1**	**12.9**	**16.9**	**14.8**	**12.53**	**12.03**

Appendix 7 – Exception Reports submitted month by month at Dorset County Hospital since adoption of the 2016 Contact



Meeting Title:	**Board of Directors**
Date of Meeting:	**26 May 2021**
Document Title:	**Committee Effectiveness Review, Priorities and Terms of Reference**
Responsible Director:	**Patricia Miller, Chief Executive**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	*If Confidential please state rationale:*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Prior consultation and discussion by committee and Board members	March – April 2021	• Committee effectiveness reviews to be reported to respective committees • Annual committee priorities to be developed and agreed • Terms of Reference to be updated and presented consistently • Committee work programmes to be reviewed and agreed
Respective Committees	May 2021	Final amendments and submission to Board for approval
Risk and Audit Committee	May 2021	Recommended to the Board

Purpose of the Paper	The purpose of the report is to present the outcome of the annual committee review of effectiveness process and seek approval of the subsequent committee priorities, work programme and revised Terms of Reference. Additionally, the report provides a collective summary of the other Board subcommittee effectiveness reviews for the committee's consideration, providing assurances on the system of internal governance and control.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	Good governance practice determines that committees of the Board of Directors should undertake an annual review of their effectiveness in order to inform changes to their terms of reference, priorities and work programmes for the forth coming year, so demonstrating effective leadership and supporting development of the overall strategy objectives. Each Committee has undertaken a review of effectiveness using an appreciative enquiry approach and the model questionnaire contained within the Audit Committee Handbook 2014. The results are appended and provided a common theme to strengthen committee scrutiny for their respective areas of risk and closer alignment of the priorities to the strategy. Greater communication and triangulation between committees on areas of shared responsibility and action was also identified. There have been a number of Director portfolio changes in year resulting in changes to committee membership and the impact of the pandemic has impacted priorities and the committee work programme. The Terms of Reference for committees have been reviewed and re formatted to provide consistency of approach and to reflect the change requirements.							

The Risk and Audit Committee (RAC) has identified the following priorities for the year 2021/22:

1. Alignment of the Board Assurance Framework (BAF) to the new strategy and ensuring that the revised BAF is understandable, usable and relevant.
2. Focussed scrutiny at all Board Committees of the key risks relevant to that committee, with those risks and actions escalated to RAC to provide scrutiny and an holistic DCH risk view.
3. RAC make greater use of the new managed risk function where risks are tolerated within risk appetite. Such risks and their mitigation and risk status will be reviewed every 6 months.

These three themes will be used to set the Agenda for an annual Board "Risk Summit" or annual Board risk review.

The Priorities for the Quality Committee and the Finance and Performance Committee are contained with the papers. With the emergent People Strategy, Equality Diversity and Inclusion Strategy and newly appointed Chief People Officer and Non-Executive Chair of the People and Culture Committee, development of the priorities for this committee are delayed and will be presented to the Board for approval in the near future.

The annual committee effectiveness review also provides the opportunity for each committee to review their Terms of Reference that determine how the committee will operate. The Terms of Reference have been rewritten this year to provide a consistent approach to their presentation and format. Key changes within the Terms of reference are:

		Previously	**Proposed**
Risk and Audit Committee	**Purpose**		Added the seeking of committee assurances regarding the oversight and scrutiny of risks
	Membership		Unchanged Added that Committee Chairs are to attend in order to report on assurance obtained by committees on their respective areas of responsibility
	Quorum	Two members	Two NEDs Two Executives (one must be CMO or CNO)
	Frequency	At least four times per year	Unchanged
Finance and Performance Committee	**Purpose**		Added responsibility for oversight of the DCH Subco
	Membership	Four NEDs	Three NEDs (one of which will be clinical)
	Quorum	Two NEDs Two Executives	Unchanged
	Frequency	10 times per year	Unchanged
Quality Committee	**Purpose**		unchanged
	Membership	Four NEDS	Three NEDs (one of which will be clinical) Added Chief Operating Officer
	Quorum	Two NEDs	One Executive must be

			Two Executives	CMO or the CNO
		Frequency	10 times per year	Unchanged
	People and Culture Committee	**Purpose**		Remains under review
		Membership		Added Director of Strategy, Transformation and Partnerships Heads of Operational HR Services moved to 'In attendance'
		Quorum	Two NEDs Three Executives	Two NEDs Two Executives
		Frequency	Monthly	10 times per year
Action recommended	The Board of Directors is asked to: 1. **NOTE** the outcome of the committee effectiveness review 2. **APPROVE** the committee priorities 3. **Approve** the revised Terms of Reference 4. **Approve** the committee work programme			

Governance and Compliance Obligations

Legal / Regulatory	Y	Committees of the Board are required to undertake an annual review of their effectiveness
Financial	N	
Impacts Strategic Objectives?	Y	Committees monitor the Trust's performance and delivery of the Strategy which informs their programmes of work
Risk?	Y	Committees seek assurances on controls and mitigations to manage risks to delivery of the Strategy which informs their programmes of work
Decision to be made?	Y	The Committee is asked to approve the revised Terms of Reference, Priorities for the coming year and Work Programme
Impacts CQC Standards?	Y	Supports delivery of the Well Led standard
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Board Committee Performance Review – March 2021

Introduction

As part of the Board of Directors' corporate governance and performance management arrangements, committees that the Board has established undertake an annual review of their performance and Terms of Reference and report these to the Audit Committee. This requirement provides assurance to the Board that its committees are working effectively and provides information to the Board of Directors for use in the Board's annual review of committee performance and effectiveness. This paper reflects the key points arising from the committee annual reviews undertaken during 2020/21 in relation to the period April to March 2021 in order to inform planned discussion by the Board and inform the respective reviews of committee Terms of Reference and work plans.

Annual reviews of committee performance and effectiveness for 2020/21 were completed using the performance checklist and effectiveness questionnaire contained within the fifth edition of the Audit Committee Handbook published in the autumn 2014 as a basis for respective reviews. An Appreciative Enquiry approach was included in order to invite comment and suggestions on areas for committee development.

Board Committees

In accordance with the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, the Trust Board has formally established the following Committees and delegated authority to these via agreed Terms of Reference:

- Risk and Audit Committee
- Finance and Performance Committee
- Quality Committee
- People and Culture Committee (formerly Workforce Committee)

Changes to the membership of Board Committees was reviewed in year following changes within both the Executive management team and the Non-Executive membership of the Board of Directors. These changes did not adversely impact delivery of Committee Work Programmes or quoracy / attendance at meetings which remained good throughout the change period.

COVID Pandemic

The Board of Directors approved that the operation of Board meetings and subcommittees during the reporting period be necessarily amended in light of national guidance to 'reduce the burden' on Executive and operational teams in

order to release capacity to address the pandemic crisis. Respective subcommittee Terms of Reference were temporarily amended in order release executive capacity and to enable subcommittees to focus on key risks and decision making. Both the performance and financial management regimes were significantly altered nationally and a number of working groups were suspended throughout. Committees have reported a feeling of loss of strategic focus nationally and locally and that the Board has not been fully sighted on strategic risk and committees have not had the capacity to deliver the planned work programmes fully throughout the year.

Meetings also moved from a face to face to teleconference and were reduced in length; the primary focus being to maintain best care and the safety and wellbeing of staff, patients and the public. Divisional representation and attendance at subcommittee meetings was not required during the pandemic.

Committee Reviews

The Audit Committee Handbook 2014 was used to form the basis of the 2020/21 Committee reviews undertaken during March 2021 and included:

- Attendance and Quoracy
- Membership
- Reporting to the Trust Board
- Meeting the Terms of Reference and work undertaken by the Committee
    - The Audit Committee Handbook 2014 Committee performance evaluation checklist was amended to reflect each Committee Terms of Reference and used as the basis for the self-assessment exercises
    - Table 1 below reflects the business transacted by each committee in line with their respective Terms of Reference / Work programmes.
- Review of areas for improvement and recommendations

Committee and Strategic Risk Review Process

The Audit Committee Handbook 2014 was published in autumn 2014. The Audit Committee Handbook provides guidance on Board reporting arrangements, production of Annual Reports, review of work plans and other best practice guidance and was used as the basis for the subcommittee reviews in 2021/22.

The Board Assurance Framework (BAF) provides a register of strategic risks, controls and mitigations potentially impacting delivery of the Trust's strategic objectives. Scrutiny and monitoring of the BAF and mitigating action is undertaken by the Risk and Audit Committee. In conjunction with the planned review of the Trust's Strategy, both the Executive and Non-Executive teams reviewed how the Board could be more actively sighted on strategic risks and a proposal was approved by the Board in March 2021. The proposal outlined a shift in scrutiny and monitoring of BAF risks from the Risk and Audit Committee to respective portfolio committees as part of their programme of work going forward. The Risk and Audit Committee will

retain oversight of the system of internal control and seek assurances on BAF risk mitigation from Committee Chairs.

Director Portfolio Changes

The Director of Workforce and OD left the Trust in October 2020. The role was reviewed and would support the greater development of a People Culture going forward. The post was renamed to Chief People Officer to reflect the change with the new appointment expect5ed to take up post in April 2021. A new Non-Executive Director was appointed in January 2021 and became Chair of the People and Culture Committee shortly afterwards.

The Senior Independent (Non-Executive) Director (SID) and Chair of the Workforce Committee left the Trust at the end of September 2020 and the SID role was assigned to another Non-Executive Director. The Non-Executive vacancy was appointed and commenced in January 2021.

The Director of Nursing and Quality post was retitled as Chief Nursing Officer and the Director of Finance and Resources was retitled Chief Finance Officer.

Table 1 – Board Committee Reviews at a Glance for Period April 2020 to March 2021

	Audit and Risk Committee	**Finance and Performance Committee**	**Quality Committee**	**People and Culture Committee** (Workforce Committee)
Attendance and Quoracy	Met on six occasions. Committee has been quorate on all occasions.	Met on 12 occasions. Committee has been quorate on all occasions.	Met on 12 occasions. Committee has been quorate on all occasions.	Met on 12 occasions. Committee has been quorate on all occasions.
Membership	• Three Non-Executive Directors • Chief Finance Officer • Medical Director and/or Chief Nursing Officer • Chief Executive (for Annual Report and Accounts)	• Four Non-Executive Directors • Chief Executive Officer • Chief Finance Officer • Chief Operating Officer • Director of Strategy, Transformation and Partnerships • Director of Workforce	• Four Non-Executive Directors • Chief Executive Officer • Chief Nursing Officer • Medical Director • Chief Operating Officer	• Three Non-Executive Directors • Chief Executive Officer • Chief Operating Officer • Medical Director • Chief Nursing Officer • Director of Strategy and Transformation • Director of Workforce
Attendance	• Head of Corporate Governance • Internal and External Audit representation at each meeting • Anti-Fraud Specialist	• Head of Corporate Governance • Divisional Directors • No additional co-opted members	• Head of Corporate Governance • Divisional Clinical Directors • Divisional Associate Directors of Nursing • No additional co-opted members	• Head of Corporate Governance • Head of Education • Head of Workforce • Head of HR Operations • Head of Diversity and Inclusion • Divisional Directors • No additional co-opted members
Board Reporting	• Escalation Report provided post meeting	• Escalation Report provided post meeting	• Escalation Report provided post meeting	• Escalation Report provided post meeting
Meeting Terms of Reference / Summary of Work Undertaken	• Internal Audit reports on a range of activities within the Internal Audit Plan • External Audit review of financial statements and Annual Governance Statement • Progress reports on Anti-Fraud activities	• Medium and long term financial strategy and planning • Performance reporting and management / trouble shooting and detailed scrutiny • Review and approval of performance indicators and Balanced Score Cards • Business case approval and	• Strategy approval and policy ratification • Corporate Risk Register • CQC Compliance • Complaints, claims and inquests • Sub-committee reports and work plan approval • Infection prevention and Control	• Workforce Strategy and planning • Operational workforce performance and metrics • HR policies • Education and leadership development • Recruitment and retention –

	Audit and Risk Committee	Finance and Performance Committee	Quality Committee	People and Culture Committee (Workforce Committee)
	• Board Assurance Framework • Head of Internal Audit Opinion • Policy approval	oversight • Capital Programme management	Monitoring • Patient Experience • Safeguarding and serious case reviews • Learning from Death Reports • Medicines Management Updates • Clinically focussed policy and strategy monitoring and approval. • DCHFT response to national report findings • Divisional Presentations	including overseas • Workforce risk • Bank and Agency usage • Equality Diversity and Inclusion • Workforce policies
Review of Terms of Reference	Annual review to be approved in April 2021	Annual review to be approved in April 2021	Annual review to be approved in April 2021	Annual review to be approved in April 2021
Cycle of Business	Annual review to be approved in April 2021	Annual review to be approved in April 2021	Annual review to be approved in April 2021	Annual review to be approved in April 2021
Areas for Development	• Greater discussion of the Clinical Audit Programme is required • Greater communication from committee to the wider trust is needed post pandemic • Reports could be more concise and follow the Trust's format with an effective coversheet summary • Internal and External Audit report specifications need greater clarity in order to improve recommendations to RAC	• Greater committee ownership of strategic risk and alignment of the work programme to the strategic objectives • Need to undertake more work on how committee objectives are measured and reviewed. • Action log to be updated prior to the meeting – this will save time in the meeting when the agenda is already full. • Reports could be more concise and follow the Trust's format.	• Greater committee ownership of strategic risk and alignment of the work programme to the strategic objectives • More work on highlighting corporate risks and linking these to the strategy • Good escalation of corporate risks, recommendations and issues to Board • Focus occasionally strays from outcome focus into operational matters • More formal reporting to the committee is required • Need to review communication process about committee decisions	• Greater committee ownership of strategic risk and alignment of the work programme to the strategic objectives – awaiting Executive appointment to refocus the committee's objectives • The focus shift to people and culture is recognised. • Timely opportunity to review the programmes of work going forward to reflect the planned step change in focus. • Need to improve feedback to the workforce team • Action log to be completed prior to the meeting

	Audit and Risk Committee	**Finance and Performance Committee**	**Quality Committee**	**People and Culture Committee** (Workforce Committee)
	• There needs to be greater reporting on information governance matters to the committee		• Data availability impacts on the timeliness of papers • Improvements are required to the completion of the Action Log. • Reports could be more concise and follow the Trust's format. • Decisions made outside of the meeting that directors not always aware of. • Further improve engagement with divisions to better understand their risks and issues.	• Reports could be more concise and follow the Trust's format with an effective coversheet summary

Conclusion

All committees of the Board have completed an annual review and self-assessment of performance using a standardised approach in 2020/21. The impact of the COVID-19 pandemic has been a common theme impacting the normal operation of committees throughout the year.

Attendance has remained good throughout 2020/21, albeit that the majority of meetings were conducted via teleconferencing arrangements and all committee meetings have been quorate allowing committee business to be appropriately transacted. Each committee has appropriately encouraged attendance by management representatives although no committee has needed to co-opt membership in order to facilitate its understanding of the business to be transacted.

Each committee has continued to meet its Terms of Reference and has delivered a comprehensive programme of work on behalf of the Board, providing timely reporting of issues via Escalation Reports, introduced in year, following each meeting. Changes in Executive Director portfolios and to Non-Executive membership of the Board of Directors did not adversely affect the operation of Committees although the national changes to the performance and finance regimes due to the pandemic, were necessarily reflected in reporting of these elements to subcommittees.

The Internal Audit programme was maintained as far as has been reasonably possible given the pandemic although progress on action delivery in a number of previously reported audit reports has been delayed. No external / third party reviews of performance or Board / subcommittee effectiveness were undertaken during the reporting period. A comprehensive External Audit Value for Money Audit was completed during Quarter 4.

A common theme has been to strengthen scrutiny of strategic risk and monitoring of mitigating actions and this has been achieved with the Board's approval for respected elements of the BAF being reviewed by sub committees and reporting assurances to the Risk and Audit Committee from April 2021.

Each committee welcomes the planned return to business as usual post pandemic and the return of divisional representation and attendance at meetings. Committees have identified a small number of areas for development and implementation during 2021/22. Common themes are summarised as follows:

- Greater committee ownership of strategic risk and alignment of the work programme to the strategic objectives
- Greater communication from committees to the wider trust on the outcome from each meeting is needed post pandemic
- Reports could be more concise and follow the Trust's format with an effective coversheet summary
- Action log to be updated prior to the meeting – this will save time in the meeting when the agenda is already full.

Other areas for specific committees to address include

- Greater discussion of the Clinical Audit Programme is required by the Risk and Audit Committee
- Information Governance reporting to Risk and Audit Committee needs to be strengthened
- The work of the People and Culture committee need to be refocussed and is recognised.
- Improve formal reporting into Quality Committee

These recommendations will be incorporated within subcommittee work programmes for 2021/22.

Recommendations

The Board is asked to note the findings of Board sub-committee annual effectiveness reviews and to note that sub-committee Terms of Reference and Cycles of Business that the address areas of development identified, will be returned to the Board for approval in April / May 2021.

Trevor Hughes

Head of Corporate Governance

March 2021

Appendices – Committee Effectiveness Questionnaires – Consolidated

Committee Effectiveness Self-Assessment Questionnaire 2020

Risk and Audit Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy		X X X X				RAC should own overall RAC processes and specific RAC risks but be looking to Assure Board that Quality FPC & P&C owned risks are being appropriately owned and managed by those committees Lots of variation during covid with developments on what the board want in terms of internal audit, risk register etc. Lack of BAF updates I feel have impacted upon the board really aware of the strategic risks
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work providing that is aligned to		X X X X				Again noting the heavy impact of Covid on our cycles of business which have inhibited our time for

	relevant strategic objectives						conducting the annual cycle appropriately Overall through the pandemic the committee have covered what it could on the work plan.
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or on the committee's work programme		X X X	X			There needs to be a better alignment to the strategic objectives risks and BAF, hampered by the committee not having reviewed it in detail for some time
4	The Committee receives regular reports on strategic risk mitigations and reviews effectiveness of internal control systems		X X X X				Overall covered the main issues, but reduced timing due to covid has had an impact.
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board		X X X	X			Excepting my comments on Committee ownership of their own strategic risks Without reviewing the BAF the committee will not have been able to fully escalate strategic risks to the Board. Many other risks are covered by auditors and escalated to the Board.

Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and this is understood by members		X X X X				There is still much to do in shaping the members understanding of BAF
7	The Committee has set a clear cycle of business to support delivery of the Work Plan		X X X	X			We are for the year to come Mostly set by the audit plan
8	Aims and objectives are clearly defined and measureable		X X X	X			Not sure. Would be good to understand how they are measured and shared with the committee
9	The Committee is clear about the level of authority/delegated power from the Board	X	X X X				
10	The Clinical Audit programme and regular progress updates are reviewed by the committee		X X X	X			However I think there could be more discussion on clinical audit and how it is aligned with the top clinical risks Unclear how clinical audit fits within the risk framework of audit work Query due to covid the time given to really scrutinizing this by the members and also those not at

							RAC that are also signing off the audit plan
11	The committee produces an annual report to the Board on it activities and review of internal control processes to support of signing the Annual Governance Statement	X	X X	X			As this is my first year I assume that we are about to do this
12	The committee has a clear programme of work and understands it role in scrutinizing and approving the Annual Report, Accounts and Quality Account	X	X X X				This has been impacted this last year due to covid
Part 2: Quality Assurance							
13	Committee members have the appropriate skills and expertise to understand the information they receives	X X	X X				Feel there has been a gap in advice to the committee from the Head of Corporate Governance impacted by the Covid pandemic. There have been many challenges in operating during the pandemic with changes that RAC may not have had the expertise to consider some of that information.
14	Committee attendees have the relevant skills to conduct committee business and	X	X X X				

	clearly understand their role						
Part 3: Quality of the Committee/Management Relationship							
15	Committee members clearly understand their role	X	X X X				
16	There is effectiveness communication between Committee, other committees managing strategic risk and the Trust Board		X X X	X			Noting my thoughts on Strategic risk ownership Gap in RASC over the last year in discussion in enough depth for assurance on the BAF and strategic risks to the board. A lot of focus has been on the operational risks and not enough escalation on the strategic risks the board is now holding
17	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	X	X X X				
18	There is effective communication of committee decisions to staff/managers	X	X X	X			No longer covered in CEO brief or Team brief or SMT during the pandemic therefore communication to managers from the committee is limited.
Part 4: Effectiveness of the Committee Processes and Meetings							

19	The Committee makes effective use of its meetings	X	X X X				Noting heavy impact of Covid on the extent of scrutiny possible
20	The content of the agenda is sufficiently focused on systems of internal control		X X X X				
21	Committee papers are available in sufficient time to enable adequate preparation for meetings	X	X X X				I think more work could be done on how reports could be more concise and follow trust format
22	The Action Log is appropriately updated in readiness for each meeting.		X X X	X			
23	Reports and briefings are concise and clearly identify the issue and required actions by the committee		X X X	X			Cover sheets should summarise key issues without need to refer to detailed reports. Audit (internal and external) reports and information can over-focus on presentation rather than content which can obscure meaning. There could be improvements to auditors reports. Also sometimes the ask is for detail then wish the report to be shorter – therefore further guidance needed on the actual ask.
24	Committee members attach the appropriate level of seriousness to preparing for and	X X	X X				

	attending Committee meetings						
25	Committee members feel free to participate in proceedings without undue inhibition.	X	X X X				
26	Decisions of the Committee are executed in a timely manner	X	X X X				
27	The frequency of meetings is appropriate	X	X X X				
Part 5: External Audit							
28	There is a clear External Audit Plan approved by the committee and progress is regularly reviewed	X	X X X				
29	The External Audit annual letter is reviewed by the committee	X X	X X				Timings on this are always a problem and need to consider the forward planning more on this
Part 6: Internal Audit							
30	The Internal Audit Plan is agreed by the committee and regular progress reports and follow up reports are received	X	X X	X			Subject of current internal review Needs to be improvement outside of RAC of finalizing the internal audit plan recommendations to RAC

31	The Committee receives regular benchmarking information		X X X	X			But we could do with more clinical and efficiency bench marking than we have seen to date I am not sure the work programme is formally agreed by the committee
32	The Committee receives the Head of Internal Audit Opinion	X	X X	X			
Part 7: Counter Fraud							
33	The Counter Fraud work programme is agreed by the committee and regular progress reports are received		X X X	X			I am not sure the work programme is formally agreed by the committee
34	The annual counter fraud self-assessment is approved by the committee prior to submission		X X X X				
Suggestions made for improving the Committee Effectiveness							
Given our increasing use of electronic records their has been little if any discussion of information governance – I believe that this is a critical area that the committee should expressly own							

Committee Effectiveness Self-Assessment Questionnaire 2020/21

– Finance and Performance Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy		X X X				
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives		X X X				I am sure it will do going forward – this year we were heavily impacted by Covid
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or the committee's work programme		X X X				Again – noting my belief that FPC related strategic risks should be owned and reviewed by FPC rather than RAC
4	The Committee receives regular reports on strategic risk mitigations		X X X				
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board		X X X				

Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and is understood by members		X X X				
7	The Committee has set a clear cycle of business to support delivery of the Work Plan		X X X				Again heavily impacted by Covid this year
8	Aims and objectives are clearly defined and measureable		X X	X			I think more work needs to be done on how the objectives are measured and reviewed
9	The Committee is clear about the level of authority/delegated power from the Board	X	X X				
Part 2: Quality Assurance							
10	Committee members have the appropriate skills and expertise to understand the information they receives	X X	X				
11	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	X	X X				
Part 3: Quality of the Committee/Management Relationship							
12	Committee members clearly understand their role	X	X X				

13	There is effectiveness communication between Committee, other committees and the Trust Board	X	X X				
14	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	X	X X				
15	There is effective communication of committee decisions to staff/managers	X	X	X			
Part 4: Effectiveness of the Committee Processes and Meetings							
16	The Committee makes effective use of its meetings	X	X	X			Noting that FPC has particularly suffered from the curtailed agendas and time limitations on discussion
17	The content of the agenda is strategically focused and relevant		X X				mostly
18	Committee papers are available in sufficient time to enable adequate preparation for meetings	X X	X				Mostly but not always
19	The Action Log is appropriately updated in readiness for each meeting.		X X	X			Actions are not always updated before the meeting. This could be improved
20	Reports and briefings are concise and clearly identify the issue and required		X	X X			Could be more concise and with greater value added

	actions by the committee						commentaries This is work in progress as some papers are too long and do not always follow the trust format
21	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	X X	X				
22	Committee members feel free to participate in proceedings without undue inhibition.	X X	X				
23	Decisions of the Committee are executed in a timely manner	X	X X				
24	The frequency of meetings is appropriate	X	X X				
Suggestions made for improving the Committee Effectiveness							
Better FPC risk ownership of FPC risks rather than reliance on RAC							

Committee Effectiveness Self-Assessment Questionnaire 2020/21

– Quality Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy		X X X X X				Occasionally takes reassurance rather than assurance
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives	X	X X X X				Clearly aligned to strategic objectives. Obviously some work deferred due the pandemic
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or the committee's work programme	X	X X X X				But my preference is that corporate Quality risks should be owned by the Quality committee rather than Risk & Audit Aligned focus of committee overall
4	The Committee receives regular reports on strategic risk mitigations		X X X	X X			I don't think that BAF related strategic risks are relevant to the Quality committee. More work on

							highlighting key corporate risks will be helpful Could be strengthened with links to strategy and BAF in the actual meeting – new front sheet may assist this
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board	X X	X X	X			I think that we primarily raise issues & recommendations to the board rather than risks There is good escalation of key corporate risks – see above re strategic risks Clear process in place and triangulation by chair sitting on other committees
Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and is understood by members	X X	X X X				Occasionally strays into the operational of how rather than outcome delivery focus
7	The Committee has set a clear cycle of business to support delivery of the Work Plan	X X	X X X				My experience in this exceptional year is that we have been driven more by events than by working through a cycle of business – but

							we did have a plan which we have in part executed Agenda steered by the plan yet positively adaptive if required
8	Aims and objectives are clearly defined and measureable	X	X X X X				Require more formal reporting to the committee
9	The Committee is clear about the level of authority/delegated power from the Board		X X X X				With the exception of quality risk ownership I think that this is broadly true and on specifics can be guided by the Trust secretary
Part 2: Quality Assurance							
10	Committee members have the appropriate skills and expertise to understand the information they receive	X X	X X X				Diverse experience of members. This year been more challenging with Covid impact
11	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	X	X X X				This has obviously been limited by the Covid restrictions on committee time and attendance
Part 3: Quality of the Committee/Management Relationship							
12	Committee members clearly understand their role	X X	X X X				Occasionally dips into operational management but more since in the covid pandemic likely due to

							not being on site and reduced divisional input
13	There is effectiveness communication between Committee, other committees and the Trust Board	X	X X X X				Only area for strengthening would be the link with BAF
14	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	X X X X	X				This is good, but we are always looking to improve this in all committees
15	There is effective communication of committee decisions to staff/managers	X X	X X	X			Not sure how effective this is so need to review communication processes. I think so and no evidence to show otherwise Cross over of membership and escalation reports assists positively with this
Part 4: Effectiveness of the Committee Processes and Meetings							
16	The Committee makes effective use of its meetings	X X	X X X				Covid has hampered this over this last year with reduced time for more in depth discussions for assurance
17	The content of the agenda is strategically	X X	X X X				But this year due to COVID impacts the opportunity for

	focused and relevant						effective and comprehensive discussion has been limited The committee is focused and relevant. I agree that the Trust Strategy is the guide, but committees are by there nature more operational
18	Committee papers are available in sufficient time to enable adequate preparation for meetings	X X X	X X				Problem always is data availability for submission timeliness meaning some reports have data missing, also some data is manual and therefore delayed. More work in progress on the latter point with development of BI and digital recording of information.
19	The Action Log is appropriately updated in readiness for each meeting.	X X X	X X				This could be improved
20	Reports and briefings are concise and clearly identify the issue and required actions by the committee		X X X X X				Mostly but not always Work in progress as some reports are too long and do not follow trust format.

							The committee Chair is always looking to improve reporting Always an issue of request for detail then wish reports to be shorter – therefore the challenge is in the ask rather than the authors. Suggest more assistance from Head of Corporate Governance to assist in report requests to be more specific to assist authors
21	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	X X X	X X				
22	Committee members feel free to participate in proceedings without undue inhibition.	X X X	X X				There are times when conversation is more restricted, often when time is an issue or a decision has already been made outside of the meeting that other directors are unaware of.
23	Decisions of the Committee are executed in a timely manner	X X X	X X				Considering a pandemic
24	The frequency of meetings is appropriate	X X X X	X				

Suggestions made for improving the Committee Effectiveness
Quality Committee ownership of quality related strategic risks **A need to explore how to further improve engagement with the Divisions and increase understanding of their quality issue and risks but also what they are doing well**

Committee Effectiveness Self-Assessment Questionnaire 2020/21

– People and Culture Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy	X	X	X X			There needs to be a greater focus on people and culture which is recognized. The committee is in a process of change at the moment, moving from Workforce
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives	X	X X	X			
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or the committee's work programme		X X	X	X		This is recognized and further work will take place once the new executive Director commences in post

							With the revised remit/naming of the committee, there may need to be a re-focus of objectives. The core performance monitoring objectives will be similar
4	The Committee receives regular reports on strategic risk mitigations		X X X	X			The key workforce risks are discussed. This may not answer the question.
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board	X	X X X				There is good escalation of key risks to Board (I am still not sure about the use of strategic here)
Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and is understood by members	X	X X X				Yes but there is recognition that the committee needs to widen its remit
7	The Committee has set a clear cycle of business to support delivery of the Work Plan		X X X	X			There have been several changes to the cycle of business due to the pandemic so I do think now is a good time to review it going forward.
8	Aims and objectives are clearly defined and measureable		X X X X				
9	The Committee is clear about the level of	X X	X	X			With the change to PCC it may

	authority/delegated power from the Board						be helpful to re-state this
Part 2: Quality Assurance							
10	Committee members have the appropriate skills and expertise to understand the information they receives	X	X X X				
11	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	X	X X X				
Part 3: Quality of the Committee/Management Relationship							
12	Committee members clearly understand their role	X	X X X				
13	There is effectiveness communication between Committee, other committees and the Trust Board		X X X X				
14	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	X X	X X				
15	There is effective communication of committee decisions to staff/managers		X X X	X			I think we could improve on the feedback we provide to the wider Workforce team following Committee Meetings.

							I assume so
Part 4: Effectiveness of the Committee Processes and Meetings							
16	The Committee makes effective use of its meetings		X X X X				
17	The content of the agenda is strategically focused and relevant	X	X X X				
18	Committee papers are available in sufficient time to enable adequate preparation for meetings	X	X X X				
19	The Action Log is appropriately updated in readiness for each meeting.	X	X X		X		This could be improved by completing before the meeting
20	Reports and briefings are concise and clearly identify the issue and required actions by the committee		X X X		X		Some papers do not follow trust format and could be more succinct
21	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	X X X	X				
22	Committee members feel free to participate in proceedings without undue inhibition.	X X	X X				
23	Decisions of the Committee are executed in a timely manner		X X X X				

24	The frequency of meetings is appropriate	X	X X X				
Suggestions made for improving the Committee Effectiveness							

Remuneration and Terms of Service Committee
Terms of Reference

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Remuneration and Terms of Service Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board had has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The Committee is authorised to investigate any matter within its terms of reference and to be provided with the resources to do so. It also has the right of access to all information that it deems relevant to fulfil its duties and is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request from the Committee.

The Committee has delegated powers to obtain any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary[1] and to determine the terms of reference for any remuneration consultants who advise the committee, in compliance with Trust procurement rules.

Purpose

The purpose of the Committee is to make recommendations to the Board in relation to the appointment of the Chief Executive[2] and Executive Directors[3] and to review and make recommendations to the Board on its Executive composition, balance and skill mix, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise that are required within the Board to meet them. The Committee is responsible for making recommendations regarding the remuneration packages for the Chief Executive, the Executive Directors and other senior managers reporting directly to the Chief Executive and ensuring that adequate Executive succession planning arrangements are in place.

The Committee is also responsible for maintaining oversight of special payment packages for the Chief Executive, Executive Directors and senior managers reporting to the Chief Executive, ensuring that these represent value for money, and for approving exceptional and non-contractual payments[4]

[1] UK Corporate Governance Code Provision D.2.1
[2] National Health Service Act 2006
[3] Executive Directors includes non-voting members of the Board of Directors.
[4] 'Managing Public Money' – Treasury requirement for FTs to gain Treasury approval for non-contractual payments.

Membership

Membership of the Committee will comprise the Non-Executive members of the Board of Directors. The Chair of the Board shall be the Chair of the Committee; the Senior Independent Director may chair the meeting in his/her absence.

A quorum shall be 4 Non Executive members. No business shall be transacted unless the meeting is quorate.

The Governor led Nominations and Remuneration Committee for Non-Executive Directors will be responsible for the nominations and appointment of the Chair and Non-Executive Directors.

Quorum
A quorum shall be made up of four members.
No business shall be conducted unless a quorum is present.

Frequency of meetings

Meetings shall be held at least twice a year, but may be held more frequently should circumstances require (to be determined by the Committee Chair).

Attendees

The following are will normally be in attendance at each meeting:

- The Head of Corporate Governance,
- The Director of Workforce and OD
- The Chief Executive, unless this is deemed inappropriate (for example, when discussing the Chief Executive's salary).
- Other Trust officers will attend as required by the Committee, at the request of the Chair.

Meetings are not open to members of the public or to Members of the Council of Governors.

Those in attendance do not count towards the quorum.

No independent external advisor shall be a member, nor have a vote on the Committee.

Committee's Duties

The duties of the Committee are to:

- Ensure that the Board is effective in terms of its governance arrangements and composition and make recommendations to the Board for necessary changes

- Make recommendations to the Board with regards to the remuneration package for the Chief Executive, Executive Directors and Senior Managers that report to the Chief Executive and provide assurance that appropriate advice has been sought in so doing
- Ensure that succession planning arrangements are in place and that necessary action is taken to ensure the continued leadership of the Trust.
- Scrutinise non-contractual termination and special payment packages for the Chief Executive, Executive Directors and senior managers reporting to the Chief Executive, ensuring that these represent value for money.

The Committee will execute these responsibilities through the following**:**

- Undertaking an annual review of the of the composition of the Board and make recommendations thereon
- Ensuring that appraisals are undertaken for Executive members of the Board in their capacity as Board members
- Ensuring that a robust appropriate process is in place for the appointment of the Chief Executive and Executive Directors and recommending appointment of the Executive Directors to the Board and the appointment of the Chief Executive to the Council of Governors.
- Approving a description of the role and capabilities required for the appointment of Executive Directors taking into account the views of the Board of Directors on the qualifications, skills and experience required for each position
- Ensuring that the remuneration of the Chief Executive, Executive Directors and senior managers reporting to the Chief Executive are sufficient to attract, retain and motivate high calibre individuals whilst ensuring that it is not more than necessary for this purpose.
- Making recommendations to the Board about the appropriate remuneration and terms of service of the Chief Executive, Executive Directors and other senior managers reporting to the Chief Executive including:
    - All aspects of salary (including any performance related element/bonuses)
    - Provisions for other benefits, including pensions and cars
    - Agreement of contracts of employment and if applicable terms of office
    - Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as appropriate
- Consider any matter relating to the continuation of office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

Delegation

By approval of these Terms of Reference the Board delegates the following functions to the Committee:

- Reviewing the composition and effectiveness of the Board on an annual basis and making recommendations to the Board thereon
- Researching market rates for the purpose of determining the remuneration for the Chief Executive, Executive Directors and senior managers reporting to the Chief Executive and making recommendations to the Trust Board thereon.
- Scrutinising non-contractual termination or special payment packages for the Chief Executive, Executive Directors and senior managers reporting to the Chief Executive.

Reporting

The Committee is accountable to the Board of Directors and the Committee Chair will report regularly on the Committee's proceedings.

The minutes of Committee meetings shall be formally recorded and, as appropriate, made available to the Board of Directors.

On an annual basis, the Committee will produce a Remuneration Committee Report in compliance with statutory and regulatory requirements for inclusion in the Annual Report.

Reporting Responsibilities

The Committee chairman shall report to the Board on the proceedings after each meeting on all matters within its duties and responsibilities.[5]

Administration

The Committee will be serviced by the Corporate Governance Team who will agree the agenda with the Chair of the Committee

Review

These Terms of Reference will be reviewed in December 2020 unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and will report this to the Trust Board.

Approved by the Board of Directors on Date

[5] FRC Guidance on Board Effectiveness, paragraph 6.2

TERMS OF REFERENCE
PEOPLE AND CULTURE COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the People and Culture Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board had has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The Committee is invested with the delegated authority to act on behalf of the Board of Directors. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee (above) and subject to the rules on Reporting, as defined below. The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Committee in the conduct of its inquiries.

The Committee is authorised by the Board to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

The Committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The purpose of the Committee is to be responsible for the monitoring of the Trust's People Strategy and Strategic Objective. The Committee will give consideration to matters relating to Workforce Planning and development, efficiency, and human resources policy. It will also have responsibility for leadership development and talent management; workforce planning and forecasting; recruitment and retention; education and training; people policies, processes and systems; diversity and inclusion and health and wellbeing, developing a culture that will deliver a workforce fit for the future.

The People and Culture Committee will be responsible to the Trust Board for the oversight of the development and delivery of the 'Enable' strategic objective and will ensure the workforce is fit for purpose through effective workforce planning resources. The Committee will ensure that leadership style and supporting employment processes are in place to embed the values and behaviours of the organisation, so developing a culture that supports staff. The Committee will assure the Board on statutory and regulatory compliance requirements including CQC essential standards.

Membership

Membership of the Committee will be appointed by the Board and shall consist of Three Non-Executive Members; one of which will be appointed by the Board as Chair and the following:

- Chief People Office
- Chief Executive
- Chief Operating Officer
- Chief Nursing Officer
- Medical Director
- Director of Strategy, Transformation and Partnerships

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

In attendance will be:

- Medical Workforce Representative
- Director of Medical Education,
- Head of Education and Development,
- Head of Workforce Development,
- Head of Workforce Resourcing,
- Head of HR Operations,
- Divisional Manager for Surgery and Family Services or
- Divisional Manager Integrated Community Care.

Three governors will be invited to attend each meeting as observers.

Other individuals may be invited to attend for all or part of any meeting, as and when required for particular agenda items.

Quorum

A quorum shall be two Non-Executive Directors and two Executive Directors. No business shall be transacted unless the meeting is quorate. A duly convened meeting of

the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

Frequency of Meetings

The Committee shall meet not less than 10 times per financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

Members the Committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The People and Culture Committee will:

- Oversee the development and delivery of the 'Enable' Strategic Objective;
- Oversee the Organisational Development Strategy, which will embed the Trusts values and develop an organisational culture in line with those values;
- The Committee will give particular attention to the delivery of the following people work streams;
    - HR Management
    - Staff Engagement through the Listening in Action Programme
    - Freedom to Speak Up
    - Equality and Diversity
    - Leadership
    - Learning, Development, Personal Growth
    - Talent Management
    - Workforce Development and Planning
    - Health, Safety and Wellbeing
- Oversee the development of a Strategic Workforce Plan to ensure that the organisation has a workforce 'Fit for purpose';
- Consider external and national workforce developments and best practice and oversee the Trust contribution to system wide people strategy
- Seek assurance on behalf of the Trust Board for the response to people risks which appear on the Board Assurance Framework and on the Corporate Risk Register;
- Seek assurance on behalf of the Trust Board that workforce systems, practices and policies are in place to support safe staffing across the Trust;
- Oversee the performance on workforce KPIs and the increased effectiveness and efficiency of workforce functions.
- Ratify and approve policy which falls under its remit as part of the governance arrangements for policy development.
- Seek assurances on behalf of the Board that arrangements are sufficient and effective in respect to the Guardianship of Safe Working Hours.
- Seek assurances on behalf of the Board that Health and Safety arrangements within the Trust are effective.

a. People Strategy

- To drive the development and monitor the execution of the Trust's People Strategy which will support how the Trust develops, supports and values its workforce.

- Ensure the cultural issues within the Trust are given priority and reviewed through scrutiny and follow through of the annual NHS staff survey.

b. Workforce Development and Planning

- To ensure that workforce planning and development is considered and appropriate actions are taken to address workforce requirements. The planning process in the NHS is affected by a range of broader political, regulatory and professional policy decisions which are related to workforce modernisation. The Committee aims to pre-empt these changes and anticipate associated workforce requirements.

- To review the productivity of the Trust workforce, the Committee will review plans for the development of new roles and skill mixes to include the utilisation of resources and financial/workforce balance for staff now and in the future.

c. Recruitment and Retention

- To effect the balance of demand for staff with its supply - to ensure that sufficient numbers of appropriate qualified personnel are available, in the right place and at the right time, with the right skills, to match the demand for their services.
- To monitor attrition rates in order to anticipate deficits in numbers of personnel and identify and implement actions to minimize turnover wherever possible.

d. Training and Development

- To anticipate changes in Professional Education and Essential Core Skills training to ensure compliance and the continued provision of high quality care.

- To monitor the provision of Training and Development and implement solutions which deliver a skilled, flexible and modernised workforce improving productivity, performance and reducing health inequalities.

- The Essential Core Skills Training Group will report to the Committee and will report on progress against action plans.

e. Organisational Development and Leadership

- To provide governance and oversight for the Trust-wide culture change programme and delivery of the Leadership Strategy.

f. Equality, Diversity and Inclusion

- To provide governance and oversight for the Trust's Equality, Diversity and Inclusion strategy.

- The Equality, Diversity and Inclusion Committee will report to the Committee and will report on progress against action plans.

g. Risk Management and the Committee

- The Workforce Development and Strategy Committee receives workforce reports from Care Groups and sub-committees, considers the mitigations and controls in place; highlighting any significant issues to the Quality Committee, Finance and Performance Committee and Trust Management Board.

- A standard report template is used for sub-committee reports. The role of the template is for the sub-committees to highlight any significant risk issues to the WDSC for information, discussion or escalation.

- The committee will review the Trust's significant risks report and receive updates on directorate workforce risk issues, action plans or unresolved matters/ concerns for escalation. The committee will consider strategic workforce risk themes for escalation to Quality Committee, Finance and Performance Committee, Senior Management Team or Board of Directors.

- Executive Directors sponsoring significant risks (as the Risk Owner) on the risk register will be responsible for ensuring that a monthly update on risk status is detailed within the risk record in order to update Quality Committee/Board via the relevant "Risk Register report".

h. General

- To review its own performance, constitution and terms of reference on an annual basis to ensure it is operating at maximum effectiveness.

- To review and approve Trust policies that fall within its remit.

- To set the direction and monitor the work of the reporting groups that inform the work of the Committee (see s xx below) and receive, review and ratify the Minutes of said groups. **]**

Reporting
The Chair of the Committee will report in writing to the Board at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the Committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive for action.

The Chair of the Committee will also attend the Audit Committee to provide assurance on the Committees processes and the work that it has undertaken.

The Committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Committee has established the following sub-committees:

a. Equality, Diversity & Inclusion Group
b. Education & Training Group
c. Medical Education Group
d. Health & Wellbeing Steering Group
e. Rostering Steering Group
f. Workforce Resources Strategy Group

The Committee will also receive Escalation Reports from Divisional Leadership / Governance meetings and Divisional representation at committee will be required.

Administration

The People and Culture Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in *XXXX* unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors.

Approved by the People and Culture Committee – Date
Ratified by the Board – Date

TERMS OF REFERENCE
QUALITY COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Quality Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board had has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The Committee is invested with the delegated authority to act on behalf of the Board of Directors. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee. The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Committee in the conduct of its inquiries.

The Committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

The Committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

The Committee is authorised by the Board to delegate power to the Clinical Governance Group to approve all clinical policies, procedures and guidelines provided that at least one Clinical Director and one of the Chief Nursing Officer or Medical Director is in attendance.

Purpose

The purpose of the Committee is to maintain oversight of the Clinical Strategies; scrutinising delivery of quality care and strategy outcomes in order to provide assurance to the Risk and Audit Committee and to the Board that risks to delivery of the Clinical Strategies are being managed appropriately. This would support the signing of the Annual Governance Statement and Quality Accounts. The Committee will ensure that all aspects of quality governance, patient safety and experience are subject to scrutiny in order to provide assurance to the Board.

Additionally, the Committee has responsibility for scrutinising and assuring delivery of relevant aspects of the Trust's 'Place' objective and ensuring that associated risks are adequately mitigated; supporting the identification and promotion of shared learning, best practice and outstanding care.

Membership

Membership of the Committee will be appointed by the Board and shall consist of three Non-Executive members; one of which will be a clinical Non-Executive who will be appointed as Chair and the following:

Chief Executive
Chief Nursing Officer
Medical Director
Chief Operating Officer

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

In Attendance

Senior clinical Divisional representatives will be required to attend the Committee in order to provide an Escalation Report of key issues arising from Divisional Leadership / Governance meetings. Other members of Trust staff, including other Directors and Non-Executive Directors, may be invited to attend to present and/or discuss particular items on the Agenda, and up to three Public Governors will be invited to observe the meeting. Patients and/or carers may be invited to attend meetings of the Committee to discuss particular items.

The Head of Corporate Governance or his/her nominee shall act as Secretary to the Committee.

Quorum

The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Medical Director). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

Frequency of Meetings

The Committee shall meet not less than 10 times per financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

Members the Committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The Committee has the following primary duties and functions:

1. To approve the Trust's Clinical Strategies and Quality Priorities; scrutinising performance against Quality Account priorities.
2. To provide assurance to the Board of adherence to all of the areas of CQC work within the 5 domains reflecting the Key Lines of Enquiry;
3. To receive key regulatory and other inspection reports and scrutinise delivery of any associated action plans.
4. To provide a forum for scrutiny of any of the Trust's clinical quality indicators at the request of the Board;
5. To provide assurance to the Board that risk within the Outstanding Care domain is being managed and to ensure that risks are escalated to the Board as appropriate.
6. Guide and instruct the direction of Clinical Audit on behalf of the Board where performance, incidents or strategic clinical risks are identified in order to provide assurance of improvement and effectiveness of mitigations to the Board.
7. To consider any national and/or strategic drivers that may impact on the quality agenda at the Trust.
8. To review the learning from complaints, incidents (serious incidents and Never Events) and claims and ensure all associated action plans are delivered and completed.
9. To monitor the development and implementation of the Trust's Quality Improvement Strategy

General

The Committee will:

1. Review the adequacy of the Trust's Clinical Strategies and monitor delivery of outcomes;
2. Monitor strategic risks within the Board Assurance framework and the Corporate Risk Register to ensure that risks are being managed and mitigated sufficiently, and that risks are escalated appropriately.
3. Receiving details of all Serious Incidents, escalating to the Board where appropriate and receive assurance around the actions taken to prevent recurrence.
4. Ensure that appropriate arrangements are in place in respect of Emergency Planning. Monitor on-going compliance with Care Quality Commission Standards and seek assurance that any areas of weakness are being addressed.
5. Monitor on-going compliance with the Well Led element of the CQC Standards as they relate to the Board to ensure maintenance/improvement of the Trust's governance risk rating.
6. Monitor compliance in relation to safeguarding children and adults.

7. Ensure procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and Nursing and Midwifery Council) are in place and are complied with to a satisfactory standard.
8. Monitor the impact of Cash Releasing Efficiency Programmes and significant service changes on quality.
9. Receive updates on an exception basis against key strategies that are approved by the Committee and those that are approved by the Board where deemed appropriate, escalating to the Board as necessary

Clinical Governance:

1. Undertake in-depth reviews of the Clinical Quality Indicators reported to the Board at the request of the Board.
2. Scrutiny of the Quality Accounts to provide assurance to the Board and Audit and risk Committee of their accuracy prior to approval.
3. Oversee the implementation and monitoring of the research programme and that the governance framework is implemented and monitored.
4. Approval and monitoring the Clinical Audit Plan and reviewing the findings of all audits and the adequacy of the management responses.
5. Monitor the Patient Experience; through receipt of information relating to patient surveys, complaints, claims, PALS contacts and incidents.

In consideration of reports, the Committee will review the improvement required, availability of resources and outcomes.

Policy Approval

1. Approving strategies that are within the remit of the Committee and are deemed appropriate for Committee approval by the Board, as provided for in the Trust's Standing Orders.
2. Ratifying policies approved by the sub-committees that report to this Committee on behalf of the Board, ensuring that due process has been followed.

Reporting

The Chair of the Committee will report in writing to the Board at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the Committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive for action.

The Chair of the Committee will also attend the Audit Committee to provide assurance on the Committees processes and the work that it has undertaken.

The Committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Committee has established the following sub-committees:

- Clinical Effectiveness and Innovation Group
- Medicines Management Group
- Infection Prevention and Control Group
- Safeguarding Adults and Children Group
- Safety Group
- End of Life Group
- Patient Experience Group
- Mortality Group
- CQC Inspection Steering Group

The Committee will also receive Escalation Reports from Divisional Leadership / Governance meetings and Divisional representation at committee will be required.

Administration

The Quality Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in *XXXX* unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors

Approved by Quality Committee – Date
Ratified by the Board – Date

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Finance and Performance Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board had has no executive powers other than those specifically delegated to it via these Terms of Reference. The Standing Orders of the Trust, Standing Financial Instructions and Scheme of Delegation shall apply to the conduct of the working of the Committee.

Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and is authorised to seek any information that it requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary.

The Committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The purpose of the Committee is to provide a forum for the Board to seek additional assurance in relation to relevant aspects of the 'Place' and 'Partnerships' Strategic Objectives; including all aspects of financial and nationally set and locally agreed performance targets, monitoring the impact of the Cost Improvement Programme (CIP) and monitoring of the Service Transformation Programme (STP).

The Committee will also ensure the adoption and application of best practice governance and decision making processes for making investments in line with the NHS Act 2006 (as amended by the 2012 Act) and the NHS Improvement "Supporting NHS providers: guidance on transactions for NHS foundation trusts" guidance (updated March 2015).

The Committee will be responsible for the scrutiny of risks identified within the Board Assurance Framework and Corporate Risk Register relating to finances and the use of resources and will work collaboratively with the Quality and People and Culture Committees to ensure that the impact on quality and the workforce of financial decision making is scrutinised.

Membership

Membership of the Committee will be appointed by the Board and shall consist of three Non-Executive members; one of which will be appointed by the Board as Chair and a further member will be a clinical Non-Executive member of the Committee. The following Executive Directors will also be members of the Committee:

Chief Executive
Director Finance Officer
Chief Operating Officer
Chief People Officer
Director of Strategy, Transformation and Partnerships
Chief Nursing Officer and or
Chief Medical Officer

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

Attendance

The following will usually be in attendance:

Divisional Senior Manager representation
Head of Corporate Governance

Other Directors and Officers of the Trust and independent advisors will be required to attend the Committee to present reports and assist the Committee in its consideration of investments.

Quorum

The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

Frequency

The Committee shall meet not less than 10 times per financial year. The Chair of the Committee may convene additional meetings as they deem necessary.

Members the Committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The Committee has the following specific duties and functions:

a. Finance

Financial Strategy

- Consider the Financial Strategy, ensuring that the financial objectives of the Trust are consistent with the strategic direction.
- Periodically review the medium- and long-term Financial Strategies.
- Review key medium term planning assumptions.
- Review external publications around the financial and operating environment and their link to planning assumptions and models.

Monitoring of the Financial Position

- Monitor the achievement of the financial strategy, financial targets and associated activity targets.
- Regularly scrutinise financial performance, trends, projections and underlying data.
- Oversee the development of financial reporting, to include:
  - Appropriate emphasis on interpretation of the financial position and development of corrective plans where necessary.
  - Structuring monitoring reports around the key financial statements, income and expenditure, balance sheet, cash flow, capital, efficiency savings, and Service Line Reporting when implemented.
  - Developing high level metrics to focus the Committee on areas where corrective action may need to be developed.
  - Linking the narrative to implications of compliance with the FT licence, in particular the financial and governance risk ratings.
- Consider the annual reference costs and review profitability analyses.

Business Case Consideration and Capital Programme Management

- Scrutinise an assure major investments and disinvestments proposals.
- Seek assurance of the overall controls which govern business case investments, using NHSI's guidance on Risk Evaluation for Investment Decisions. In accordance with the Reservation of Powers and Scheme of Delegation rigorously scrutinise business cases.
- Seek assurance that robust processes are followed, evaluating, scrutinising and monitoring investments and disinvestments so that benefits realisation can be confirmed.
- To ensure testing of all relevant options for larger business cases
- Focus on financial metrics within business cases e.g. payback periods, rate of return etc.

- Oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board of Directors accordingly.

Other Financial Matters

- Provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge.
- Consider ad hoc financial issues that arise (e.g. check Private Patient Cap, estate revaluation etc.)
- Develop the Trust's Treasury Policy in line with NHSI's guidance on Managing Operating Cash.
- Scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.
- Consider such other matters and take such other decisions of a generally financial nature as the Board of Directors shall delegate to it.

The Committee will be exclusively responsible for determining the selection criteria; selecting, appointing, and setting the Terms of Reference for any external consultants who advise the Committee.

b. Performance

- Review performance against key national, local and internal targets and indicators.
- Review exception reports and action plans for those targets and indicators where delivery is at risk.
- Review the contractual risk attached to non-achievement of national and local targets.
- Agree the composition of the performance scorecard on an annual basis.
- Receive a view of performance against relevant national productivity metrics and agree action where performance falls below agreed benchmarks.

c. Subsidiary Companies and Joint Ventures

Where the Trust establishes either a subsidiary company or a joint venture, the Finance and Performance Committee will be responsible for maintaining oversight of the activity and governance arrangements surround each respectively. The Committee will ensure that the Trust's Standing Financial Instructions and Scheme of Delegation reflect the delegated authorities provided under each arrangement and seek assurances of compliance on behalf of the Board. The Committee will require the following after a meeting of any subsidiary company or Joint Venture Board:

- Summary of activities undertaken and decisions made
- A report assuring statutory compliance with applicable regulations and submission of statutory returns
- Timely escalation of identified risk and mitigating actions agreed.

d. General

- Review its own performance, constitution and Terms of Reference on an annual basis to ensure it is operating at maximum effectiveness.
- Review and approve Trust policies that fall within its remit.

Policy Approval

1. Approving strategies that are within the remit of the Committee and are deemed appropriate for Committee approval by the Board, as provided for in the Trust's Standing Orders.
2. Ratifying policies approved by the sub-committees that report to this Committee on behalf of the Board, ensuring that due process has been followed.

Reporting

The Chair of the Committee will report in writing to the Board at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the Committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive for action.

The Chair of the Committee will also attend the Audit Committee to provide assurance on the Committees processes and the work that it has undertaken.

The Committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Committee's attention. The Committee has established the following sub-committees:

- Better Value Better Care
- Medical Devices
- Sustainability and Travel Working Group
- Capital Planning and Space Utilisation
- Access and Flow group
- Commercial Group
- Winter / Emergency Planning and Resilience Group

The Committee will also receive reports on activities and assurances of regulatory compliance from:

- DCH Subco Ltd
- Dorset Estates Partnership Joint Venture

Administration

The Finance and Performance Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in XXXX unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors.

Approved by Finance and Performance Committee - Date
Ratified by the Board – Date

TERMS OF REFERENCE
RISK AND AUDIT COMMITTEE

Constitution

The Board of Directors (the Board) hereby resolves to establish a Committee to be known as the Risk and Audit Committee (the Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee is authorised to establish short life working groups to undertake specific pieces of work and the Committee shall establish Terms of Reference accordingly. The Committee may not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The principle purpose of the Risk and Audit Committee is to ensure that there are effective systems of financial and corporate governance, risk management and internal controls in place within the Trust and to provide assurance to the Board on the same. This includes financial, clinical, operational and compliance controls and risk management and corporate governance systems. The Committee is also responsible for maintaining an appropriate relationship with the Trust's auditors. To this end, the Committee will seek assurances from Board Committees regarding the scrutiny and oversight of the strategy and risks to achievement of the Strategic Objectives within the Board Assurance Framework and Corporate Risk Register; escalating these to the Board as necessary.

Membership

The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members (including the Chair), one of whom shall possess recent, relevant financial experience, the Chairs of other Board Committees and the following:

- Chief Finance Officer
- Deputy CEO / Director of Strategy, Transformation and Partnerships
- Chief Operating Officer
- Medical Director
- Chief Executive Officer (Annual Governance Statement and Accounts only)

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

Attendance

The following will normally be in attendance:

- Head of Internal Audit
- A representative from External Audit
- Local Anti-Fraud Specialist.
- Head of Corporate Governance (Minutes and to support the Chair)

The Chairs of the Quality, Finance and Performance and People and Culture Committees will attend to report on the assurance that their committees have obtained in relation to the monitoring and management of governance and risk in the areas of their responsibility and delegated authority at least annually.
At least once a year, the Committee shall meet privately with the External and Internal Auditors.

The Chief Executive and other Executive Directors may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

Up to three members of the Council of Governor will be invited to observe the meeting.

Quorum
The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Medical Director). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.
The Chair of the organisation shall not be a member of the Committee.

Frequency

Meetings shall be held at least four times a year. The Chair of the Committee may convene additional meetings as they deem necessary. The External Auditor or Head of Internal Audit may also request a meeting if they consider that one is necessary.

Members the Committee must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The duties of the Committee are as follows:

Governance, Risk Management and Internal Control

The Committee shall ensure effective system of integrated governance, risk management and internal control is in place across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- processes to ensure appropriate information flows to the Risk and Audit Committee from Executive Management and other Board committees in relation to the Trust's overall internal control and risk management position in liaison with the Quality, Finance and Performance and People and Culture Committee Chairs.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect.
- The process for declarations of interest and gifts and hospitality

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executive Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The Committee will use the Board Assurance Framework to drive its programme of work and that of the audit and assurance functions that report to it. The Committee will ensure that the Board Assurance Framework acts as a key driver of committee and operational plans and that it is appropriately informed by operational risks arising through the Corporate Risk Register and that mitigations are adequately identified to ensure delivery of the trust's Strategy.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Risk and Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment and ongoing provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the Internal Audit strategy and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified by the Board Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall approve the Annual Counter Fraud Work Plan and review the outcomes of counter fraud work.

External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Develop and agree with the Council of Governors the criteria for the appointment, re-appointment and removal of the External Auditors.
- Make recommendations to the Council of Governors in relation to the above.
- Approval of the remuneration and terms of engagement of the External Auditor, supplying information as necessary to support statutory function of the Council of Governors to appoint, or remove, the auditor.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all External Audit reports and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Review and monitor of the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.
- Ensure there is a clear policy in place for the engagement of External Auditors to undertaken non audit services.

Other Assurance Functions

The Risk and Audit Committee shall review the findings of other relevant significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Regulators/Inspectors (e.g. NHS Improvement, CQC, NHS Resolution, etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other Board committees within the organisation, whose work can provide relevant assurance to the Risk and Audit Committee's own scope of work.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Risk and Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Risk and Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Risk and Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of Representation.
- Qualitative aspects of financial reporting.

Quality Reporting

The Risk and Audit Committee shall monitor the integrity of the Trust's Quality Report and any formal announcements relating to the Trust's clinical outcomes and quality standards.

The Committee should ensure that the systems for quality monitoring and reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

The Risk and Audit Committee shall review the annual Quality Report before submission to the Board.

Reporting

The Chair of the Committee will report in writing to the Board, at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and decision making and the Chair of the Committee will ensure that attention is drawn to any risks or issues that require escalation to the Board or Executive for action.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the Quality Accounts.

The Committee will receive an Escalation Report from the sub-committees that it formally establishes that records key issues and decision making and escalation of risks and issues for the Committee's attention. The Committee has established the following sub-committees:

- Information Governance Group
- Health Informatics Project Board
- Winter / Emergency Planning and Resilience Group

Administration

The Risk and Audit Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in December 2020 unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors via an Annual Report.

Approved by Risk and Audit Committee Date:
Ratified by the Board – [date]

People and Culture Committee Work plan - 21 22

2021

	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Standard Reporting and Metrics									
Workforce Performance Report	x	x	x	x	x	x	x	x	x
Education and Development Report (bi-monthly)		x		x		x		x	
Library services annual report							x		
Freedom to Speak Up Report				x					
Review of Whistleblowing arrangements									
Staff Survey Results and action plan									
Survey results									
Action plan review post survey and pre next survey		x				x			
Equality & Diversity									
Diversity & Inclusion Progress Review / Report - Includes Gender Pay Gap	x			x					x
People and Culture Strategy 2021-2024 Quarterly progress review									
Quarterly review		x			x			x	
Deep dives (key strategic priorities):									
Workforce Deployment									
Workforce Planning				x					
Temporary Staffing Review	x								
Review Nursing staff trajectories				x					
Leavers & Retention			x						
Bank and Agency Usage and Expenditure Report			x			x			x
Staff Wellbeing									
Health & Wellbeing Activity update					x				
Staff Development									
Leadership Development	x								
GMC survey action plan							x		
OD activity update									
Divisional WF reports									
UIC division - bimonthly		x		x		x		x	
FSS division - bimonthly	x		x		x		x		x
Estates & Facilities - quarterly		x			x			x	
Informatics / BI - quarterly	x			x			x		
Governance									
Review meeting templates from all reporting in committees.						x			
Workforce Risk Report	x			x			x		
Medical Revlaidation Report				x					
Sub Committee Escalation Reports									
??									
Other									
Review of Terms of Reference									
Review of Effectiveness									

Quality Committee Work Plan: Proposed Work plan overarching priorities 2021/22

The Quality committee (QC) work plan reflects the Board Assurance Framework (BAF) strategic objective 'Outstanding: Delivering outstanding services every day', aligned to national priorities for safe, well-led, quality care. This is aligned to the CQC standards and any updated actions for continuous quality improvement.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to fully integrate as part of our quality and safety priorities. This will be considered in line of the Trust risk appetite, including financial implications of Covid-19.

Quality Committee has an administration reporting plan that underpins its agenda planning on core business of the committee, such as quality performance report, annual sub-groups reporting etc. The administration plan supports the effective organisation management of clinical governance and associated CQC standards, including:

- Risks management relating to quality and safety
- Assurance and identification of any gaps in control in improvement to deliver the strategic objective
- Lessons learnt that aid improvement and learning to benefit quality, safe care and best practice including clinical audit.
- Clinical adherence to national guidelines or standards such as NICE
- Patient and public feedback including complaints, plaudits, surveys and patient involvement in services (such as volunteers experience and carers' experience).
- Policies that apply to quality and safety principles.

To support this work Quality committee propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous quality improvement. They reflect the learning over the last year and the restart, recover priorities for the NHS and Trust in the forthcoming year.

Quality Committee will undertake quarterly deep dives on key risk areas of safety to gain a higher level of assurance and challenge.

Underpinning all of these priorities are key themes that run as a golden thread, these are: Digital strategy; system working with associated care pathways; capacity and demand as outlined in the Long Term planning assumptions; estates strategy; and the peoples strategy. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded. Monitoring of achievement will be associated reports or key performance indicators (KPIs).

Work plan priorities	Regulatory reference	How will we know we achieved it?
1. In partnership with the Digital Board to further develop the intelligence for the committee that includes key information needed for assurance and quality improvement (including analytical capabilities)	CQC ref: Effective, Well-led BAF risk objective 1, 3 & 5 CRR: 709, 710, 641,	Progress towards a refreshed quality performance report that direct the committee more on quality improvement and assurance
2. Quality improvement through	CQC domain: Effective,	Outcome data, audits benchmarks and

Work plan priorities	Regulatory reference	How will we know we achieved it?
a focus upon health promotion and health inequalities, including: - Assurance upon clinical pathways that reduce variation in outcomes in the population - Deep dives in clinical services led by the clinical divisional teams - Oversight and scrutiny of the clinical audits and learning from them that feed into quality improvement for improving health inequalities and outcomes (such as peer reviews/ Getting It Right First Time (GIRFT)	Responsive BAF risk objective 1, 2,3 & 4 CRR: 464, 450, 461, 866, 1037	associated KPIs (where applicable)
3. As part of recovery the need to balance quality, safety of patient experience with staff experience to achieve a blended quality improvement.	CQC domain: Responsive, Well-led BAF risk objective 1 & 4 CRR: 468, 463, 919, 709, 710, 450,	Access standards with patient experience feedback and safety metrics
Underpinning fundamental CQC standards (Regulation8)		
Underpinning performance reporting on quality account quality priorities; contracted quality surveillance targets; and CQUINs		

To support the above the ongoing triangulation across committees will be required. Below outlines key priorities/ work streams the other sub-board committees have assurance responsibility for that link

Shared Priorities with other Sub-Board Committees	
Work plan priorities	**Sub-Board committee/ CQC/BAF reference**
1. Finance & Performance Committee (FPC): Waiting list recovery and harm reviews QC will oversee and link any quality and safety indicators/ information that relate to this priority (e.g. incidents, complaints, patient experience, clinical outcomes, clinical audit, legal claims, safety reports, external and internal inspections)	CQC domain: Responsive BAF risk objective 1,2 & 3 CRR: 709; 710; 450

As a result of the pause from Covid-19 waiting lists are longer, with potential impact on clinical and mental health of those waiting for treatment. Clinical prioritisation in line with any revised guidance as part of Restart will have Quality Committee oversight and share with FPC.	
2. People & Culture Committee (PCC): Staff recovery aligned with Safe Staffing/ staff experience QC will oversee and link any quality and safety indicators/ information that relate to this priority (e.g. incidents, complaints, patient experience, clinical outcomes, clinical audit, legal claims, safety reports, external and internal inspections) This will also include any Health and safety at work related to Covid-19 (PPE/ space and IPC practices and testing). In addition staff wellbeing and health promotion aligned to staff staffing, including protecting high risk staff groups (e.g.: immune suppressed staff; BAME)	CQC domain: Safe and Well-led BAF risk objective 1, 3, & 4 CRR: 468; 463; 979
3. Risk & Assurance Committee (RAC): Risks related to operational recovery and the Trust strategy QC will oversee and link any quality and safety indicators/ information that relate to the overall risk appetite and risk management. Key consideration of any indicators that will help inform this will be reviewed at QC and triangulated with the corporate risk register and BAF. Financial risks will be considered triangulated with safety.	CQC domain: Well-led BAF risk objective: 1 & 5 CRR: 449
4. Digital Portfolio Board (DPB): the development of clinical pathways supported by digital innovation alongside the development of 'knowing how we are doing' in patient and staff experience with the development of business intelligence.	CQC domain: Effective, Well-led BAF risk objective: 3 & 5 CRR: 641, 463

Annual Work Plan for Quality Committee 2021/22

& QUALITY	Frequency	April	May	June	July	August	September	October	November	December	January	February	March
Quality aspect of integrated performance report: Patient Safety, Effectiveness and Experience Report - including safer staffing	Mthly												
Divisional escalation / exception reports	Mthly												
Quality Accounts Quarterly Reports	QRTLY Priorities									submit		priorities	
Medicines Committee exception report (meets first wed)	BI-MTHLY												
Safety Group exception report: including Learning from Serious Incidents, claims and legal cases (meets first Friday)	QTRLY												
Clinical Practice Group exception reports	MTHLY					Dates for new group TBA							
Medical Director Safety Report (Mandy Ford Collates incidents and claims)	QRTLY		Q4 2021	Q4 2020 catch up		Q1 2020 Q1 2021			Q2 2021	Q2 2020		Q3 2021	
Mortality Report	QRTLY		Q4			Q1			Q2			Q3	
Infection Prevention and Control Group exception reports (meets first wed)	BI-MTHLY												
End of Life Care Group exception reports (meets second wed)	BI-MTHLY												
Patient Experience Group exception reports (meets third Tues): INCLUDING PATIENT ENVIRONMENT (plus PLACE)	QRTLY												
Mortality Group exception reports/ updates	MTHLY												
Clinical Ethics Forum Activity Report (Phil Wylie)	biannually												
Safeguarding Adults and Children Group exception reports	QRTLY												

Kerry - any other groups added that now report to QQC - Add these in i.e. nutritional steering group - exception report

ASSURANCE													
Annual Quality Report	ANNUAL	DRAFT	FINAL										
Committee Annual Review of Effectiveness, Review of ToRs	ANNUAL												
Safeguarding Children and Aduts Annual Report	ANNUAL												
Infection Prevention and Control annual report	ANNUAL												
Risk Management Strategy update	ANNUAL												
Clinical Audit Plan	ANNUAL		FINAL									DRAFT	
Annual patient surveys	ANNUAL												
Clinical Audit Annual Report	ANNUAL												
Information Governance Annual Report	ANNUAL												
Assurance Report on Nutrition Strategy	ANNUAL												
Annual QI Strategy Report and 6 monthly update													
PLACE Annual Review	ANNUAL						TBC (Nationally set)						
Complaints Annual Report	ANNUAL												

Finance and Performance Committee Work Plan: Proposed Work plan overarching priorities 2021/22

The Finance and Performance Committee (FPC) work plan reflects the Board Assurance Framework (BAF) strategic objectives 'Collaborative: working with patients and partners', 'Sustainable: Productive, effective and efficient' and 'Integrated: Joining up our services' and is aligned to national priorities integrated care provision that provides efficient and effective use of resources.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to optimise integrated care provision across the local health and social care system as the country emerges from the pandemic and as in line with the national direction to promote collaboration between system partners in support of Integrated Care System (ICS) development. The work plan will be consider the Trust's risk appetite, including financial implications of the emerging agenda.

FPC has an administration and reporting plan that underpins its agenda planning on core business of the committee, such as activity and financial performance reports, annual sub-groups reporting etc. The administration plan supports the effective organisation and management of financial and partnership governance and associated standards, including:

- Risks management relating to finance and activity,
- Assurance and identification of any gaps in control in improvement to deliver the strategic objectives
- Lessons learnt that aid improvement and learning to improve efficiency in performance and financial sustainability
- Adherence to national guidelines and contractual standards
- Service transformation, estates and infrastructure development and the wider partnering agenda
- Policies that apply to financial management.

To support this work FPC propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous service improvement and efficiency. They reflect the learning over the last year and the recovery priorities for the NHS and Trust in the forthcoming year.

FPC will undertake quarterly deep dives on key risk areas in order to gain a higher level of assurance and challenge.

Underpinning these priorities are key themes and enabling strategies that will support delivery of the overall objectives. These include: Digital Strategy; collaborative system working; capacity and demand as outlined in the business planning assumptions; Estates Strategy; and the Peoples' Strategy. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded.

Work plan priorities	Regulatory Reference	Outcome
1. Planning framework including: ▪ H1 and H2 submission; and ▪ Elective service recovery ▪ ERF trajectory monitoring	BAF Risk Objective 2, 3, 5 CRR 919, 709, 710, 641, 461 CQC Domain: Effective, Well Led	

Work plan priorities	Regulatory Reference	Outcome
2. Winter Plan: ▪ Surge demand and capacity plan ▪ Associated workforce models for escalation areas and increased emergency activity	BAF Risk Objective 1, 2 CRR 919, 450, 461 CQC Domain: Effective, Well Led	
3. Underlying financial deficit: ▪ understanding the con: ▪ text of this on the trust as well as the rest of the ICS and the consequences on the deficit once the implications of the H2 planning period are known	BAF Risk Objective 5 CRR 919 CQC Domain: Effective, Well Led	
4. Capital Programme, in particular the two key strategic projects but also the risks associated with the internal programme: ▪ ED15; and ▪ HiP2	BAF Risk Objective 5 CRR 919 CQC Domain: Effective, Well Led	
5. In year performance monitoring: ▪ Operational standards; and ▪ Performance against the H1 and H2 Financial Plans	BAF Risk Objective 1, 2, 3 and 5 CRR 919, 709, 710, 461 CQC Domain: Effective, Well Led	

To support the above, ongoing communication and triangulation will be required with other Board committees. The assurance responsibilities and key priorities / work streams of other sub-board committees that link to the work of FPC are outlined below:

Shared Priorities with other Sub-Board Committees	
Sub-Board Committee Work Plan Priorities	**CQC / BAF / Recovery / Annual Plan Reference**
1. Quality Committee (QC): Waiting list recovery, clinical validation and harm reviews FPC will oversee and link performance indicators / information that relate to this priority (e.g. length of wait, Activity, discharge data, average length of stay, bed occupancy, partnership arrangements) FPC will oversee recovery activity in line with national guidance with QC maintaining oversight of the clinical impact of long waiting times and clinical prioritisation.	BAF Risk Objective 1, 2, 3 and 5 CRR 919, 709, 710, 463 CQC Domain: Effective, Well Led

2. People & Culture Committee (PCC): Staff recovery aligned with Safe Staffing / staff experience FPC will oversee expenditure to support delivery of the Safe Staffing and provision of equipment and services to ensure staff are able to operate in a safe environment and that sufficient resources are available to ensure their ongoing well-being.	BAF Risk Objective 5 CRR 919, 710 CQC Domain: Effective, Well Led
3. Risk & Assurance Committee (RAC): Risks related to operational recovery and the Trust strategy FPC will keep under review the trust's appetite on financial risks in its decision making, triangulating these with the trust's appetite for ensuring safe outstanding care; recording and escalating risks to the Corporate Risk Register and BAF.	BAF Risk Objective 3 CRR 919 CQC Domain: Effective, Well Led
4. Digital Portfolio Board (DPB): FPC will maintain oversight of the expenditure required to support delivery of the digital infrastructure, balancing and triangulating this with information and safety priorities identified by other Board sub-committees in line with the Trust's appetite for risk.	BAF Risk Objective 3 CRR 919 CQC Domain: Effective, Well Led

Finance and Performance Committee Work plan - 2021/2

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance Reporting												
Operational Performance inc Divisonal Exception reports	x	x	x	x	x	x	x	x	x	x	x	x
HR	x	x	x	x	x	x	x	x	x	x	x	x
Finance inc monthly and predicted year end outturns	x	x	x	x	x	x	x	x	x	x	x	x
Model Hospital & Use of Resources Review					x						x	
Dorset ICS Performance			x			x			x			x
Information Governance Escalation Report												
Financial assurance												
Business planning guidance to approve										x		
Draft Budgets to be approved											x	
Final budgets to be approved												x
NHSI Draft Operational Plan to be approved										x		
NHSI Final Operational Plan to be approved											x	
Report from Better Value Better Care - assurance review on CIP				x				x				
Review of cash flow reporting and borrowing requirements - Head of Financial Accounts to attend	x						x					
Assurance on Financial Reforecast Process							x					
FY22 Financial Strategy assurance						x						
Deep dives where required			x			x			x			x
Operational Performance assurance												
Division A to attend to discuss business plans								x			x	
Division B to attend to discuss business plans								x			x	
Deep dives into assurance and performance issues as and when required	x		x		x		x		x		x	
Report from Access and Flow Group. Access Manager to attend				x								
Post investment business case review											x	x
Referrals From Other Committees	x	x	x	x	x	x	x	x	x	x	x	x
Estates and Facilities Assurance												
Review of Estate and Capital Planning to include reports from- Space utilisation, sustainability and capital planning. Head of EFM to attend		x								x		
Report on Estates Statutory compliance and travel working group. Head of EFM to attend.									x			
Capex Risk Mitigation - assurance on mitigation processes for projects delayed	x											
Deep dives where required												
Quarterly updates on the Strategic Estaes Masterplan	x			x			x			x		
Strategic Estates Partnership including Business Cases												
DEP Management Board - Activity and escalation report - as and when												

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Governance												
Review meeting templates from all reporting in committees.	x			x		x		x		x		x
DCH Subco Ltd - Quarterly update to shareholder		x			x	x A/R		x			x	
Approval of business cases as and when												
Other												
Review of Terms of reference												x
Review of Effectiveness of FPC												x

Risk and Audit Committee Work plan 2021-22

	Sep 21	Nov 21	Jan 22	Mar 22	May 22
Governance					
Review the BAF & significant risk register					
Revision of assurance framework (in context of Trust Strategy review)					
Escalations from Sub-Groups					
Review Standing Orders, SFIs, and Scheme of Delegation					
Review losses and special payments					
Review of Tender Activity and Waivers					
Risk Summit					
Charitable Funds Consolidation					
Review of accounting policies areas of estimation					
Going Concern Report					
Engagement of External Auditors for Non-Audit Services Policy Annual Review					
Annual EPRR Assurance Statement (forward to Board)					
Auditors Annual Governance Report including letter of representation					
Draft Annual Account, Quality Report and Governance Statement					
Auditors Report on the Quality Account					
External Audit - KPMG					
Agree final annual report and accounts timetable and plans					
External audit plans and fees					
Review the effectiveness of external audit					
Review external audit progress reports, technical update and benchmarking					
Review audited annual accounts including the external audit opinion					
Receive the external auditors report to those charged with governance					
Receive/consider the external auditors annual audit letter (including review of non-audit services)					
Counter Fraud - TiAA					
Approve the annual work plan					
Progress Report					
Review the effectiveness of counter fraud					
Review the annual report on counter fraud					
Self Review Tool					
Internal Audit - BDO					
Review and agree work plan					
Progress Report					
Recommendations Follow Up Report					
Internal audit reports - Per the Audit Plan					
Review the annual effectiveness of internal audit					
Internal Audit Annual Report and Annual Statement of Assurance, inc Head of Internal Audit Opinion					
Other					
Review of Terms of Reference					
Review of Effectiveness of Audit Committee					
Committee Workplan					
Register of gifts and hospitality					
Declarations of interest					
Auditors meet Chair without management					
Referred items from other committees/emerging themes - as required					

Ref: MA/TH

To the Members of the Board of Directors of Dorset County Hospital NHS Foundation Trust

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **26th May 2020** at **08.30am to 11.05am** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Presentation	Rachel Cookson / Nicky Lucey	Note	8.30-8.50
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	8.50-8.55
	a) Apologies for Absence: Alastair Hutchison, Richard Sim	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 28th April 2021	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**CEO Update**	Enclosure	Patricia Miller	Note	8.55-9.05
4.	**COVID-19 Update**	Verbal	Inese Robotham	Note	9.05-9.15
5.	**Performance Scorecard and Board Sub-Committee Escalation Reports** a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee d) Risk and Audit Committee	Enclosure	Committee Chairs and Executive Leads	Note	9.15-9.35
6.	**Recovery Overview**	Enclosure	Nick Johnson	Discuss	9.35-9.50
Coffee Break 9.50 – 10.00					

7.	**Draft Strategy 2025**	Enclosure	Nick Johnson	Approve	10.00-10.15
8.	**Social Value Action Plan Update**	Enclosure	Simon Pearson / Nick Johnson	Approve	10.15-10.30
9.	**Guardian of Safe Working Report**	Enclosure	Kyle Mitchell	Note	10.30-10.45
10.	**Board Sub-Committees:** • **Effectiveness Reviews** • **Terms of Reference** • **Priorities** • **Cycles of Business**	Enclosures	Trevor Hughes	Discussion	10.45-11.05
	CONSENT SECTION				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
11.	**Annual Statutory Declarations**	Enclosure	Trevor Hughes	Approve	
12.	**NED Committee Membership Proposal**	Enclosure	Trevor Hughes	Note	
13.	**Safeguarding Annual Report** (Quality Committee)	Enclosure	Nicky Lucey	Note	
14.	**Corporate Risk Register** (Risk and Audit Committee)	Enclosure	Nicky Lucey	Note	
15.	**Board Assurance Framework** (Risk and Audit Committee)	Enclosure	Nick Johnson	Note	
16.	**Communications Report October 2020 to March 2021**	Enclosure	Nick Johnson	Note	
17.	**Any Other Business**				
	Nil Notified	Verbal	Mark Addison	Note	
18.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 28th July 2021 via MS Teams / Venue to be confirmed.**				

Meeting Title:	**Board of Directors**
Date of Meeting:	**26th May 2021**
Document Title:	**Annual License Condition Declarations:** • **Continuity of Services Condition 7 of the NHS Provider Licence – Availability of Resources** • **License Condition FT 4 – Corporate Governance Statement,** • **Training of Governors** • **General License Condition 6**
Responsible Director:	**Patricia Miller, Chief Executive**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	*If Confidential please state rationale:*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
None – this paper is for the Board of Directors		

Purpose of the Paper	The purpose of this paper is to detail the Board's self-assessment and declarations of compliance against: • Continuity of Services Condition 7 of the NHS Provider Licence Appendix 1 • License Condition FT 4 – Corporate Governance Statement and Training of Governors – Appendix 2 • General Condition 6 of the Provider License – Appendix 3						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	It is a statutory requirement for foundation trusts to review their arrangements for effective governance and use and availability of resources and to make a public declaration, approved by the Board of Directors, within two months of the financial year ending. -							
Action recommended	The **Trust Board** is asked to a) **Approve** the Continuity of Service (CoS7) self-certification declaration statement 3b, that over the course of the following 12 months, and subject to the explanation provided, the Board of Directors reasonably expects to have the required resources to deliver Commissioner Requested Services; b) **Approve** the self-certification declaration to confirm compliance with license condition FT4 and Governor training; c) **Approve** the self-certification declaration to confirm compliance with General License Condition 6; d) **Delegate** authority to the Trust Chair and Chief Executive to sign these declarations; e) **Publish** the approved declarations within one month.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to comply would have regulatory and reputational impact.
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	Y/N	
Decision to be made?	Y	To approve the Annual Declarations prior to publication
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Dorset County Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	1 Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board has sound systems of corporate governance and internal controls in place and receives annual assurance of this from the Head of Internal Audit through the Head of Internal Audit Opinion.	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board has due regard to guidance issued in respect of good corporate governance basing its arrangements on the Code of Good Governance and Single [illegible]	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The trust has an established Board and committee structure in place with agreed Terms of Reference and Business Cycles. Divisional Services are represented at committee level providing the opportunity for scrutiny of performance, activity and risk mitigation and for escalation of risks and issues by services to the Board. The Board has received the Annual Report, the Annual Governance Statement and the Statement of Accounts for Financial Year 2019/20. The aforementioned documents,	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed		Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Quality agenda is shared by all members of the Board and led by the Director of Nursing and Quality and Medical Director. The Quality Committee meets on a monthly basis and is chaired by a Non-Executive Director; promoting scrutiny and accountability, and receives detailed reports relating to patient experience, friends and family test and quality indicators.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board has maintained an appropriate membership and effective balance between Executive and Non-Executive members throughout the reporting period ensuring a diversity od skills and qualifications.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name [ ] **Name** [ ]

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A [ ] Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		Signature	
Name		Name	
Capacity		Capacity	
Date		Date	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Dorset County Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed

Please fill details in cell E22

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

With the continuation of the CoVID 19 pandemic, and within the guidance of the interim finance regime, the Trust is planning on a breakeven plan for the first half year (H1) of 2021/22. In the abscence of any formal guidance on planning for the period beyond October 2021, this places a degree of doubt that the Trust can provide the assurances that there are sufficient resources availalble during the H2 period. If the planning assumptions return to those seen prior to the pandemic, the Trust is likely to be facing a significant underlying deficit.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Appendix 1

Title of Meeting	**Board Of Directors**
Date of Meeting	**26th May 2021**
Report Title	**Continuity of Services Condition 7 of the NHS Provider Licence – Availability of Resources**
Author	Trevor Hughes, Head of Corporate Governance

Introduction

This declaration pertains to condition CoS 7 of the NHS Provider Licence and relates to having the resources required to continue to deliver services designated as being 'Commissioner Requested' over the next 12 months. Commissioner Requested Services (CRS) are services Commissioners consider should continue to be provided locally, even if a provider is at risk of failing financially, and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:.

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

The terms of license condition CoS 7 state:

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the required resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the required resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the required resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the required resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be

declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the required resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to NHS Improvement with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS Improvement in accordance with paragraph 4 shall be approved by a resolution of the Board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS Improvement immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

3. Self-Assessment

Foundation trusts are required to confirm one of three declarations about the resources required to provide CRS designated services summarised as:

a. the required resources will be available over the next financial year
b. the required resources will be available over the next financial year but specific factors may cast may doubt on this
c. the required resources will not be available over the next financial year.

and to explain the reasons for the chosen declaration.

Required resources include: management resources, financial resources and facilities, personnel, physical and other assets.

The Trust considers the services that it is commissioned to provide are 'commissioner requested' services and has confidence that it operates a robust programme of performance management against a number of key quality, performance and finance indicators that are monitored via the performance Score Card and scrutinised via respective Board subcommittees.

The Board also receives the following information on a regular basis:

- Quality and Performance Report including;
  - Quality performance
  - Use of resources
  - Financial performance and rating scores in line with regulatory guidance
- Board Assurance Framework
- Annual Plan and progress reports
- Interim Reports and Minutes from Board sub-committees

Additionally, the Board of Directors meet with the Council of Governors and has regard to their views and is able to be assured about the effective deployment and availability of resources.

The COVID-19 pandemic significantly impacted NHS providers throughout 2020/21 and financing arrangements were radically amended nationally in order to address the crisis. The Operating Plan for 2020/21 has subsequently not been formally agreed to date and the Board of Directors is therefore requested to approve the declaration 3b.

It is no longer a requirement to submit this declaration to NHS Improvement. However, audits will be undertaken by NHSI to ensure that Trusts complete a self-assessment and approve the subsequent declaration.

4. Recommendation

Therefore the Trust Board is asked to:

- **note** the assessment of factors considered in respect of CoS7 licence requirements
- **approve** confirmation of declaration 3b and;
- **approve** delegated authority to the Chief Executive Officer and Chairman to sign the declaration on behalf of the Board of Directors.

Signed

Trust Chair	**Chief Executive**
Date	**Date**

Appendix 2

Title of Meeting	**Board Of Directors**
Date of Meeting	**26th May 2021**
Report Title	**License Condition FT 4 – Corporate Governance Statement and Training of Governors**
Author	Trevor Hughes, Head of Corporate Governance

NHS Foundation Trusts are required to make two self-certificated declarations regarding the robustness of corporate governance arrangements and compliance with the NHS Provider License annually. Additional declarations are required concerning governance arrangements and consideration of the impact on the Trust's governance and finance arrangements of partnership working where the Trust is part of a major Joint Venture.

The attached paper comprises declarations requiring approval by the Board of Directors in relation to the following two areas as follows;

- Corporate Governance Statement
- Training of Governors

A brief rationale of compliance is outlined against each statement. No risks to compliance with the Provider License conditions or mitigating actions have been identified against each required declaration and the Board of Directors is making a positive declaration.

4. Recommendation

Therefore the Trust Board is asked to:

- Approve the enclosed declarations and rationales
- delegate the signing of these declarations on behalf of the Board of Directors to the Trust Chair and Chief Executive Officer
- Publish the signed declarations.

Signed

Trust Chair **Chief Executive**

Date **Date**

Appendix 3

Title of Meeting	**Board Of Directors**
Date of Meeting	**26th May 2021**
Report Title	**General License Condition 6 of the NHS Provider Licence**
Author	Trevor Hughes, Head of Corporate Governance

Introduction

The NHS Provider Licence sets out the conditions the Trust must comply with to operate as an NHS foundation trust. NHS Improvement may take action against an NHS foundation trust if it is found to be in breach of its Licence conditions. Therefore it is a requirement of an NHS Foundation Trust Board of Directors to make prescribed declarations in regard to the Trust's on-going compliance with the terms of its Provider Licence and Constitution.

This declaration pertains to General Condition 6 of the NHS Provider Licence and relates to having systems for compliance with licence conditions and related obligations in place. The terms of this condition are as follows:

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) the Conditions of this Licence,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are / or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate for the purpose of this Condition within one month of its approval in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Declarations Required by General Condition 6 of the NHS Provider Licence

In regard to this declaration, the Board of Directors is required to either “Confirm" or "Not Confirm" the following statements:

General Condition 6 - systems for compliance with licence conditions
1. Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution;

and

2. The Board of Directors declares that the Licensee continues to meet the criteria for holding a licence. The declaration requires the signature of two Board members to sign on behalf of the Board of Directors and for the Board to have had regard to the views of the Governors.

3. Recommendation

The Board has received the Annual Governance Statement for the 2020/21 Financial Year period. This statement provides assurance of sound corporate and quality governance, risk management and control systems in place to ensure the Trust has met its requirements over this period. Further, the Head of Internal Audit Opinion provided for moderate assurance on the Trust’s internal risk management and control systems.

Therefore the **Trust Board** is asked to

- **confirm** compliance with G6 licence requirements and;
- **approve** delegated authority to the Chief Executive Officer and Trust Chair to sign the declaration on behalf of the Board of Directors.

Signed

Trust Chair	**Chief Executive**
Date	**Date**

Meeting Title:	Trust Board
Date of Meeting:	26th May2021
Document Title:	**Proposed Committee Membership**
Responsible Director:	Mark Addison, Trust Chair Patricia Miller, Chief Executive
Author:	Trevor Hughes, Head of Corporate Governance

Confidentiality:	*If Confidential please state rationale:*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Non-Executive Directors' Meeting	April 2021	Proposal supported

Purpose of the Paper	The purpose of this paper is to set out proposed Non-Executive Director (NED) membership of the Board sub-committees following the recent appointment of a new Non-Executive Director in order to maximise the knowledge, skills and experience the Non-Executive team brings to the Board and in order to ensure an equitable workload. The Board is asked to discuss and approve the proposal.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	A review of Board sub-committee membership at this time is appropriate as: • Interim committee membership arrangements have been operating during the period to recruit to the NED vacancy resulting in inequitable workloads within the NED team; • Interim supplementary NED lead roles have been undertaken during the recruitment period; • A new NED has recently been appointed to the vacancy • The timing is consistent with the annual committee review of effectiveness • The DCHFT strategy and strategic objectives have been reviewed and sub-committee programmes of work will be aligned to this over the coming months. The sub-committee membership proposal aims to maximise benefit to the Trust by ensuring appropriate membership and maximises NED knowledge, skills and experience. The proposal also aims to deliver a more equitable workload for NED team members.							
Action recommended	The Board of Directors is recommended to: 1. **Discuss** the benefits and changes contained within the proposal; making amendments if necessary; 2. **Approve** the proposal.							

Governance and Compliance Obligations

Legal / Regulatory	Y/N	The Trust Board is required to ensure that the arrangements it establishes demonstrate that the organisation is 'Well Led'.
Financial	Y/N	No
Impacts Strategic Objectives?	Y/N	Appropriate alignment of NED knowledge, skills and experience within board sub-committees will support scrutiny and delivery of the refreshed

		strategic objectives of the Trust.
Risk?	Y/N	Appropriate alignment of NED knowledge, skills and experience within board sub-committees will support scrutiny of risk mitigations and assurance.
Decision to be made?	Y/N	The proposal is consistent with the Trust's workforce risk appetite statement to maximise potential, support the Trust's values and strategic objectives.
Impacts CQC Standards?	Y/N	The proposal supports delivery of the 'Well Led' standard by maximising the use of NED knowledge, skills and experience
Impacts Social Value ambitions?	Y/N	No
Equality Impact Assessment?	Y/N	The proposal aims to deliver an equitable workload for members of the NED team
Quality Impact Assessment?	Y/N	No

Committee Memberships

Key:

Added to meeting
Discretionary attendance / further discussion
Removed from meeting

	Current		Proposed		Commentary
Risk and Audit Committee Quorum = 2 NEDs	**Chair**	Ian Metcalfe	**Chair**	Ian Metcalfe	
	NEDs	Sue Atkinson Judy Gillow (Quality) Stephen Tilton (FPC) Dave Underwood (Charity)	**NEDs** Quorum = 2 NEDs and 2 Execs	Sue Atkinson Margaret Blankson (PCC) Judy Gillow (Quality) Stephen Tilton (FPC) Dave Underwood (Charity)	Committee Chairs to provide risk and governance assurance.
	Exec's CFO and either MD or CNO to attend	Paul Goddard Nick Johnson Nicky Lucey Inese Robotham Stephen Slough Alastair Hutchison Patricia Miller (Annual Governance Statement)	**Exec's** CFO and either MD or CNO to attend	Paul Goddard Nick Johnson Nicky Lucey Inese Robotham – as requested Stephen Slough – as requested Alastair Hutchison Patricia Miller (Annual Governance Statement)	Propose DCH Subco to report to RAC rather than FPC – removes the conflict of ST as Subco Director reporting to FPC which he Chairs Propose DEP Joint Venture to report to RAC on activities and approvals Management of BAF risks to move to Committees – oversight to be retained by RAC with Assurances on mitigations provided by

	Current		Proposed		Commentary
					Committee Chairs following Committee discussion.
Finance and Performance Committee	**Chair**	Stephen Tilton	**Chair**	Stephen Tilton	
Quorum = 2 NEDs and two Execs	**NEDs**	Judy Gillow (Quality) Victoria Hodges (WFC) Ian Metcalfe (RAC) Dave Underwood (Charity)	**NEDs** Quorum = 2 NEDs and two Execs	Judy Gillow (Quality) Ian Metcalfe (RAC) Dave Underwood (Charity)	
	Exec's	Paul Goddard Nick Johnson Patricia Miller Inese Robotham Dawn Harvey Nicky Lucey - as required	**Exec's**	Paul Goddard Nick Johnson Patricia Miller Inese Robotham Dawn Harvey Nicky Lucey - as required	Unchanged
Quality Committee Quorum = 2 NEDs and 2 Execs (one must be MD or CNO)	**Chair**	Judy Gillow	**Chair**	Judy Gillow	
	NEDs	Sue Atkinson Ian Metcalfe (RAC) Stephen Tilton (FPC) Dave Underwood (Charity)	**NEDs** Quorum = 2 NEDs and two Execs (one must be MD or CNO)	Sue Atkinson Ian Metcalfe Stephen Tilton (FPC) Dave Underwood (Charity) Margaret Blankson (PCC)	
	Exec's	Alastair Hutchison Nick Johnson Nicky Lucey	**Exec's**	Alastair Hutchison Nicky Lucey Patricia Miller	

	Current		Proposed		Commentary
		Patricia Miller Inese Robotham Nick Johnson - as required		Inese Robotham Dawn Harvey Nick Johnson - as required	
People and Culture Committee Quorum = 2 NEDs and 3 Execs (COO, MD and CNO)	**Chair**	Victoria Hodges	**Chair**	Margaret Blankson	
	NEDs	Judy Gillow Ian Metcalfe	**NEDs** Quorum = 2 NEDs and 2 Execs (Either COO and/or MD and/or CNO)	Judy Gillow Ian Metcalfe Dave Underwood	Dave Underwood added as FTSU NED lead
	Exec's	Paul Goddard Alastair Hutchison Nicky Lucey Patricia Miller Inese Robotham	**Exec's**	Paul Goddard Alastair Hutchison Nicky Lucey Patricia Miller Inese Robotham	
Charitable Funds Committee	**Chair**	Dave Underwood		Dave Underwood	
	NEDs	Mark Addison Judy Gillow Victoria Hodges		Mark Addison Margaret Blankson Stephen Tilton	
	Exec's	Nick Johnson Paul Goddard Nicky Lucey Inese Robotham			
DCH Subco Ltd	**Chair**	Stephen Tilton		Stephen Tilton	
	NEDs	-		-	

	Current		Proposed		Commentary
	Exec's	Nick Johnson		Nick Johnson	
Master Plan	**NEDs**	Stephen Tilton Ian Metcalfe Dave Underwood		Stephen Tilton Ian Metcalfe Dave Underwood	
		Nick Johnson		Nick Johnson	
Strategy	**NEDs**	Mark Addison Judy Gillow Sue Atkinson		Mark Addison Judy Gillow Sue Atkinson	
ED&I	**NEDs**	Margaret Johnson Stephen Tilton		Margaret Johnson Stephen Tilton	
Estates					

NED Workload Summary

Name	Chair of	Attends	Other Roles
Mark Addison	Trust		•
Judy Gillow	Quality Committee	• Risk and Audit Committee • Finance and Performance Committee • People and Culture Committee	• Vice Chair • Mortality
Sue Atkinson		• Risk and Audit Committee • Quality Committee	• Senior Independent Director • Maternity • End of Life
Ian Metcalfe	Risk and Audit Committee	• Finance and Performance Committee • Quality Committee • People and Culture Committee	• Emergency Preparedness
Stephen Tilton	Finance and	• Risk and Audit Committee	• DCH Subco Chair

	Performance Committee	• Quality Committee	
Dave Underwood	Charitable Funds Committee	• Risk and Audit Committee • Finance and Performance Committee • Quality Committee • People and Culture Committee	• Freedom to Speak Up Lead
Margaret Blankson	People and Culture Committee	• Risk and Audit Committee • Quality Committee • Charitable Funds Committee	•

Title of Meeting	**Board of Directors**
Date of Meeting	**26 May 2021**
Report Title	**Annual Safeguarding Report**
Author	Sarah Cake– Safeguarding Lead (RN) Co –Authors Jo Findlay Learning Disability and Mental Capacity Act Lead (RN) Gerry Graham Safeguarding Lead for Maternity, Hanna Wellman Specialist Safeguarding Nurse
Responsible Executive	Nicky Lucey – Director of Nursing and Quality

Purpose of Report

The purpose of this annual report is to inform and assure members of the Quality Assurance Committee the Safeguarding activities within Dorset County Hospital during 1st April 2020 – 31ST March 2021

Foreword

Dorset County Hospital Foundation Trust (DCHFT), its Executive Team, Safeguarding Leads / Practitioners & Managers are committed to ensuring that the mental capacity and safeguarding of our patients, their families, our staff and our communities is at the foundation of our Trust values and is embedded within our day to day practice.

DCHFT recognise that one of the most important principles of safeguarding is that it is 'everyone's responsibility'. Safeguarding children, young people and adults can only be effective when we work collaboratively with our partner agencies and respectively with those who need protecting from the risk of harm, abuse or neglect. The Trust gives due regard to ensuring all its services protect individual human rights, treat individuals with dignity and respect and safeguards them against abuse, neglect, discrimination or poor treatment.

Safeguarding is increasingly multifaceted, & challenging, and poses a balancing act for practitioners when ensuring the rights and choices of an individual with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm.

The annual Safeguarding Adults report aims to:

- Provide assurance of compliance with the local multi agency guidelines for safeguarding adults (Dorset Adults Safeguarding Board / Dorset Clinical Commissioners Group, Dorset County Council).
- Provide assurance of compliance with the Care Quality Commission Registration Standards: Regulation 13 (safeguarding service users from abuse and improper treatment), fundamental standard 5 (safeguarding from abuse) and Safe Domain (safeguarding arrangements).
- Inform the Board of safeguarding adult's activity including progress against the

annual work plan.

- Provide assurance of compliance with the local multi agency guidelines for safeguarding children (Dorset Children's Safeguarding Board / Dorset Clinical Commissioning Group and County Council).
- Provide assurance of compliance with the Section 11 of the Children Act (1989, 2004)

Safeguarding Policies

Policy Name	Available	Last updated
Safeguarding Adult Policy including links to Safeguarding Partnership websites	☒	Within the past 3 months
Safeguarding Children Policy including links to Safeguarding Partnership websites	☒	Within the past 6 months
MCA and DoLS Policy	☒	Within the past 3months
Safer Recruitment Policy	☒	HR
Allegations Against Staff Policy	☒	HR
Whistleblowing Policy	☒	HR
Supervision Policy	☒	Safeguarding guidance available to supplement this policy
Was Not Brought		Updated April 2021
Domestic Abuse Policy and Guidance	yes	Updated in March 2021
PREVENT	Yes	Past 14 months
Learning disability Framework & Supporting adults with learning disability / autism policy	yes	Last 6 months

There are a number of local changes in addition to the national perspective that have occurred in the past year in relation to the safeguarding agenda in Dorset.

National

Domestic Abuse Bill awaiting Royal accent.

Mental Capacity (Amendment) Act 2019. Implementation date April 2022

Department of Education review into sexual abuse in schools commenced March 2021.

Local

Review of adult safeguarding boards concluded that there are no plans to join with the children's partnership or for the two council to have an integrated board. Dorset Council Safeguarding adult's board and Bournemouth Poole and Christchurch council will continue to work jointly through the working groups but will maintain their separate board meetings.

In development a Pan Dorset Approach to Safeguarding by Health providers and Commissioners to integrate to an ICS.

Paper Previously Reviewed By

This paper is a summary of the Safeguarding Adults Group; therefore the content has been discussed and reviewed via that Group, which has the delegated responsibility for safeguarding adult's governance. Quality Committee 18 May 2021.

Strategic Impact

All providers have a legal responsibility to safeguard the welfare of adults under Care Act 2014, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DOLS) 2009.

All providers that deliver services to children have a legal requirement to meet Section 11 of the Children Act (1989, 2004).

Domestic Abuse and violence against woman has been widely covered in both local and National media and remains an area of focus politically

Safeguarding Children is still on the political agenda with increased focus on Modern Slavery, Child sexual exploitation, Criminal exploitation, County Lines sexual abuse within education and increasing knife crime by teenagers.

Risk Evaluation

Key Risks for the service

1. **Activity and Demand –** increasing safeguarding activity Trust wide post each easing of restrictions through COVID.
2. **Training –** training compliance, specifically for level 3 children's compliance Requirement to align with the intercollegiate guidance for adult Safeguarding at level 3 & maintaining supervision during COVID restrictions
3. **Information Sharing –** to ensure information shared with community services in a timely and robust manner following the attendance of a child at DCHFT.
4. **Talent Management –** ensuring that the DCH Safeguarding Team has the correct people with the capabilities to deliver outstanding care, now and going forward.
5. **Mental Health –** increasing need for Mental Health provision in an acute physical environment, specifically for children and young people.
6. **Mental Capacity –** the new Liberty Protection Safeguards (LPS) are due to come into force in April 2022 via the Mental Capacity (Amendment) Act 2019. The LPS will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty.

   The legislation will create Responsible Bodies to authorise an incapacitated person's deprivation of liberty. The identity of the Responsible Body will depend entirely upon the arrangements for the persons' care which could be:

   - An NHS Trust or Local Health Board if the person is being cared for in the hospital, or
   - A CCG or Local Health Board for arrangements under NHS CHC, or
   - A Local Authority in all other situations, such as care homes, supported living and private hospitals.

Under LPS, deprivation of liberty will have to be authorised by the Responsible Body and will also apply to 16 and 17 year olds, as well as adults.
Impact on Care Quality Commission Registration and/or Clinical Quality Safeguarding Children, Young People & Adults, Mental Capacity Act compliance and Deprivation of Liberty assessments are key quality indicators and are subject to external inspection. All Deprivation of Liberty outcomes are forwarded to CQC for notification.
Governance Implications (legal, clinical, equality and diversity or other): The trust has legal responsibilities as detailed within the strategic impact section. The reassurance of a robust service is measured through audit or assurance tools comparing practice against policy. Electronic flagging of patients with learning disabilities and / or Autism is a recognized national system, however this does categorise individuals and therefore has an acknowledged implication for equality and diversity. This is in line with our equality duty and supporting published papers on Equality in Health. This ensures pathways of care are reasonably adjusted and patients with disability are not disadvantaged by the service provided. National Flagging through CPIS (Child Protection Information Sharing) for children who are subject to a Child Protection Plan; or a cared for child or an unborn infant, who will be subject to a Child Protection at birth, is maintained by Social Care partners and is shared to Health Providers.
Financial Implications: Failure to adhere to the standards can result in penalties and/or legal claims. Cost and resource implications for the introduction of the Liberty Protection Safeguards.

Freedom of Information Implications – can the report be published?	Yes

Recommendations	The Board are asked to a) To receive and review the report, recommending any areas for further improvement at Safeguarding Group b) Receive assurance of Safeguarding activity c) Support delegated responsibility to the Safeguarding Group for the development of the 2020–2021 work-plan, which the Lead for Safeguarding will focus on, in conjunction with the Safeguarding Team.

Safeguarding Annual Report

April 2021

A co-ordinated approach – safeguarding is everyone's responsibility

1.0 PURPOSE OF REPORT

1.1 This report provides a summary of the Safeguarding activity from 1st April 2020 – 31st March 2021. The purpose of this annual report is to provide assurance and inform members of the committee of how Dorset County Hospital meets its duties to safeguard adults by preventing and responding to concerns of abuse, harm or neglect.

2.0 INTRODUCTION

2.1 Welcome to the Safeguarding Annual Report 2020-2021for Dorset County Hospital Foundation Trust (DCHFT). The safeguarding team has matured over the past 12 months into a fully integrated team encompassing adults and children with shared safeguarding agendas, shared ethos and duty of care.

The purpose of this report is to provide an assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with our services.

The Safeguarding Team provide expert advice, support, supervision and specialist training to support all Trust staff to fulfil their safeguarding responsibilities and duties. The safeguarding work is underpinned by DCHFT`S strategy 'outstanding care' for people in ways which matter to them, to ensure their voice is always heard.

The term 'Safeguarding' encompasses all activities to assist children, young people and adults at risk, to live a life that is free from abuse and neglect and to enable independence, wellbeing, dignity and choice. Safeguarding includes the early identification and/or prevention of harm, exploitation and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' and promoting best practice from serious incidents to improve future services development for patients and staff.

The Safeguarding Annual Report 2020- 2021 provides a summary of the activities of the Adult, Children and Midwifery Safeguarding Teams across the Trust to demonstrate to the Trust Board, external agencies and the wider community how the Trust discharges its statutory duties in relation to current safeguarding expected national standards and best practice guidelines challenges and future priority.

2.2 Definitions

Safeguarding:

The Care Quality Commission (CQC) state; 'Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care' (CQC, 2016).

Safeguarding Children; a child is defined within the Children Act 1989 as – "an individual who has not reached their 18th birthday".
Even when they:

- Live independently
- Are a parent themselves
- Are in custody
- Are a member of the armed forces

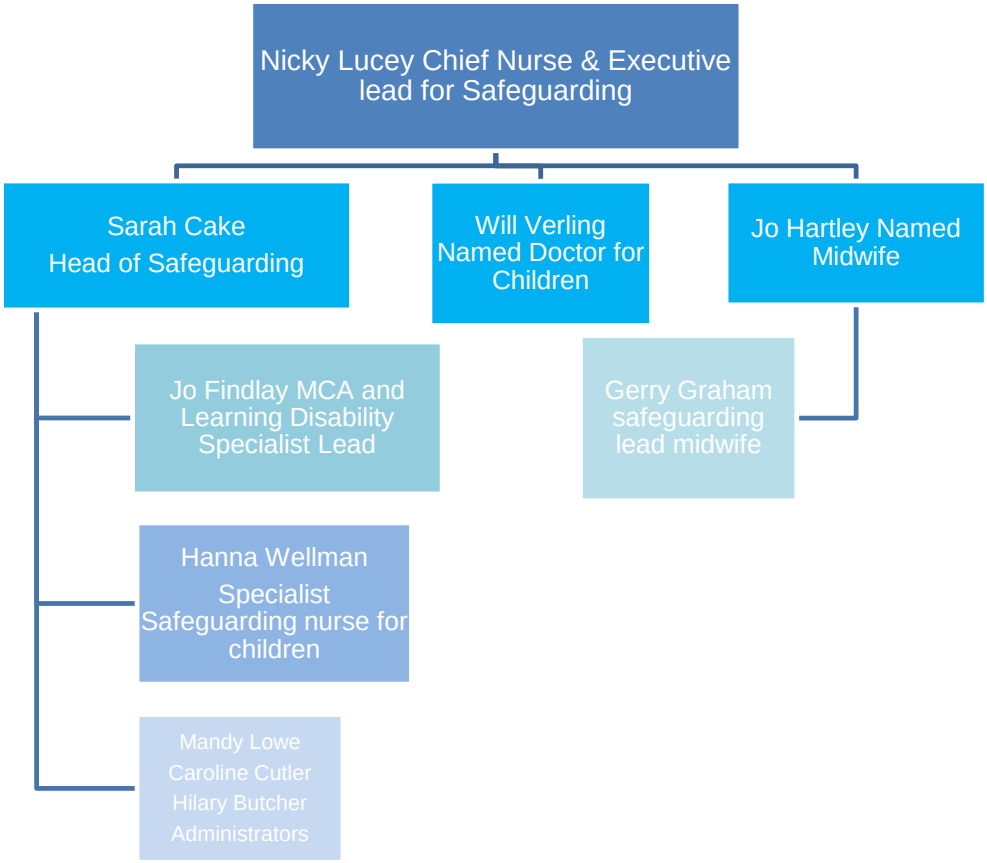
This does not change their entitlement to protection, or Safeguarding.

Safeguarding Adults: An adult is an individual aged 18 years or over. The Care Act 2014 defines an 'adult at risk' as:

- an adult who has care and support needs (whether the needs are being met or not);
- is experiencing, or at risk of, abuse or neglect;
- And as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All DCHFT staff has a statutory responsibility to safeguard and protect those who access our care regardless of their position in the Trust. Though, some defined named safeguarding roles do exist. Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Intercollegiate Safeguarding Competencies Children (2019).

The Safeguarding Team at Dorset County Hospital foundation Trust



2.3 Key National Themes

2.3.1 CE (Child Exploitation)

Child exploitation (CE) is a form of physical, sexual, emotional and criminal abuse which involves the manipulation and/or coercion of a child/young person under the age of 18. This may be through the use of technology. CE continues to be a priority for DCHFT. The safeguarding team has undertaken a lot of work around CE over the past year. The team have raised further awareness of CE across the organisation, strengthening the resources

available and training across all areas. CE training is now incorporated into the Trust Induction training, which means staff new to the organisation will be equipped with the necessary skills required from the moment they start employment with Trust. The Emergency Department (ED) and Paediatrics have embedded into practice the CE screening/risk assessment tool and this has become a core part of the assessment process. As a Trust the safeguarding team attend the monthly partnership child exploitation tactical group (CAROLE) to review emerging themes, review process for assessment of CYP who are deemed to be at significant risk, & share information pertaining to CE activity in Dorset. Children/young people identified at risk via one of these meetings are flagged within the Trust, enhancing information available to staff aiding effective and safe risk assessments.

2.3.2 Female Genital Mutilation

FGM (Female Genital Mutilation) The Serious Crime Act 2015 introduced mandatory reporting by regulated professionals from October 2015. In order to ensure compliance with legislation, and to provide assurance to the board that DCHFT colleagues are competent and confident to recognise and respond appropriately,

FGM is highlighted within all levels of training across the Trust. It is imperative that all colleagues remain vigilant for signs and indicators of FGM to ensure that an urgent response via police and Children's Social Care is initiated in the event a girl presents to DCHFT with trauma as a result.

The Named Midwife provides assurance for the Trust and leads upon any statutory responses to identified risks or cases from a safeguarding perspective.

2.3.3 COVID-19:

The impact of COVID-19 has been significant nationally and a Level 4 emergency was declared regarding the NHS in March 2020. COVID-19 was a new virus affecting humans and the impact on the NHS has been unprecedented. In addition the pace at which NHS organisations have had to change and adapt has been phenomenal. Throughout the pandemic, Government guidance remained clear that functions into safeguarding remained in place, however there was some easement of statutory responsibilities in respect of Safeguarding Practice Reviews and Safeguarding Adult Reviews DCHFT safeguarding team have been proactive in assisting with all safeguarding concerns throughout the pandemic.

2.3.4 Protect, respect, connect – decisions about living and dying well during COVID-19. CQC 18 March 2021

A hard-hitting report looking at DNACPR decision-making during the first year of the pandemic.

This report was shared via the Trust communication bulletin for all staff along with further links to Mental Capacity Law and Policy website where Alex Ruck Keene posts a short webinar around DNACPR decision making and Advance Care Planning

2.3.4 Children and Mental Health

The past 12 months have seen an increase in activity in children and young people seeking help for self-harm, eating disorders and mental health concerns both nationally and locally. In the Trust we have experienced children and young people with very complex needs, requiring specialised mental health care that have required protracted lengths of stay , as the paediatric unit being utilised as a `safe` place, whilst awaiting this specific care. In reality the generalised consensus from paediatrics & safeguarding that it is actually more detrimental to these CYP`S emotional health and wellbeing and does not aid their recovery once they are deemed medically fit for discharge.

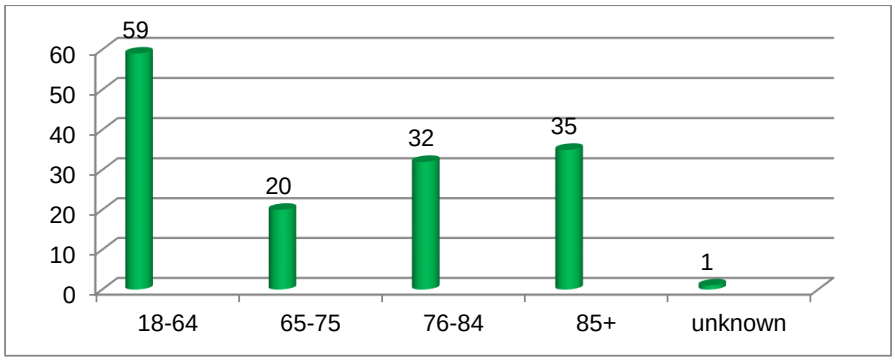
3.0 ADULT SAFEGUARDING ACTIVITY

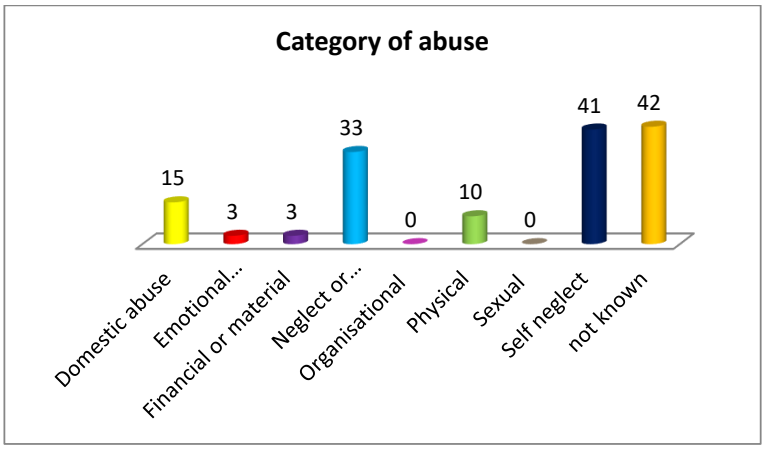
3.1 During the past 12 months staff have formally submitted concerns for 147 people using our service. The majority of these were not investigated through a Safeguarding investigation, but were signposted to other services. The activity in relation to contact with the Safeguarding team has also intensified , common themes have been advice for employees / advice on discharge planning/ advice on mental capacity. In 2020- 2021 there were 8 concerns raised in relation to Dorset County Hospital Foundation Trust by external agencies All of these were investigated through a nominated enquiry process and did not proceed on through to a full safeguarding investigation. The main issues related to communication and safe transfer into the community. The findings of the investigation are communicated to the department where the incident occurred for learning, they are informed that the issue is not being pursued through Safeguarding, but any changes to practice will need to be adopted through their quality of care agenda.

3.2 All concerns are discussed with the Head of Safeguarding or deputised to another member of the team to complete an initial investigation, the outcome of which informs the decision to proceed to a full investigation under Safeguarding Adult Procedure. Ultimately the decision is decided by the Dorset Council Safeguarding Triage Team manager.

3.3 There were **no** external investigations by Dorset County Council under Adult Safeguarding Procedures during 2020-2021.

3.4 The graph below demonstrates the age demographics of the referrals received in each quarter, review of the data has indicated that the age group with the highest reported concerns was 18-64; predominantly the vulnerability for this group was substance misuse and self-neglect.





3.5 The highest category of abuse reported was self-neglect; this is the first time that this has been recorded as the highest category. Anecdotal evidence would allude to this being a direct result of COVID and consequently people may have been fearful to seek help or assistance, concerned about accessing services and a higher percentage of dependence on alcohol & or drugs.

4.0 CHILDREN SAFEGUARDING ACTIVITY

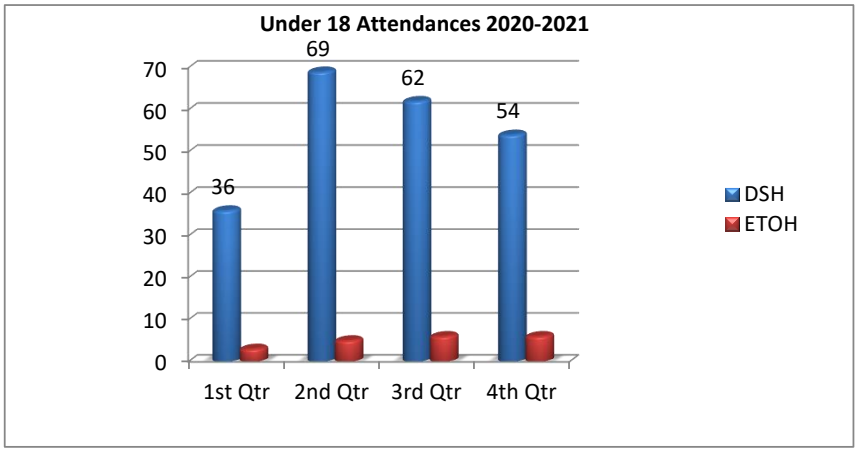
4.1 The Dorset Council approach to safeguarding is aligned with a strength based approach to managing concerns. This methodology formulates part of the training and supervision offered to staff who are more used to a more protection or paternalistic approach. The professional who has concerns about a child can call the consultant social workers, who will talk through the concerns, and discuss actions, to make sure the child receives the right support at the right time.

The change in process has been conversed through internal communication updates, email communication and the intranet has been revised. Monitoring of the activity for the Trust has been challenging as the Safeguarding Team are no longer made aware of all the conversations that have taken place as they often do not result in any action being required.

4.2 The Safeguarding Team continue to review the Emergency Department records for all under 5's and any 5-17 year olds, who has a vulnerable diagnosis, any issues are then escalated to the applicable team. The team have been fully involved in the creation of the safeguarding module for the new IT system (AGYLE) in the emergency department

4.3 The Safeguarding Team in conjunction with Kingfisher Ward / liaison psychiatry / ED and Paediatricians review on a weekly basis any children that have a mental health diagnosis, presented with self-harm safeguarding concern or a frequent attender to ensure all documentation, and processes have been completed. Any learning is escalated through the departments or to external agencies. The figures for children and young people have been collated, as it become an increasing concern for the

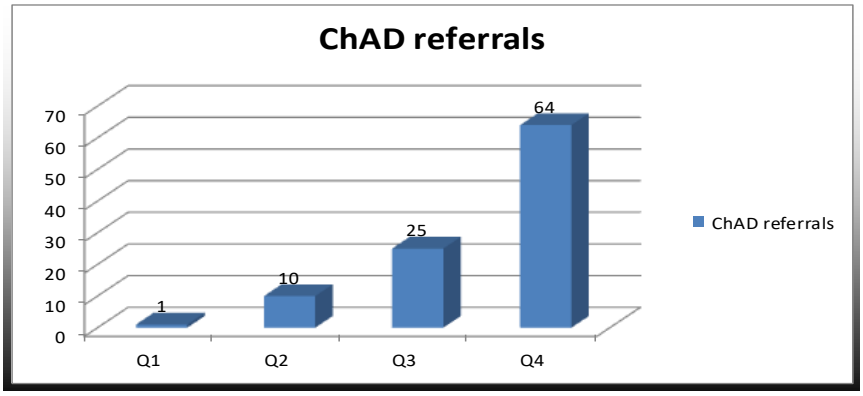
Safeguarding Group members, with high incidents of deliberate self-harm (overdose/cutting etc.) in younger patients, the youngest being 10 years old. All children that present with self-harming behaviour have an assessment by psychiatric liaison /CAMHS (Child & Adolescent Mental Health services) provided by Dorset Healthcare



4.4 Children's and Advice Duty Service

CHAD is the Children's and Advice Duty Service, which is a 24 hour service/ priority line, in Dorset, that offices advice to professionals requiring immediate responses for safeguarding children/ young people and families. CHAD is a single point entry for contacts regarding safeguarding and promoting the well-being of children in Dorset. CHAD is not a referral; it is a contact/ conversation to determine the appropriate action for any Safeguarding or Social concern relating to a child/ young person or concerns relating to the adult who cares for a child/ young person. CHAD offers professionals the chance to speak to the most relevant person/ or team for the child/ family in question, discuss the actions that need to be take and helps to ensure the child receives the right support at the right time.

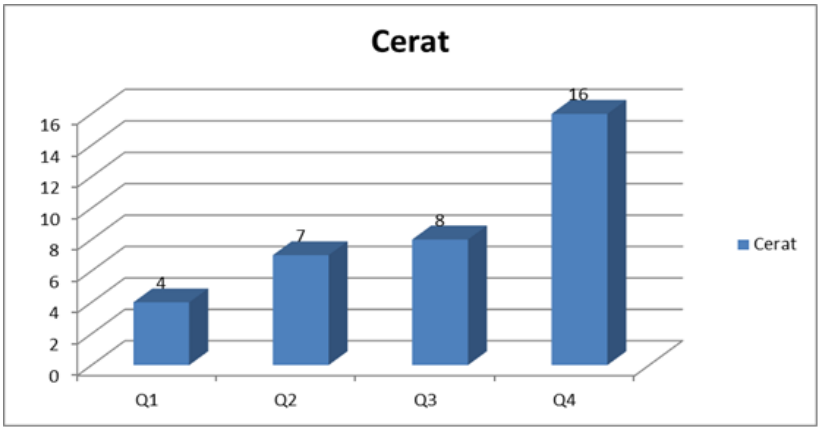
As previously identified, the initial monitoring of CHAD activity for the Trust's safeguarding team presented with challenges; this was due to the team not being notified of every contact or conversation with the CHAD service. However, as shown in the graph below, there has been a steady improvement in capturing this activity within the Trust over the past year. Confidence levels have grown for staff in all areas, particularly ED and Paediatrics in communicating their contacts with CHAD and informing the safeguarding team of outcomes. In addition to this, as an outcome of the advice, support and guidance offered by the safeguarding team, has shown further increase in staff confidence to use the CHAD service to its fullest potential.



4.5 Shortened Health Child Exploitation Risk Assessment Tool (CERAT)

A CERAT (Shortened Health Child Exploitation Risk Assessment Tool), predominantly used in the Emergency Department or Paediatric ward, is a tool used by staff to help identify a child or young person's risk of being exploited.

A CERAT is usually completed when a child or young person aged 10-18 years presents with certain risk factors, indicative of child exploitation. A CERAT consists of 4 short questions asked by the practitioner, who then adds these up and makes the relevant referral/ enquiry dependant on the outcome.



As can be seen in the graph above, there has been a rise in the use of CERATs completed in the Trust over the year, with figures doubling in Q4 from Q3. This is undoubtedly owing to the impact COVID-19 has had on the mental health status of children and young people in/ around Dorset, indicating the need to complete a CERAT on presentation to the Acute Trust. The impact of education setting closures and children and young people being exposed to increased uses of media has no doubt increased the risk of exploitation but also the vulnerability to online bullying/ grooming. This has recognised a decline in poor mental health for children and young people, which has been captured through the use of the CERAT.

4.6 Child Protection Medicals undertaken by Dorset County Hospital Paediatricians are for children and young people who may have experienced physical abuse or neglect, paediatricians undertake medical assessment` of the child to identify any injuries or health need related to the abuse. Dorset County Hospital does not undertake sexual abuse medical assessment; these are referred to either United Hospital Dorset (Poole site or the Sexual assault referral centre). The paediatricians, clinical staff and a representative from social care review all these cases on a monthly basis, as part of their governance, supervision and learning process

5.0 MATERNITY SAFEGUARDING ACTIVITY

5.1 Female Genital Mutilation

The Serious Crime Act 2015 introduced mandatory reporting by regulated professionals from October 2015. In order to ensure compliance with legislation, and to provide assurance to the board that SFHFT colleagues are competent and confident to recognise and respond appropriately.

FGM is highlighted within all levels of training across the Trust. It is imperative that all colleagues remain vigilant for signs and indicators of FGM to ensure that an urgent response via police and Children's Social Care is initiated in the event a girl presents to DCHFT with trauma as a result.

The Named Midwife provides assurance for the Trust and leads upon any statutory responses to identified risks or cases from a safeguarding perspective. The Associate Director of Midwifery has access to the FGM Enhanced data set and this year two women have been added to the database. There is a named consultant for FGM and women are appointed to see him.

Vigilance over FGM is highlighted within the newly developed Care Bundle for Black, Asian and minority ethnic women. Designed in response to the increased risk of a poor outcome for pregnant BAME women and their greater risk from covid-19, this care bundle also requires good quality translation services must be available (if required) and/or an appointment with a consultant who speaks the woman's first language (where this is possible).

Of additional interest is the presence of a midwife in the team at DCH who led on the FGM Maternity service for a large London Trust. She will review the DCH guideline and contribute to any specialist teaching required.

5.2 Training

All midwives are compliant with level 3 safeguarding training. This has been provided as a combination of mandatory training and supervision sessions. Supervision sessions are now provided on Teams. Overall, this is successful with some connectivity issues for staff at home.

The Lead Midwife for Safeguarding and her assistant completely overhauled the mandatory training package for 2021 to incorporate the supervision session within the mandatory allocated time so that all staff attended and

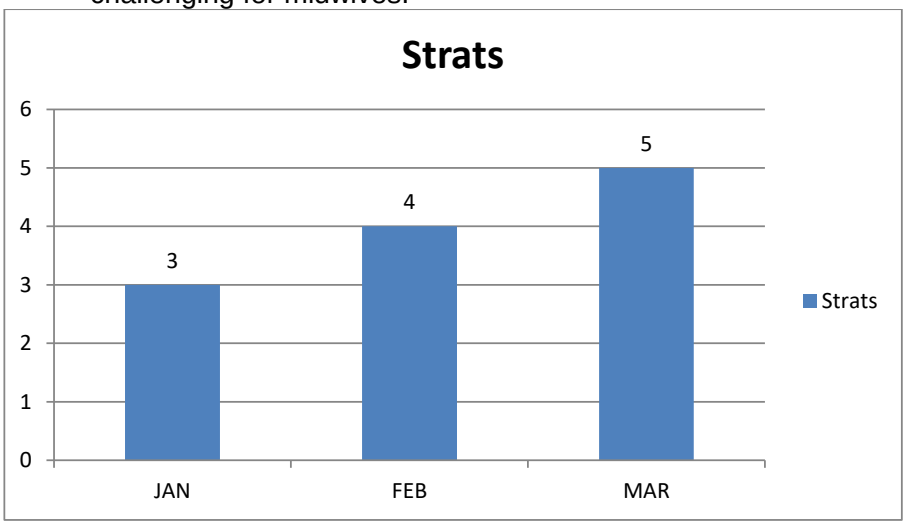
were compliant. The new package was interactive, stimulating and used mixed media to keep staff engaged. Case studies are used as are music videos, information videos, TED talks and infographics.

Unfortunately plans to provide the training on Teams was a failure due to connectivity issues. This was escalated to the IT Department but with no resolution forthcoming, the training has reverted to face-to-face, thereby requiring more allocated time for training provision.

Individual supervision continues to be offered. Midwives who are required to provide a Child Protection or Child in Need report, have been asked to book supervision with a member of the Maternity Safeguarding Team, to ensure we have a "fresh eyes approach" prior to submission. This is noticeably improving the quality of reports submitted.

5.3 Strategy discussions led by MASH

In 2019, the Lead Midwife requested that midwifery be invited to strategy discussions where all professionals involved with a family were present. This provided an opportunity for the midwives to ensure that the voice of the unborn is not lost, particularly when there are other children in the family; it is an opportunity to gain and contribute essential information to inform the decision as to whether the unborn is at risk of significant harm. Data has only been collected for the last three months but in that time midwifery has attended 12 such meetings. There are occasions, when a Strategy meeting is called within a few hours and in those cases, attendance is extremely challenging for midwives.



5.4 External training

The Lead Midwife for Safeguarding contributes to a Workforce Development initiative with DCC and provided training for social workers to understand the role of midwife and how we can work more effectively to safeguard unborn babies.

5.5 Working with external partners

The Maternity Safeguarding Team continues to meet with partners in DCC/Early Help to discuss vulnerable families 0-5 across West Dorset. The Lead Midwife meets regularly with senior management in DCC to discuss cases of concern and when required, will evoke the Escalation Policy if she identifies concerns around management of cases.

5.6 The Young Parents Service

Our young parents (aged up to 19 years) continue to receive 100% continuity for their care during pregnancy and afterwards.

Mental health crisis in our young mothers (under 23 yrs) remains high as the figures demonstrate below. The impact of this on them and their children is significant and long-lasting.

	Weymouth and Portland caseload delivered.	North Dorset	Bridport	Dorchester
2018	73% (25/34)	100% (3/3)	16% (2/12)	50% (9/18)
2019	60% (17/28)	50% (2/4)	71% (5/7)	33% (4/12)
2020	58% (25/43)	NIL (0/6)	53% (7/13)	38% (5/13)
2021 to date	65% (26/40) Includes booked to deliver in 2021	50% (6/12)	72% (8/11)	53% (8/15)

We have requested assistance from a local alliance in Weymouth and Portland to develop the support we give to young parents, many of whom have struggled during COVID with coping with existing issues/ financial security/social isolation etc. The alliance is comprised of DCC, schools, colleges, early help, other health professionals.

We have also discussed with the CCG ways in which to secure alternative/bespoke mental health support for young parents. Commissioners have agreed to look at existing services and ensure that the new mental health pathway considers the needs of young parents.

Our Perinatal Mental Health Service continues to see increasing referrals into their multi-disciplinary service. As required, the PNMH service works closely with the Safeguarding Service and a recent development is a dedicated social worker within the PNMH Team.

5.7 Alcohol Screening in Pregnancy

We are revisiting our Alcohol Screening tool and pathway in line with new NICE guideline due to be published, and we are currently in talks with Public Health to join a national pilot training scheme with FASD services (Fetal Alcohol Syndrome Disorder). FASD Network UK is a social enterprise which is able to respond to contracting, service level agreements and spot purchasing requests with local authorities and voluntary and community sector groups across the region. It is able to provide training, consultancy and advocacy

services in order to raise awareness of the condition and to provide input about service and support requirements.

5.8 Guideline development

A guideline for Concealed Pregnancy and Late Booking has been circulated for comment. This incorporates recommendations from NICE regarding careful assessment of the woman on presentation.

6.0 SERIOUS CASE REVIEWS

Dorset County Hospital has been involved in x2 Adult safeguarding reviews, neither of which has reached their completion. There is likely to be minimal learning for the Trust as we had very little contact with either of the adults being reviewed.

The team have also been involved in the SCR 43, although this young person only had a brief interaction with our outpatient's services. All authors' submissions have been undertaken, there is an expected publishing of the full report in May. Areas already highlighted, cross county placements, transition, early years rejection, and possibly coercion and control in relationship.

7.0 TRAINING

7.1 *Adults*

All staff is required to undertake training in Safeguarding Adults, either level 1 or level 2. This is aligned with the competency framework and dependent on their job role. The training package is accessed via the e-learning platform and requires testing of understanding post completion of the learning activity. At this time level 3 & 4 are not recorded as these competencies are for a very small number of employees. Scoping has been completed to identify which employees will require a heightened expertise in identifying & dealing with issues relating to safeguarding in adults. This will include legal literacy, domestic abuse & contextual safeguarding.

7.2 *Children*

Level 1 and 2 Safeguarding Children Training is provided internally to DCHFT staff. Level 1 training is initially provided at induction and then staff maintain their own competence via the e-learning platform.

All non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers utilise the on-line training at Level 2.

Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person are offered internal training at Level 3. All training has been appraised and updated during 2020-2021 to ensure emerging themes,

such as contextual safeguarding are included within the training. Level 3 during COVID19 has been offered via e-learning / PowerPoint presentations/ video`s and reading lists, going forward the aim will be develop and improve the online training with podcasts and webinars.

The team have been able to maintain specific tailored training for preceptorship programme &, for the nurses who have been recruited into the Trust from overseas, and junior medical staff.

The training figures have been appraised and the reduction in compliance appears due to the reduction in volunteers and bank staff undertaking training. In the next year it is planned to separate the figures for substantive posts and those for staff that are temporary or volunteers.

Supervision

Due to the Pandemic the offer of supervision for staff has been condensed, however staff have been able to liaise with the team at any time if they require supervision, the emergency department have been active in receiving supervision via the team's platform on a monthly basis. The proposed external training for staff in delivering supervision was postponed in 2020, but funding has been assured for this coming year.

Trust Wide Results.	Quarter1 (average) scores includes all staff and volunteers	Quarter 2 (average) scores includes all staff and volunteers	Quarter 3 scores includes all staff and volunteers	Quarter 4 scores includes all staff and volunteers
Adults				
SGA level 1 >90%	87%	87%	**86%**	85%
SGA level 2 >90%	88%	89%	**89%**	90%
MCA/ DoLS level 1 >90%	88%	89%	**87%**	82
MCA/ DoLS level 2 >90%	88%	89%	**87%**	87
BPAT	91.%	93%	**81%**	81
WRAP	91%	81%	**93%**	93
Children				
Level 1 >90%	88%	87%	**85%**	81

Level 2>90%	89%	90%	**90%**	90
Level 3 >90%	77%	75%	**76%**	75

8.0 MENTAL CAPACITY ACT

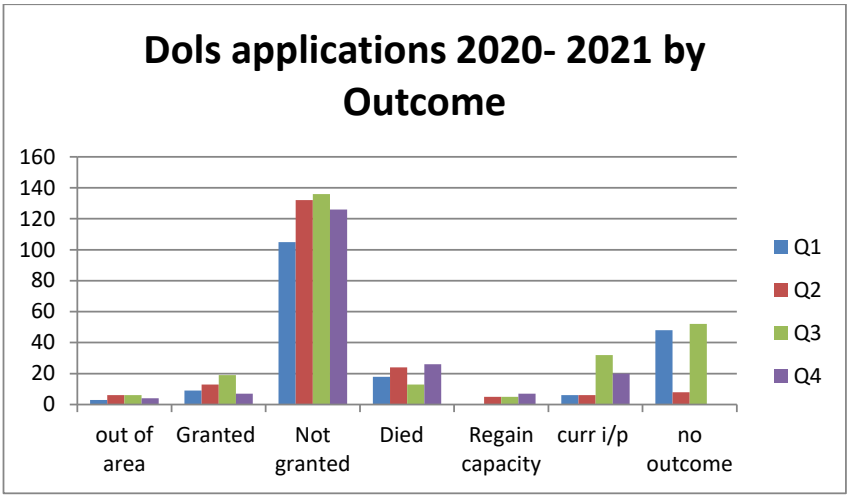
8.1 Throughout the pandemic the message to staff around the Mental Capacity Act, was very much 'business as usual'. The Safeguarding team continued to give advice and guidance to staff around their application of the Mental Capacity Act. The staff intranet pages were kept up to date with the latest advice and guidance notes.

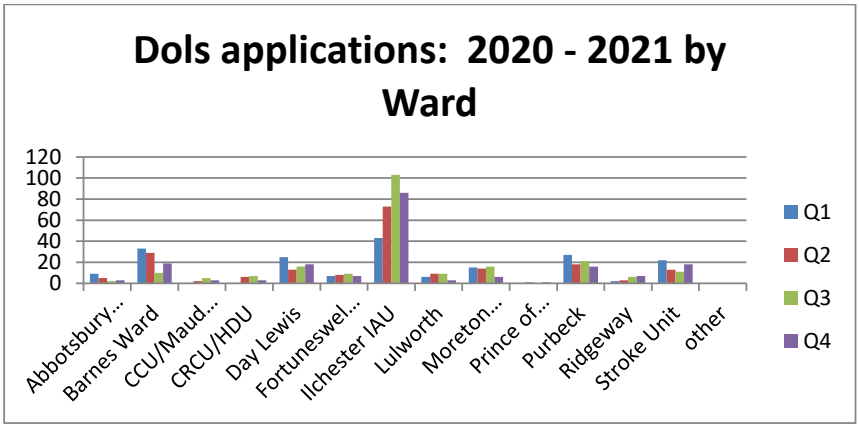
9.0 DEPRIVATION OF LIBERTY SAFEGUARDS

9.1 Until the Mental Capacity Amendment Act (2019) Liberty Protection Safeguards come in to force in April 2022, the Deprivation of Liberty Safeguards continue to be the prescribed process by law for the authorisation of any deprivation of liberty within a hospital setting.

9.2 We now have the time scales for the Liberty Protection Safeguards which have a hoped for go live date of April 2022 which is later than we had initially expected. We received the updated Initial Impact assessment, but this relates only to the Primary Legislation. We still await the draft Code of Practice and Regulations (Spring 2021). There will be a 3 month consultation period on the draft Code of Practice.
The LD and MCA Lead is representing Acute Trusts for the SW on the newly formed SW Liberty Protection Safeguards Group as well as Dorset County Hospital on the Pan Dorset LPS group. The Pan Dorset LPS group has been on hold for the last year, but meetings will be recommencing in the near future.

9.3 There have been a total 787 Deprivation of Liberty Safeguards (DOLs) applications in the reporting period; this is an increase from (558) 2019-2020.





10 DOMESTIC ABUSE

10.1 The Home Office defines domestic violence and abuse as:

'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This encompasses but is not limited to the following types of abuse: psychological, physical, sexual, financial, or emotional.'

10.2 Controlling behaviour is: 'a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'

10.3 Coercive behaviour is: 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'

10.4 Domestic Abuse is significant to the healthcare agenda due to:

a) *Patient Care:* Achieving high quality care for patients.

b) *Regulations*: Domestic Abuse is integral to Children and Adults. Safeguarding is a fundamental requirement for registration and complying with the Care Quality Commission.

c) *Legislation*: Complying with legislation including the Children Act, Human Rights Act; Equality Act; Mental Capacity Act and Safeguarding Vulnerable Groups Act.

d) *Cost Effectiveness*: Harm, neglect and abuse cost the NHS millions each year in avoidable admissions and care.

10.5 All staff receive domestic abuse awareness as part of their mandatory training.

10.6 There is a new process that has been rolled out across the Dorset Council area for high risk case *HIGH RISK DOMESTIC ABUSE* (HRDA). Dorset County Hospital has been active in promoting this process.

10.7 To promote the Domestic Abuse 16 days of action in 2020, the towers in the Trust were lit up every night in the colours of the event, white and purple. This initiative was publicised within the local press.

10.8 The DRIVE project – working with high risk and high harm domestic abuse perpetrators has commenced, The new DRIVE project is now being implemented Pan Dorset to work with high risk and high harm perpetrators of domestic abuse. The aims of DRIVE are:

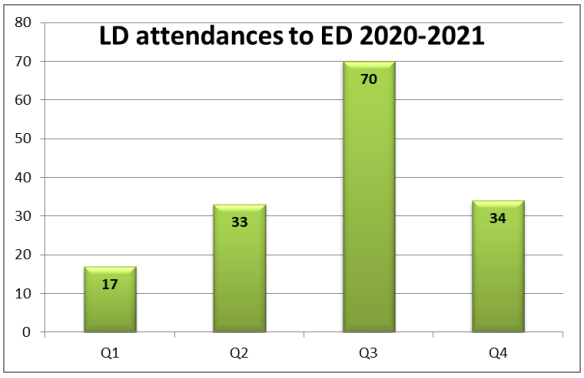
Disruption: put barriers and obstacles in place to prevent abuse from taking place.
Support: address the needs of the Perpetrator with the aim of removing barriers to the change process and disrupting abuse.
Change: focused and specific interventions to explicitly address the Perpetrator's attitudes and behaviour in relation to domestic abuse.

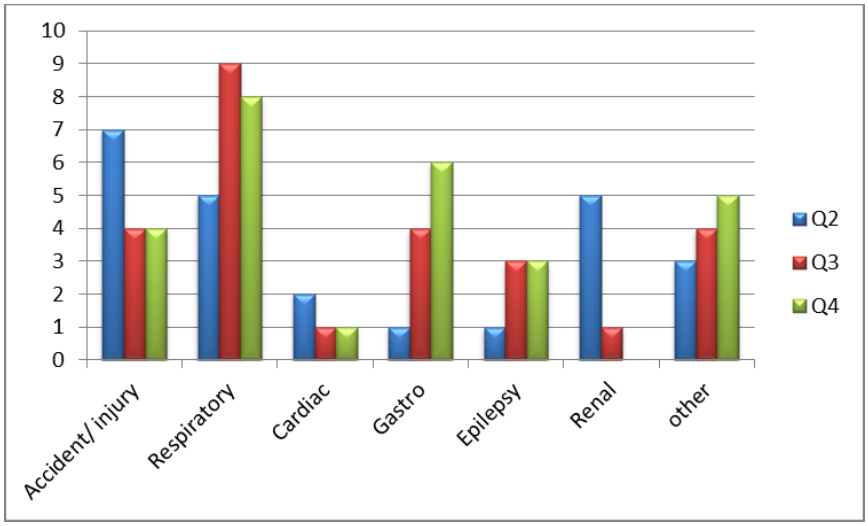
DCH are not actively involved in the project as this is very much a community based

There is currently no funding available for a Health Domestic Advisor to be linked to the Trust, although this is being reviewed by You First.

11 LEARNING DISABILITY

11.1 Attendances at ED for people with a learning disability





11.2 DCH submitted data to the NHS I E Learning Disability Benchmarking exercise 2020-21. The report for the previous year (2019-20) has only recently been published (March 2021)

The report details the findings of the second NHS England NHS Improvement learning disability improvements standards collection. The standards focus on 4 areas:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce
4. Specialist learning Disability service

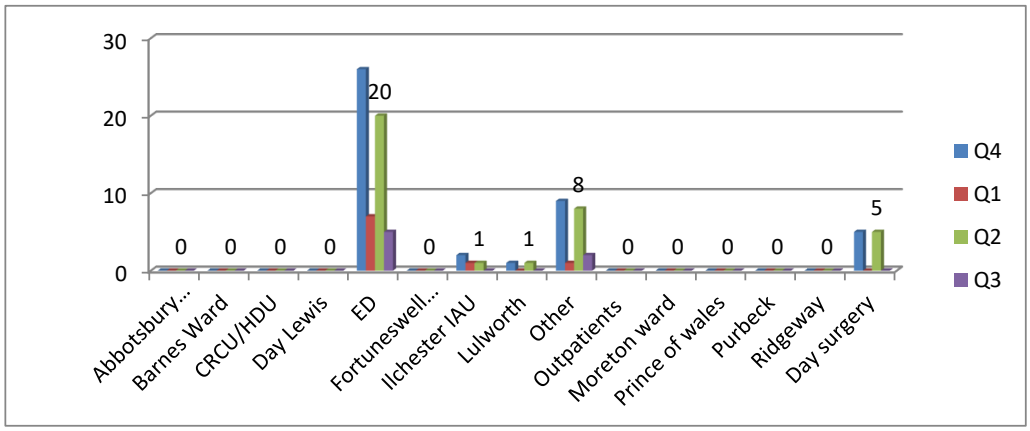
There is a 3 pronged approach of organisational level, staff level and service user level data collection

Key points for future consideration include:

- Providing a low stimulus waiting area
- Providing accessible appointment letters
- Providing changing places toilet facilities
- Providing home visits instead of outpatient appointments
- Triaging people with a learning disability and autism

The report also focus's on the provision of learning disability liaison staff. DCHFT has a Learning Disability and Mental Capacity Act lead who's role is different to that of a liaison nurse but provides leadership around supporting people with a learning disability to Trust Staff. The report does not recognise this.
There is an emphasis on employment of people with a learning disability or autism. DCHFT currently doesn't have any data around this
The report also explores training around learning disabilities, something that is not yet mandatory but likely to be in the near future.

11.3



Not all people with a learning disability who use our service are flagged as having a learning disability. Through COVID 19 we put out a request to our partners in the community teams to send through to us their service users 'This Is Me' documents and asked if they consented to be flagged.
Guidance was also created and shared with staff relating to Covid 19 and people with a learning disability.

LD Hospital Poster DCHFT May 20.pdf

11.4 The LD and MCA Lead worked closely with Paediatric services, Learning Disability Services as well as Dorset Parent Carer Council and Dorset Abilities to create patient information and family carers pack for Transitions.

11.5 The LD and MCA Lead continues to work with the Community LD Services to draft an admissions and attendance pathway for people with a learning disability looking at key LeDeR learning points as well as reasons for attending ED and how we as a system may be able to improve outcomes for people with a learning disability and possibly avoid unnecessary hospital admissions

11.6 LeDeR report: Covid 19 and deaths of people with a learning disability report.
The key finding of this study was that people with learning disabilities had significantly and substantially higher death rates in the first wave of COVID-19 in England than the general population. Adjusting for the likely level of under-notification it was 6.3 times the general population rate. Deaths with COVID-19 in adults with learning

disabilities were spread more widely across the age groups than those in the general population. As in the general population, the COVID-19 death rate in people with learning disabilities was higher for men than for women. The overall increase in deaths was also greater in Asian or Asian-British, and Black or Black-British people.

The Trust continues to notify the LeDeR programme of any deaths of people with a learning disability and is represented on the Dorset LeDeR Steering group.

12.0 PREVENT

12.1 Prevent forms part of the Counter Terrorism and Security Act, 2015. Prevent is concerned with preventing children and vulnerable adults becoming radicalised into terrorism.

12.2 NHS Trusts are required to:-

- Train their staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised, and how to raise a concern.
- Train Workshop to Raise Awareness of Prevent Training (WRAP) facilitators to cascade more detailed Prevent training to staff.
- Report concerns of people becoming radicalised to the Prevent hotline.
- Attend the local authority Channel panel. This multiagency panel discusses the risk posed by vulnerable people who are referred for multiagency support.
- Report the training figures and number of people referred to Channel on a quarterly basis to NHS England.

12.3 The Training is now completely e-learning.
WRAP package is a one off heightened awareness for staff that is aligned with requiring SGA Level 2 / SGC level 2; this is a 20-40 minute e-learning package.

12.4 PREVENT learning is required by all Trust staff and requires an update every 3 years. The e-learning package that has been developed by NHS England, will ensure a consistent approach to both training and competency, and will meet our contractual obligations in relation to safeguarding training as set out in the NHS Standard Contract.

12.5 The compliance and activity is monitored quarterly by NHS digital and Dorset Commissioning Group through submission of data.

12.6 There have been no PREVENT referrals or CHANNEL referrals in the past 12 months.

13.0 SAFEGUARDING INCIDENTS INVOLVING STAFF

13.1 Over the past 12 months the safeguarding team have worked in conjunction with HR and LADO (Dorset Council) when safeguarding concerns have been raised about employees. There have been 3 cases; all have been resolved from a Trust perspective.

14.0 AUDIT

14.1 Overarching MCA/Safeguarding Assurance audit is completed 6 monthly. The format for this aligned with the CQC KLOES, however due to the inspection process changing it will need to reference the new key line of enquiry .This will be part of our workplan 2021- 2022 to redesign.

14.2 Dorset Safeguarding Board requested the participation of its members in a review of the MARM (multi agency risk management) process. DCH submitted data, pertaining to its participation in the process. The action plan and learning has yet to be clarified

15.0 DORSET Adult Safeguarding & Children's Partnership

15.1 The Safeguarding Adults Board is a multi-agency group including Health, Social Care, Police and Voluntary agencies. This Board became statutory from April 2014 under the Care Act.

15.2 The Trust is represented at the Dorset Adults Safeguarding Board (DASB) by the Director of Nursing and Quality as executive lead or the Head of Safeguarding.

15.3 The Safeguarding Board produces multi-agency policy and procedures which the Trust adheres to and reflects within its own local policy.

15.4 The Safeguarding Lead represents the Trust at the B&PDASB Policy and Procedure sub group, the B&PDSAB Training and Development sub group, B&PDSAB Quality Assurance sub group, and Adult Health Leads Group for Safeguarding.

15.5 The Children's Partnership sub groups are attended by the Head of Safeguarding, health are represented at board level by the Director of Nursing for the CCG .

16.0 OTHER ACTIVITIES UNDERTAKEN BY THE TEAM DURING 2020-2021

Development of a bespoke training package for level 3 Safeguarding children.

Both intranets sites for Safeguarding have been updated and refreshed.

Six monthly Safeguarding newsletters shared with all employees at DCH.

External internet site updated to include more links to accessible information.

Improvements to recording Safeguarding with in the DPR system.

7 minute briefings

In autumn 2020, a series of 7 minute briefings were created to aid the learning and development of staff in some of the key areas of safeguarding. The series of briefings were uploaded to the Trust Intranet site for staff to access at any time. It is thought that 7 minute briefings/ learnings are an ideal way to adapt to the different learning styles of individuals. The short briefings/ learnings are thought to be beneficial as they are short and succinct, assisting learners to concentrate and retain information more efficiently.

The briefings cover some different and key themes based on findings from paediatric attendances and current safeguarding topics across the county. They include a mixture of information, key learning points, resourceful links and information on further help. The 7 minute briefings cover the main learning points for the topic discussed and allows for the reader/ learner to reflect on these. The briefings give the opportunity for staff to ask questions and identify areas for development of team members and systems.

Social media posters

In summer 2020, it was recognised by the safeguarding team that there had been an increase in poor mental health for CYP. The key theme from this was increased and extended social media use in CYP. This is likely to have been an impact from the lockdown period due to COVID-19, and this identified an area in safeguarding that required some learning, support and guidance for staff and parents on the use of social media. The safeguarding team developed a series of social media posters designed to guide staff and parents on internet safety. The posters included information regarding the most frequently used social media sites and how information is accessed on these. In addition, the posters included signposting information on how to get help and where to get help from in relation to online bullying or abuse.

17.0 SAFEGUARDING DORSET COUNTY HOSPITAL WORK PLAN 2021-2022 KEY OBJECTIVES

With the continued lifting of sanctions post COVID 19 it is likely there will be an increase in the activity of the Safeguarding Team, with many vulnerable, isolated children, young people & adults emerging from social isolation who may have suffered harm during this period of time. This therefore will be our initial focus for the 2021-2022

Authors:
Sarah Cake Head of Safeguarding
Jo Findlay Learning Disability and Mental Capacity Act Lead
Gerry Graham Lead Midwife for Safeguarding
Hanna Wellman Specialist Safeguarding Nurse

References.

1/ Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

2/ Deprivation of Liberty Safeguards
https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards

3/ Dorset Adult Safeguarding Board Policy
https://www.dorsetforyou.gov.uk/dorsetsafeguardingadultsboard

4/ Regulation 13: Safeguarding service users from abuse and improper treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13
http://www.cqc.org.uk/content/regulation-13-safeguarding-service-users-abuse-and-improper-treatment

5/ Mental Capacity Act 2005
http://www.legislation.gov.uk/ukpga/2005/9/contents

Meeting Title:	Board of Directors Part One
Date of Meeting:	26 May 2021
Document Title:	**Corporate Risk Register**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Mandy Ford, Head of Risk Management and Quality Assurance

Confidentiality:	*n/a*
Publishable under FOI?	*Yes*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated.
Risk and Audit Committee	18 May 2021	Recommended to Board

Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that risks corporate risks are effectively being managed and that controls are in place to monitor these. All care group risk registers are being reviewed by the Service Manager and Division. The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*	✓	*Approve (✓)*	
Summary of Key Issues	The most significant risks which could prevent us from achieving our strategic objectives are detailed in the tables within the report. All current active risks continue to be reviewed with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.							
Action recommended	The Audit and Risk committee is recommended to: • review the current Corporate Risk Register • note the Extreme and High risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances before recommending to the Board							

Governance and Compliance Obligations

Legal / Regulatory	Y	*Duty to ensure identified risks are managed*
Financial	Y	*Failure to manage risk could have financial implications*
Impacts Strategic Objectives?	Y	*Failure to manage risk will impact on the strategic objectives*
Risk?	Y	*Links and mitigations to the Board Assurance Framework are detailed in the individual risk entries.*
Decision to be made?	Y	*Movement of two workforce related risks to managed or tolerated within risk appetite.*
Impacts CQC Standards?	Y	*This will impact on all Key Lines of Enquiry if risk is not appropriately reported, recorded, mitigated and managed in line with the Risk Appetite.*
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Audit and Risk Committee
Corporate Risk Register as at 30.04.2021

Executive Summary
The Committee will note that the highest risks are associated with the impact of delayed patient treatment due to suspension of services as a result of COVID 19 pandemic control, and the recruitment and retention of staff. There has been some impact on services as a result of staff absence linked to Covid-19.

1. Introduction

1.1 This report provides an update from the report presented to the March 2021 Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 30.04.2021 unless otherwise stated and is reflective of the operational risks.

1.2 This report is to provide the Committee with assurance of the continued focus on the identification, recording and management of risks across the Trust at all levels. These are managed in line with the Trust's Risk Management Framework. The Corporate Risk Register is an amalgamation of the operational risks that require Trust level oversight. The Corporate Risk Register items are the overarching cumulative risks that cover a number of services and the divisions where individual risk elements are being actively managed.

1.3 Presented to the Committee at Appendix 1 is a heat map of those items currently on the Corporate Risk Register with Appendix 2 providing the detail.

- Heat Map (detailed in Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)

2. Updates

2.1 **449 – Financial Sustainability**
(This is managed/tolerated within risk appetite but is under monthly review)

2.1.1 The Trust finished last year at slightly better than breakeven and the submitted plan for the first half year of 21/22 is the same position. However, there is an expected risk that the finances for the second half year will be significantly tighter and will be kept under review once we know the details of the new finance regime.

2.2 **704 – Brexit – UK leaving the EU without a deal.**
(This is managed/tolerated within risk appetite but is under bi-monthly review)

2.2.1 The Trust has written to all our known EU staff and offered assistance with the settlement scheme application; good response in terms of those staff who have already applied. The deadline for application to the scheme is 30 June 21. Outcomes of this will be reported via the People and Culture Committee but assurance has been provided that all relevant staff have been identified and contacted and support offered.

2.2.2 In relation to the supply chain there have been isolated, often complex incidents, of disruption since 1 January. The Trust has not seen the level of disruption to supply that underpinned our planning assumptions. Acknowledging that this is good news, the view

of the Department is that organisations must maintain current levels of preparedness for some months yet, as part of our shared goal of ensuring patient safety through resilient supply chains.

2.2.3 There are existing challenges that must be recognised, not least of which is the ongoing response to the Covid-19 pandemic, the growing third wave in Europe and likely impact here in the UK. There remains a residual risk of Covid-19 impacting global borders and, as we have seen over the past 12 months, the impact of this is hard to anticipate and mitigate against, though we are doing so where possible. For these reasons, the Department has asked NHS Supply Chain to maintain contingency stock for medical devices and clinical consumables in the Centralised Stock Build (CSB) for the foreseeable future, and we strongly encourage you to continue to hold your UK stockpiles, where these have been built and remain.

3. Top Themes:

3.1 **Covid 19**

- 919 – Covid 19 (Extreme 20 (down from 25))

3.1.1 The Trust has continued to see a reduction in the number of patients being treated for Covid 19 over the last few months. PPE stock levels remain high with no reported issues on stock lines, and DCH remains at Major Incident Stand-by status along with the other Dorset acute hospitals. Vaccination hub closed on 30 April 2021, successfully vaccinating 24000+health and social; care staff. As a result of this reduction and ations taken the risk has been recalculated, it still remains as extreme as the impact on ways of working and risk remain, however a reduction in the likelihood score has been actioned from certain (5) to Likely (4). This will continue to be reviewed and monitored monthly on the risk register or sooner if circumstances change.

3.2 Constitutional standards

- 709 - Failure to achieve constitutional standards (elective care) (Extreme 20)
- 710 - Follow up waiting list backlog (Extreme 20)
- 450 - Emergency Department Target, Delays to Care & Patient Flow (Moderate 12)

3.2.1 All of these risks are due for review at the end of March 2021. During Covid 19 the access team have been contacting patients on the waiting lists during this period and some clinics have been held in different formats. Patients are being called in clinical priority with consultants having oversight of the lists. Monitoring standards were postposed when the pandemic commenced, but these are now being reintroduced.

3.2.2 Currently 709 and 710 remain as ‘Extreme’ due to the potential impact on patient safety and delay in treatment that could potentially lead to harm. (This is being mitigated by reviewing patients based on clinical need and any changes in presentations). There may be financial implications if constitutional standards are met.

3.2.3 ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average.

3.3 Mortality

- 641 – clinical coding (High 15)
- 464 – Mortality Indicator (Moderate 12)

3.3.1 Both of these items are discussed and reviewed regularly at the Hospital Mortality Group chaired by the Chief Medical Officer.

3.3.2 Overall trend is downwards though the last SHIMI has gone up very slightly. It was noted at the Hospital Mortality Group that the mean depth of coding being achieved by the coding department was improved. The Trust began with a mean depth of around 3 to the latest figure which is 5.6 which is the national average. Trusts doing very well achieve a figure of 6.5/7. If this rise continues the Trust could achieve a mean depth of coding of 6 which will be very beneficial.

3.3.2 SHIMI tables can be put in league table format. However there are only 3 groups for SHIMI, you are either above, below or within the expected range. If within expected range, statistically there is no difference between Trusts. We are currently rated 15 out of 160 Trusts and hope, with continued investment in the coding department to see improvements in this data. The Chief Medical Officer will address the question of where the Trust rate on the National SHMI table at the next Board meeting.

4 Divisional Emerging Risks (Details in Appendix 3)

4.1 Urgent and Integrated Care

- 461: Inpatient length of stay (Scored as 15 (High) (Moderate (3) x Certain (5))

4.2 Family Services and Surgical Division

- 1037* – No transition services at DCH Scored as 20 (Extreme) (Major (4) x Certain (5))
- 866 - External Multiagency delays resulting in delayed discharge of complex paediatric patients (Scored as 16 (High) (Moderate (4) x Certain (4))
- 1002 *- Lack of suitable room availability for Pre-Assessment Unit in Outpatients (Extreme) (Major (4) x Certain (5))

*Please note: 1037 and 1002 are due for review at the end of May 2021 and it is likely that the risk score will be reduced. No incidents have been reported regarding either issue to assist with evidencing the risk score. These will be reviewed with the Divisions.

4.2.1 These are all current siting at Divisional level where mitigations are in place. These are being highlighted as all three have the potential to impact on patient flow through the hospital, and could potentially cause patients harm by prolonged admissions or failure to undertake the necessary tests. These are not new issues but have become more prevalent during the pandemic management due to the requirement of flow and bed capacity. It should also be noted that space is an issue across the Trust and for may services.

4.2.2 The Division have requested agreement for the movement of risk reference 866: External Multiagency delays resulting in delayed discharge of complex paediatric patients to the Corporate Risk Register. This is a system wide issue and it is unlikely this can be managed within the Division.

4.3 ICT

- 1084 PACS storage Scored as 20 (Extreme) (Major (4) x Certain (5))

The new CT scanner takes a more in depth picture that is therefore larger and takes up more storage. Unfortunately the increased storage requirements were not factored in at the time, but there has been a change in the consumption forecast. PACS storage projected to reach 100% utilisation Jan 2022. Previous projection advised full storage Summer 2022

Risk level increase due to the department purchasing an additional MRI scanner which is due to be commissioned this summer. The mitigation would be to purchase additional storage, but the service does not believe it will be a capital pressure until next financial year (2022/23).

4.4 ESTATES

- 1094 Lack of staff accommodation. Scored as High (Major (4) x Likely (4))

Due to the International Nurses scheme and the Trusts plan to introduce 85 nurses into the Trust by the end of 2021 the accommodation office has predicted a shortfall of staff accommodation by the end of July 2021. Social media has been used to try and reach any local landlords that may be interested in supporting the Trust with accommodation.

5. Conclusion

Risks continue to be regularly reviewed and updated in line with the Risk Management Framework and is linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place.

The Risk team are in the process of reviewing all open and active entries on the live risk register with the service managers and relevant staff to ensure that scoring is correct and that risks are being reviewed and appropriately followed up and actions being followed through. It is anticipated that this full review will be completed by the end of Quarter 2.

6. Recommendation

The Audit and Risk committee is recommended to:

- review the current Corporate Risk Register ; and
- Agree the movement of risk reference 866: External Multiagency delays resulting in delayed discharge of complex paediatric patients to the Corporate Risk Register as it is unlikely this can continue to be managed within the Division.
- note the Extreme and High risk areas and actions
- consider overall risks to strategic objectives and BAF
- request any further assurances before recommending to the Board

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 06.05.2021

Appendices
Appendix 1 – Heat map
Appendix 2 - Corporate Risk Register
Appendix 3 – Emerging Divisional Risk Details

Heat Map

Appendix 1

		Likelihood Score				
score		**1**	**2**	**3**	**4**	**5**
		Rare (this will probably never happen 1x year)	**Unlikely (Do not expect it to happen but it is possible 2 x year)**	**Possible (might happen occasionally - monthly)**	**Likely (will probably happen - weekly)**	**Certain (will undoubtedly happen – daily)**
Consequence Score	**5 Catastrophic**	**5**	**10**	**15** (466)	**20**	**25**
	4 Major	**4**	**8**	**12** (450, 1000)	**16** (474)	**20** (709, 710, 919↓)
	3 Moderate	**3**	**6**	**9** (470)	**12** (464)	**15** (641)
	2 Minor	**2**	**4**	**6**	**8**	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**
	KEY	**(↓number)** Risk score has decreased since previous report **(↑number)** Risk score has increased since previous report				
	Closed/Managed/Tolerated risks since last report	449 – Financial Sustainability remains in 'managed' status at the start of 2021/22 financial year. 704 – Brexit 468 - Recruitment and retention of Medical staff across specialities (Extreme 20) 463 - Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff (Extreme 20)				

Corporate Risk Register **Appendix 2**

The Risk Items on the Corporate Risk Register have been reviewed by the appropriate risk leads and the Executive Team.

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review)	Extreme (25) Consequence: Catastrophic Likelihood: Likely Reviewed: 24.02.2021
919	Covid- 19	Previous Rating	Extreme (20) (down from 25)
This will impact on all of our strategic objectives.		Lead Executive	Inese Robotham
How this risk has been scored: **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Tony James
Current position/Progress/ Mitigation As at 06.05.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible undetermined
• Vaccination roll out has opened to 40-41 year olds as of 30th April. • Staff Lateral Flow Device (LFD) testing remains in place twice weekly. • The Hospital Hub for vaccinations has now closed WEF from 30th April. • The DCH IMT are now meeting once a week on a Wednesday. ICC is in place to be stood up if required as per the Level 3 requirements. • PPE levels remain good within the Trust with at least 2 weeks supply and no issues with ordering further supplies. • National Daily COVID-19 SitRep reporting continues 7 days a week. • DCH remains at Major Incident Stand-by status along with the other Dorset acute hospitals. • No issues with Mortuary capacity at DCH or within the other Dorset acute hospitals. • NHS SW Regional Operation Centre (SROC) has changed its opening hours; it now runs 0900-1700 weekdays regarding Covid and is closed at weekends. The Regional Vaccine Operational Centre (RVOC) remains open 0800-1800 weekdays and 0900-1700 hrs at weekends.		Next review date	31.07.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 07.05.2021
709	Failure to achieve constitutional standards (elective Care)	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : **Outstanding:** Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards Strategic Objective 3 Not achieving a 96% score on our friends and family test, Not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities **Strategic Objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Inese Robotham
Current position/Progress/Mitigation As at 07.05.2021 (data correct as at 07.05.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Covid- 19 impacted on services – this is being reviewed as part of the start-up work. • This is coded as extreme due to the potential impact on patient safety and delay in treatment that could potentially lead to harm – this is being mitigated by reviewing patients based on clinical need and any changes in presentations. • The 2021/22 planning guidance requests the trust to deliver 85% of our 2019/20 activity volumes by July 2021. The Trust is achieving 86% in April 2021 and is forecasted to be achieving 100% or above by July 2021. This returns the trust to pre-COVID levels of activity. The trusts has an elective recovery programme which is tasks with delivering above this level, as such levels of activity will not be enough to reduce the backlog of patients. A large scale insourcing and outsourcing programme has commenced to support this. • Diagnostics – Recovery plans and trajectories are in place and being monitored by the Elective Performance Management Group to return the trust to achieving the required standard. Use of insourcing and		Next review date	31.07.2021

outsourcing providers is underway. • Cancer – The Trust has recovered cancer performance to pre-COVID levels as per the 2021/22 guidance; with an improved 104 day backstop position. The required standard is still not being met and a trajectory to achieve this by the end of the year is in place. • ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average.		
OTHER RISK REGISTERS LINKED TO RISK 709	**Current rating following local review**	**Target rating following completion of all actions**
473 Failure to meet 6 week diagnostic targets for paediatric and adult audiology 554 Non-compliance with QS33 Rheumatoid arthritis in over 16s 555 Partial non-compliance with NG100 – rheumatology Numerous incidents reported in relation to cancellation of clinics and increase in complaints regarding treatment delays.	Low Risk Low Risk Low Risk Potential for litigation due to patient harm	Low Risk Very low risk Very low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 07.05.2021
710	Follow up waiting list backlog	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	All services
Current position/Progress/Mitigation As at 07.05.2021(data correct as at 07.05.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Robust reporting arrangements are in place to allow the services to oversee and manage all of the patients on their waiting lists. • Follow up waiting list numbers and profile of the waiting list is routinely reported to FPC. • Patient initiated follow ups are being launched in 3 specialities in 2021/22. This will reduce the volume of non-value adding appointments, releasing capacity to address the backlog. • Where clinically appropriate, virtual appointments are now offered, either via video consultation or via telephone. Virtual appointments are more efficient and result in higher volumes of patients being seen per clinic.		Next review date	31.07.2021

OTHER RISK REGISTERS LINKED TO RISK 709	Current rating following local review	Target rating following completion of all actions
462 Lack of ophthalmology service capacity to meet demand	Moderate	Low risk
472 Community paediatric long waits for ASD patients	Extreme	Moderate
505 Volume of patients on the gastroenterology follow up outpatient waiting list	Low risk	Low risk
557 Surveillance colonoscopy patients waiting greater than 6 months from their due date	Moderate	Very low risk
561 Volume of patients on the orthopaedic admitted list	Extreme	Low risk
581 Volume of patients on the dermatology outpatient waiting list	High	Low risk
777 Long waiting list for outpatient orthotic appointments	Low risk	Low risk
956 Excessive sleep diagnostic waiting times	Low risk	Very low risk
991 Increasing waiting list for paediatric dietetic outpatients	Moderate	Very low risk
1003 Ambulatory EEG waiting list	High	Low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 30.04.2021
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Sue Eve-Jones
Current position/Progress/Mitigation As at 30.04.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING (Target) Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31/03/2022
Discussed regularly at the Hospital Mortality Group Overall trend is downwards though the last SHIMI has gone up very slightly. Really encouraging is the mean depth of coding being achieved by the coding department and AH congratulated SEJ and her team on this improvement. The Trust began with a mean depth of around 3 to the latest figure which is 5.6 which is bang on national average. Trusts doing very well achieve a figure of 6.5/7. If this rise continues we could achieve a mean depth of coding of 6 which will be very beneficial. We do not have any un-coded activity up to the end of December 2020. May have an issue for next 2 months, as have to change working processes to aid the elective recovery. As at 30.04.2021 there were 70 deceased patients in January that were not coded. It was noted the potential of the upturn could be due to the COVID second wave.		Next review date:	31.07.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	High (16) Consequence: Major Likelihood: Likely Reviewed: 11.11.2020
979	Removal/reduction of education funding from HEE commencing April 21.	Previous Rating	Moderate (12)
Impact on Strategic Objectives		Lead Executive	Nicky Lucey covering
Strategic objective 1 : Outstanding Not having the appropriate workforce in place to deliver our patient needs **Strategic objective 4: Enabling** Failure to deliver flexible and appropriate service models**,** Loss of training status for junior doctors **Strategic objective 5:** Sustainable **How this risk has been scored:** **Consequence: Moderate** **Patient safety** – event that impacts on a small number of patients, increase length of stay by 4-16 days **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Likelihood:** Certain		Local Manager	Elaine Hartley
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date	Awaiting confirmation of actual impact 30.06.2021
This is currently being reviewed by the Dorset ICS with a plan to coordinate requests that meet system priorities by accessing a small pot of funding called Workforce Development funding. This however will be significantly less than what we would previously receive.		Next review date	31.05.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 25.02.2021
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 5: **Sustainable :** Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** Discussion at SMT 15.01.2020 Electrical work is now underway Data is back and work will commence on this before financial year end Tender will be out shortly for new installation work - this will fall in to the new financial year. **UPDATED PROGRESS:** Electrical installation 30% complete. Data out to tender. To be complete by 31MAR21. New system install specification nearing completion. Roll out anticipated end Q1 FY20/21 **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Andy Morris
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING (TARGET) Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31/03/2022
Completion of power installation adjusted to end of FEB 2021. Project delayed to FY21/22 Tender with procurement and almost ready for release to procure the replacement system which is currently planned to commence early new financial year, powers supply enabling works now nearing completion Scope complete. Now with Procurement for tender**.**		Next review date	31.07.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:30.04.2021
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective 1: Outstanding : Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit -** non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity -** National media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2022
Data is reviewed at the HMG with Dr Foster report information and analytics. This is discussed and minuted at this group, with actions being detailed and listed with in the HMG meeting and followed up to ensure action is taken. Anomalies and conditions that are flagging in the data are discussed and reviewed. The SHIMI tables can be put in league table format. However there are only 3 groups for SHIMI, you are either above, below or within the expected range. If within expected range statically there is no difference between Trusts. We are currently rated 15 out of 160 Trusts and hope, with continued investment in the coding department to see improvements in this data. AH will address this at the next Board meeting.		Next review date	31.05.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (Following review)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 29.09.2020
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible**		Local Manager	Samantha Hartley
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING	Moderate (12) Consequence: Major Likelihood: Possible
Mitigation: Liaison Service on site. ED service activity is starting to rise again. Increase in activity is being managed with IMT ED area increase during pandemic to assist with flow and capacity. Building works commenced to enlarge ED 2021 ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national		Next review date	30.09.2021 (annual review)

average.		
OTHER RISK REGISTERS LINKED TO RISK 450	**Current rating following local review**	**Target rating following completion of all actions**
1060 ED Footprint not fit for purpose 1061 Workforce requirements for new ED 709 – Failure to achieve constitutional standards.	Low risk Moderate risk	Very Low risk Very Low risk

Emerging Divisional Risks

Appendix 3

Movement on Risk Register: 	Risk Statement Lack of suitable room availability for Pre-Assessment Unit in Outpatients **Date added to Risk Register 15.12.2020**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 20.04.2021
461	Inadequate rooms available in outpatients- Pre assessment team displaced to medical out-patients. From 5 rooms to 2 rooms. Two risks in as many weeks around lack of rooms in Outpatients for Pre-Assessment to carry out clinical tests i.e., ECG, swabbing and blood tests. 20.4.2021 - Incident that 3 specialist nurses available for Face to face clinics but only one room available, Triage continued however, due to extreme increase in demand unable to fulfil face to face safe consultations for patients which potential cause delay of treatment.	Previous Rating	High
Current position/Progress/Mitigation As at 20.04.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely Due date: 30.06.2021
Space is being reviewed across the Trust. Incidents are currently being investigated, each case will be reviewed to ascertain whether any patient has come to harm as a result of the lack of space. Update will be provided when incidents have been fully investigated.		Next review date	31.05.2021

Movement on Risk Register: 	Risk Statement External Multiagency delays resulting in delayed discharge of complex paediatric patients **It was added to the service risk register 24.12.2019 reviewed 11.05.2020, 07.10.2020 and escalated to the Divisional Risk Register 22.12.2020**	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 25.02.2021
866	Increasing amount of children and young people are requiring the local authority to provide accommodation on discharge from Kingfisher Ward. These children often have emotional or mental health issues but do not require mental health inpatient admission but require a safe, nurturing environment away from the family home for their own safety and/or the safety of family/siblings. There are often delays in processes and locating appropriate placements resulting in prolonged hospital admission in an inappropriate environment. Additionally the Trust have seen a significant increase in patients admitted with Eating Disorders, requiring specialist input and / or inpatient bed. This has been highlighted both locally and nationally.	Previous Rating	Low Risk
Current position/Progress/Mitigation As at 06.05.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING	Low (6) Consequence: Minor Likelihood: Possible
Mitigation: • Weekly escalation though Division B updating with progress of patients. • Weekly reporting of incidents involving these patients to Dorset Healthcare to the Head of Mental Health Services • Formal escalations are happening when required between multiple agencies involved with patients. • Children all discussed at Weekly ILM meetings. • 1:1 support for patients being sought when appropriate for safety. Risk reports entered locally to evidence delays. • Training provided by DHCFT to support staff in restraint techniques • DHCFT providing staff (either from their own bank or agency) to support the staff on Kingfisher • Legal support and advice requested and provided in complex cases to try and assist with the correct placement being found for the children • Continued working with the Local Authority and DHCFT to find appropriate placement for the children. • Possibility of a safe room within the unit being explored.		Next review date	31.05.2021

Movement on Risk Register:	Risk Statement No Transition Service at DCH **Date added to Risk Register 09.02.2021**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 30.03.2021
1037	DCH has no transition service to safely and effectively transfer children to adult services from 14 years upwards. This is a national requirement highlighted by the CQC, RCPCH amongst other. Full business case submitted. There is no nursing input into transitioning children and young people into adult services. The CCN team are able to identify those children in their service who are transitionable, however not all children who require transition are managed by the CCN team, so the other children would be identified by their Paediatrician. The Paediatricians try to arrange formal handover of patient to Adult clinicians to make the process as smooth as possible and in some cases there are join clinics run in the process, but this does not happen for all. Without adequate staffing, fully functioning transition service for children and young people the mitigations that can be put into place to ensure that this process is as smooth and safe as possible is limited.	Previous Rating	Extreme
Current position/Progress/Mitigation As at 30.03.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely
Mitigation: • Request for Band 7 1.0wte Transition Nurse Specialist has been put forward in 2021/22 business planning. Business case completed and submitted. • Some confusion noted over Transition Nurse Specialist Role and Diabetes Transition Service. These are two completely separate eservices and cannot be combined. • The Transition Nurse Specialist would work to develop a successfully functioning transition service to transition children and young people into adult services. • Transition processes should begin from 14 yrs. old, with the intention that once successfully transitioned over, the Transition Nurse requires no further involved as this is not a young person's service (16-25yrs), but a transitioning service. This post would involve the recruitment of a Paediatric Nurse into this role. • The Matron has begun scoping out existing transition services in other NHS trusts to ascertain how the services were set up, staffing levels and patient populations, models and policies.		Next review date	30.05.2021

Movement on Risk Register: 	Risk Statement PACS Storage **Date added to Risk Register 22.04.2021**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 22.04.2021
1084	The issue is that the new CT scanner takes a more in depth picture that is therefore larger and takes up more storage. Unfortunately the increased storage requirements weren't factored in at the time, but there has been a change in the consumption forecast.	Previous Rating	New to register
Current position/Progress/Mitigation As at 06.05.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely
Mitigation: • ICT produce the summary report to Radiology monthly to evidence consumption • the monthly reports are working well to enable a reasonably accurate forecast on consumption • The mitigation would be to purchase additional storage, we do not believe this is a capital pressure until next financial year (2022/23)		Next review date	31.05.2021

Movement on Risk Register: NEW	Risk Statement Lack of staff accommodation **Date added to Risk Register**	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 11.05.2021
1094	Staff accommodation is very tight and we are likely to not have enough by July this year.	Previous Rating	New to register
Current position/Progress/Mitigation As at 06.05.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING	Very Low Risk Consequence: Minor Likelihood: Unlikey
• Use of B&B's, Hotels and Caravan parks is not an option, as all have advised they are fully booked from June/July 2021, due to a demand in staycations! • Some potential properties have been identified to purchase, however, funding is required to initiate, and the buying and legal elements of the process will not likely complete in time for the shortfall in rooms required. • Discussions with Housing Associations have not been as fruitful as anticipated, although we are still exploring one line of enquiry. • Some success has been achieved in acquiring additional leases, which seems to be the most favorable option, especially as they are mainly cost neutral, with exception to upfront costs of set up and furnishing. We have started to seek new leases directly with potential landlords, by; advertising via the Trusts social media sites and local press. Along the lines of; the Trust is looking to increase its current private lease arrangements to provide additional accommodation for its Clinical/Medical staff and is interested in hearing from landlords who wish to lease their properties the Trust. • Early discussions have taken place with Dorset County Council who has identified a number of their property portfolio for disposal and redevelopment. These are being pursued further that may provide some accommodation opportunities in the longer term, but not in time for our pinch points. • In conclusion the housing market in Dorchester is always buoyant, with more demand than properties available that in turn affects value and availability. This makes it difficult for the trust in the short term to use this route to meet its accommodation shortfall within the timescale to accommodate the additional International Nurses. • The Trust has made provision within its Masterplan to build key worker affordable accommodation, although this is mid to long-term. • Unfortunately, as a result of the Governments Covid Safe measures and current lockdown that is being lifted in phases, it impacts on availability of B&B's, Hotels and Caravan Parks. In addition foreign travel is limited, including holiday destinations, thus there is an increase in people booking holidays locally, therefore, a very limited back-up option if at all.		Next review date	30.06.2021

Meeting Title:	Board of Directors Part One
Date of Meeting:	26 May 2021
Document Title:	**Board Assurance Framework**
Responsible Director:	Nick Johnson – Deputy CEO
Author:	Paul Lewis – Head of Transformation & Improvement

Confidentiality:	*Not Confidential*
FOI Publishable?	*Yes/~~No~~*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Executive Management Team		
Risk and Audit Committee	18 May 2021	Recommended to Board

Purpose of the Paper								
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

Summary of Key Issues

Summary

The Board needs to understand the Trust's strategic objectives and the principle risks that may threaten the achievement of these objectives. The Board Assurance Framework (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has assurance about the effectiveness of these controls.

The principle risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix. The summary position of the BAF continues to highlight the Outstanding Services and Sustainable strategic objectives as the two which are most at risk of delivery. All Executives were asked to review and provide updates where appropriate to the relevant BAF items.

The BAF will be redesigned once the refreshed Trust strategy has been approved and developed, reflecting the new strategic objectives, risks, controls and assurances.

The following section outlines the substantial changes made to the BAF since the last period:

- Summary. There is a high risk in ensuring we are SUSTAINABLE. The Trust has submitted a plan for the first six months of 21/22 which predicts a breakeven but this is more consequential of the financial regime rather than the underlying income base. The Trust is likely to return to a reported deficit in the second half of the year if the regime returns to something similar to that in operation prior to the pandemic. The strength of control and assurance however remains the same.
- Objective 1 - Outstanding: Delivering outstanding services everyday.
  - Risk 5 Not having the appropriate workforce in place to deliver our patient needs.
    Control - Workforce supply and retention is at the heart of the NHS

	People Plan and this will be mirrored in the refreshed People Strategy (presently being drafted). The Trust will also be moving to a Workforce Business Partner model with a focus on workforce planning and redesign. This will ensure that each division has a workforce model linked to the clinical model. The Trust is working with the Dorset system on both national and international recruitment streams. Vacancy and turnover rates are reviewed monthly at People and Culture Committee and will also become a focus at monthly divisional performance management meetings. (R5)
	
	• Objective 3 – Collaborative
	  • Risk 4. Workforce planning consequences across the system are not fully considered which de-stabilises individual organisation's workforce. Control - Investment in DCH workforce planning team has occurred. DWAB resourced Dorset wide workforce planning capacity has also been implemented to co-ordinate system work. The implementation of the Workforce Business Partner model will help us to better assess our own workforce needs and ensure we are appropriately represented externally, assisting the coordinated Dorset approach. (R4)
	
	• Objective 4 Enabling, empowering staff.
	  • Risk 1. Not achieving a staff engagement score in the top 20% nationally. Control - People are at the heart of the NHS People Plan and the refreshed DCH People Strategy will reflect this. The Trust undertook a three-step cultural review (Discover, Diagnose, Design) to better understand and engage the whole workforce. A Head of OD was appointed and commenced in October 2020. Health and Wellbeing champions are active within all divisions to ensure local action plans developed and discussed. A suite of staff networks have been launched. The results from the 2020 staff survey are showing important improvements. The updated EDI strategy and refreshed People Strategy will have the outputs from the cultural review as the foundation. (R1)

Action recommended	The Board is requested to: • review the Board Assurance Framework; and • note the high-risk areas

Governance and Compliance Obligations

Legal / Regulatory	Y/~~N~~	
Financial	Y/~~N~~	The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.
Impacts Strategic Objectives?	Y/~~N~~	The Board Assurance Framework outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.
Risk?	Y/~~N~~	The Board Assurance Framework highlights that risks have been identified and captured. The Document provides an outline of the work being undertaken to manage and mitigate each risk. Where there are governance implications to risks on the Board Assurance Framework these will be considered as part of the mitigating actions.
Decision to be	~~Y~~/N	

made?		
Impacts CQC Standards?	Y/~~N~~	It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Impacts Social Value ambitions?	~~Y~~/N	
Equality Impact Assessment?	~~Y~~/N	
Quality Impact Assessment?	~~Y~~/N	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: MAY 2021

Summary Narrative

The most significant risk which could prevent us from achieving our strategic objectives is not being **OUTSTANDING**

We may not have the appropriate workforce in place to deliver our patient needs. We continue to experience increasing dependency on the use of temporary clinical staff and the failure to maintain spend within the regulator ceiling for agency staff. The current COVID-19 Pandemic is putting severe strain on the Trust in the short term which may have consequences for the longer term achievement of the Strategic Objectives. However, it is too early to determine this.

There is also a high risk in ensuring we are SUSTAINABLE. The Trust has submitted a plan for the first six months of 21/22 which predicts a breakeven but this is more consequential of the financial regime rather than the underlying income base. The Trust is likely to return to a reported deficit in the second half of the year if the regime returns to something similar to that in operation prior to the pandemic. The strength of control and assurance however remains the same.

There is a moderate risk in the strength of controls on ensuring we have **INTEGRATED** and joined up services. ED activity is high and demand for secondary care services continues to out strip supply. Stranded patient numbers are increasing and the pace of integrated demand management with primary and community services is not progressing at the required pace.

Objective	Range of Risk Scores	Strength of Controls	Strength of assurance
1. Outstanding: Delivering outstanding services every day. We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	**6-20**	**A**	**G**
2. Integrated: Joining up our Services. We will drive forward more joined up patient pathways, particularly working more closely with and supporting GP's.	**2-20**	**A**	**G**
3. Collaborative: Working with our patients and partners. We will work with all of our partners across Dorset to co-design and deliver efficient and sustainable patient-centred, outcome focussed services.	**6-9**	**A**	**G**
4. Enabling: Empowering Staff. We will engage with our staff to ensure our workforce is empowered and fit for the future.	**4-9**	**G**	**A**
5. Sustainable: Productive, effective and efficient. We will ensure we are productive, effective and efficient in all that we do to achieve long term financial sustainability.	**2-16**	**A**	**R**

0 - 4	Very low risk
5 - 9	Low risk
10 - 14	Moderate risk
15 - 19	High risk
20 - 25	Extreme risk

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
1	**Outstanding: Delivering outstanding services everyday.** We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	Strength of controls		A
		Strength of assurance		G

A) Principle RISKS						
REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not achieving an outstanding rating from the Care Quality Commission within next two years (2021)	NL	3	**4**	**12**	6
R2	Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality can lead to reduced confidence in the organisation from the public and other bodies.	NL	3	4	**12**	6
R3	Not achieving national and constitutional performance and access standards	IR	4	4	**16**	12
R4	Not having effective Emergency Preparedness, Resilience and business continuity plans	IR	3	2	**6**	6
R5	Not having the appropriate workforce in place to deliver our patient needs	DH	4	5	**20**	12
R6	Failing to improve the Trust SHMI index	AH	4	3	**12**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits). ICS quality surveillance Group monitors and scrutinises safety and quality with the system and the regulator. (R1)	G	data, CQC quarterly meetings. Dorset Quality Surveillance meeting in place that reviews hard and soft intelligence remain in 'Routine Surveillance' with acknowledgement to planned waiting list RTT risk. Positive feedback following CQC Transitioning Monitoring Approach reviews of Outpatients and Maternity services 2021.	G
C2	Performance monitoring and management of key priorities for improvement in quality and safe care (R2)	G	and KPIs via The Quality Committee; alongside safety visits (NEDs) that are restarting post Covid-19 governance changes; and back to floor time for Executive Directors to triangulate data with direct observations of care quality and safety. National NHSI /CCG and CQC reporting . Select number of KPIs not at standard being managed as Quality Improvement programmes (MUST/VTE) with investment required for Dementia team to address Dementia. QI on VTE has been successful and focus no on Electronic Discharge Summaries, led by CMO. Reductions seen in Patient experience relating to planned admission and cancelled operations - related to access constitutional standards - gap in assurance and reduced strength in delivery being monitoed through Recovery plan.	A
C3	Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement (R3)	G	Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee. Governance has returned to normal business with Divisional attendance at Quality Committee.	G
C4	Performance Framework - triggers for intervention/support (R3)	A	Performance monitoring via weekly PTL meetings and monthly Divisional Performance Meetings (through to Sub-Board and Board). Divisional Performance Framework presented at July 2019 Trust Board.	G
C5	Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE (R4)	G	Reporting from EPRR Committee to Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership.	G
C6	Workforce supply and retention is at the heart of the NHS People Plan and this will be mirrored in the refreshed People Strategy (presently being drafted). The Trust will also be moving to a Workforce Business Partner model with a focus on workforce planning and redesign. This will ensure that each division has a workforce model linked to the clinical model. The Trust is working with the Dorset system on both national and international recruitment streams. Vacancy and turnover rates are reviewed monthly at People and Culture Committee and will also become a focus at monthly divisional performance management meetings. (R5)	A	We review safe staffing through Board reports; junior doctor workforce issues through the GOSW reports; vacancy levels through the People and Culture Committee and Board workforce reports; develop strategic solutions through the Resourcing Operations Group.	A
C7	People Strategy published May 2018. Refreshed People Strategy presently being drafted. (R5)	G	Board sign off of 2018-2021 people Strategy in May 2018.	G
C6	Weekly review of medical workforce recruitment activity (R5 &6), Review of nursing vacancies and recruitment plans at the Resource Strategy Group.	A	Recruitment update report provided by recruitment team on a weekly basis. Workforce Planning capacity and capability has increased, through the introduction of the Workforce Planning Team. Plan to strengthen this further via the introduction of the Workforce Business Partner model. Dorset Workforce Action Board partner and joint working to mitigate and collectively tackle Dorset workforce issues.	A
C7	Scrutinising other care quality indicators to assure standards of care (R6)	A	Regular reports to Hospital Mortality group , Quality Committee and Board. The latest figure of 1.11 is the best it's been since Dec 2014	G
C8	Poor data capture drives patient coding which effects SHMI (R2)	A	Internal audit of sample of 1000 patient notes and national benchmarking undertaken by PWC	A
Overall Strength		A		G

D) We have actually received these POSITIVE ASSURANCES...		
	Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.	
CONTROL	ASSURANCE	EVIDENCE
C1	November 2018 CQC rating as 'Good', remain on Routine Surveillance at system and regulator level through Quality Surveillance Group (QSG). Quarterly review with Regulators review of KPIs (CQC; NHSI/E). New Tranisitional Moniroting Approach implementation by CQC with regulation.	CQC report. QSG notes. Other benchmark datasets via internal KPIs. National patient surveys
C2	National benchmarked datasets such as RCEM, ICNARC, HQIP, Surveys	Quality Committee and Divisional Reports
C3	CCG assurance visits and contract monitoring	CCG assurance reports
C4	Internal performance reports	Board and FPC reports
C2	External auditors - Quality Account (transparency and accuracy of reporting)	Board and QC reports
C5	Internal Audit of systems and processes; and CCG assurance of the EPRR standards	Audit Committee and Board
C1	External review of Divisional Governance Structures and the PWC Well Led Review	Quality Committee and Board
C6	Monthly workforce reports detailing vacancies and trajectories.	Strategic Resourcing Group, Workforce Committee
C8	NHSE/I regular scrutiny and support (R6)	Ongoing NHSI/E reviews

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
	E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.	
ISSUE 1		**ACTION**
C1	CQC inspection process being redefined as it progresses due to global COVID-19 pandemic, which may result in some services not being reviewed to enable an 'outstanding' rating within the time frame of the Trust strategy.	Work with the CQC during the year through quarterly meetings and monitoring (as per the new methodology) to actively promote reviews of services where possible. To undertake our own review in 2021 to outline where we have triangulated evidence against CQC regulatory standards as a overview of the Trust position, whilst pending any inspection.
ISSUE 2		**ACTION**
C2	Significant resource constraints to deal with increased demand for both Elective and Emergency services.	System wide working on changes to care models and capacity and demand analysis to identify areas for additional investment. Escalation via Elective Care Board, Urgent Emergency Care Board, OFRG and SLT. Revised Phase 3 recovery plan submitted to Region and CCG as part of the recovery from COVID-19
ISSUE 3		**ACTION**
	Uncertainty over no deal Brexit and associated impact on procurement, staffing and charging of overseas patients.	Receiving regular briefings from regional team, participation in national data submissions, task and finish group reporting to Audit Committee.
C3	COVID-19 new virus that requires responsiveness to new guidance and ERPP planning	COVID-19 Incident Management Team in place with a steering group overseeing all actions and planning. Responsiveness to changes in national guidance daily with assurance reports on actions in place.
ISSUE 4		**ACTION**
C4	Inconsistent application of the Performance framework within the Divisions leading to failure to pick up early warnings of deteriorating performance	
ISSUE 5		**ACTION**
C5	Late visibility in junior doctor gaps from Deanery rotations	Regular communications with the Deanery, and profiling of historic gaps. "At risk" recruitment in anticipation of gaps.

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
2	**Integrated: Joining up our services.** We will drive forward more joined up patient pathways particularly working more closely with and supporting GPs.			
		Strength of controls		A
		Strength of assurance		G

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Emergency Department admissions continuing to increase per 100,000 population	IR	4	5	**20**	9
R2	Occupied hospital beds days continue to increase per 100,000 population	IR	3	4	**12**	9
R3	Having stranded patients	IR	3	4	**12**	9
R4	Not achieving an integrated community health care hub based on the DCH site	IR	4	4	**16**	6
R5	Not achieving a minimum of 35% of our outpatient activity being delivered away from the DCH site	IR	2	1	**2**	6

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Reframed Urgent and Emergency care Boards and ICPCS Boards objectives linked to the Boards delivery plan. CEO is now the system SRO care and health inequalities. (R1,2,&3)	A	Upward reporting and escalation from UECB to SLT and DCH Board.	A
C2	Performance Framework reporting - triggers for intervention/support (R1,2&3)	G	Ward to Board reporting	G
C3	Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management (R3)	A	Patient flow project as part of operational efficiency strand of Transformation strategy.	G
C4	Proactively working in partnership with Integrated Community and Primary care Portfolio, West integrated Health and Care partnership, and Primary care networks. (R4)	G	Transformation (SMT) Reporting and Strategic updates to Board and ICPCS portfolio Board to SLT.	G
C5	Outpatient Improvements (within Elective Care Board Programme) (R5)	A	Reports to SMT and through to Board via Strategy updates	G
Overall Strength		A		G

D) We have actually received these POSITIVE ASSURANCES...

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	Continuous high performance against national Emergency access standard (R1)	Performance reporting
C2	Primary Care engagement with Locality Projects - Cardiology, Dermatology, Ophthalmology, Diabetes and Paediatrics (R1).	SMT (Transformation) reporting and updates to Board
C3	Full community and primary care engagement (R2&3)	SMT (Transformation) reporting and updates to Board
C4	Dorset designated as a wave one ICS (R1-5)	ICS Memorandum of Understanding and shared collaborative agreement

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		ACTION
C3	Delayed Discharges - above national ambition (R3)	Implementation of national template for weekly reporting of delayed PTL. Executive challenge panel established July 2019
ISSUE 2		**ACTION**
C1	Emergency Department capacity (R1)	Business case development for investment in progress.
ISSUE 3		**ACTION**

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
3	**Collaborative:** We will work with all our partners across Dorset to co-design and deliver efficient and sustainable patient centred outcome focussed services.	Strength of controls		A
		Strength of assurance		G

A) Principle RISKS						
REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Failing to deliver services which have been co-designed with patients and partners	NL	3	3	**9**	6
R2	Not being at the centre of an integrated care system, commissioned to achieve the best outcomes for our patients and communities	PM	3	3	**9**	6
R3	Failure to play an integral role to MDT working leading to unsustainable services and poor outcomes	AH	3	2	**6**	6
R4	Workforce planning consequences across the system are not fully considered which de-stabilises individual organisation's workforce	DH	3	2	**6**	4
R5	Not achieving a Dorset wide integrated electronic shared care record	SS	**2**	**3**	**6**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	Patient and Public engagement as part of transformation framework, with Trust Transformation lead and team trained in service improvement; plus Patient Experience lead in place; Communications team link with CCG for public consultations and engagement events where relevant (R1)	A	Senior Management Team (SMT), Executive Management Team (EMT), Patient Experience Group (PEG) - via CCG , Health Oversight and Scrutiny Committee, Healthwatch, special interest groups, Patient Voices group.	A
C2	CEO Leadership role in SPB, SRO for UECB and broader membership of SLT meetings including leading on the Dorset Clinical Networks and LMS (R2) The SW region has just prioritised the expansion of ED as their top priority. CEO is the SRO for the Dorset maternity transformation programme which is a national priority in the LTP. CEO Poole/RBCH and DCH have agreed that when appointments are reviewed for clinical leads at a specialty level to lead the transformation work, there needs to be balance between the East and West.	A	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	A
C3	All improvement programmes (Elective Care Recovery and Sustainability Programme) (R2)	G	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	G
C4	Divisions supported by the Transformation Team (DCH) integral part of Locality and service redesign meetings (R3)	G	SMT Meeting updates and escalation to Execs and Board where applicable	G
C5	Investment in DCH workforce planning team has occurred. DWAB resourced Dorset wide workforce planning capacity has also been implemented to co-ordinate system work. The implementation of the Workforce Business Partner model will help us to better assess our own workforce needs and ensure we are appropriately represented externally, assisting the coordinated Dorset approach. (R4).	G	Regular reports considered at DWAB and escalated to People and Culture Committee	G
C6	Dorset Care Record project lead is the Director of Informatics at Royal Bournemouth Hospital. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director. (R5)	G	Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	A
Overall Strength		A		G

D) We have actually received these POSITIVE ASSURANCES...		
Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.		
REF	ASSURANCE	EVIDENCE
C1	Learning Disabilities engagement system wide (R1)	Safeguarding Adults work plan
C2	CSR collaboration of engagement with CCG (R2)	CSR outcome publication
C3	Leadership of Project 3 (Elective Care) and Project 4 (Urgent and Emergency Care) (R2)	Minutes, exception reports
C4	Primary Care collaboration in locality projects and DHC/Primary Care collaboration in frailty pathway. (R3)	Mid-Dorset Hub/ICS Minutes

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.		
ISSUE 1		ACTION
C1	Public engagement in all elements of developments is not embedded and requires strengthening strategies to deliver this	Communication Team, Head of PALS/Complaints and Transformation team to build and embed processes to deliver patient and public engagement
ISSUE 2		ACTION
C2	No independent assurance on controls in place for the Dorset Care Record (R5)	Progress reported through the Dorset Informatics Group. DCH input is progressing well but other partners are behind their milestones.
ISSUE 3		ACTION

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
4	**Enabling. Empowering Staff.** We will engage with our staff to ensure our workforce is empowered and fit for the future	Strength of controls		G
		Strength of assurance		A

A) Principle RISKS						
REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not achieving a staff engagement score in the top 20% nationally	DH	2	4	**8**	6
R2	Not benefitting from the successful delivery of our People Strategy	DH	4	2	**8**	6
R3	Failure to deliver flexible and appropriate support service models	Exec team	3	3	**9**	9
R4	Not being an exemplar site for clinical research and innovation	AH	2	2	**4**	9
R5	Loss of training status for junior doctors	DH	4	1	**4**	4
R6	Lack of medical leadership in senior management positions	AH	3	3	**9**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	People are at the heart of the NHS People Plan and the refreshed DCH People Strategy will reflect this. The Trust undertook a three-step cultural review (Discover, Diagnose, Design) to better understand and engage the whole workforce. An appointment to Head of OD was made in order to lead on this work (JB commenced in Post in October 2020). Diversity and Inclusion/ Wellbeing Manager appointed to provide a dedicated resource to this agenda (BP commenced in post October 2019) . Health and Wellbeing champions are active within all divisions to ensure local action plans developed and discussed. A suite of staff networks have been launched. The results from the 2020 staff survey are showing important improvements. The updated EDI strategy and refreshed People Strategy will have the outputs from the cultural review as the foundation. (R1)	A	Staff survey results reported to the People and Culture Committee and Board. The Equality, Diversity and Inclusion Board Committee and Health and Wellbeing Steering Group also reviews results and actions. Overall oversight is provided by the People and Culture Committee.	A
C2	People Strategy approved at May 2018 Trust Board. The refreshed People Strategy is currently being drafted and will be socialised with staff at all levels to gain feedback and commitment before being finalised. (R2)	G	Workforce committee originally established to consider and report progress against People Strategy. Workforce Committee was extended to become the People and Culture Committee in January 2021.	G
C3	Better Value Better Care Group provides model hospital overview. Proposal to establish SLAs and performance measures for support services. (R3)	A	Proposal to establish SLAs and performance measures for support services	A
C5	Strong clinical research and innovation programme (R4)	G	Reports to the Quality Committee	G
C6	Medical training activity and issues reviewed by the Director of Medical Education at the Medical Education Committee. Escalation through to the Resourcing Operations Group, and People and Culture Committee as necessary. (R5)	G	Medical Education update provided at People and Culture Committee. GMC junior doctor survey presented to board annually.	G
C7	Ensure a clinical leadership program is in place and appropriate delegates attending. (R6)	G	Both the Divisional Directors have very competent deputies and all other leadership posts are filled. Recent recruitment has produced at least 2 other consultants who could step up if required.	G
Overall Strength		G		A

D) We have actually received these POSITIVE ASSURANCES...		
Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.		
CONTROL	ASSURANCE	EVIDENCE
C1	Appointment now in place. Staff survey promoted appropriately and launch of staff recognition scheme (R1).	Confirmation of appointment
C2	Assurance provided through Board agreement of the refreshed People Strategy. Progress updates to be provided regularly to the Workforce Committee (R2).	Trust Board approved People Strategy in May 2018. Updates to be reported to Workforce Committee on a regular basis.
C3	Wide ranging risk. Model hospital and corporate benchmarking information will assist with assurance (R3).	Benchmarking information
C5	Recognition via nominations and awards within Research networks (R4)	Wessex CRN awards 2019

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.		
ISSUE 1		**ACTION**
C1	Poor responses to the quarterly Staff Family and Friends test do not provide assurance of staff engagement (R1).	Focus on annual staff survey action plans. Review current people strategy.
ISSUE 2		**ACTION**
C2	Medical engagement continues to be hard to gauge. Recently formed Medical Engagement Forum too early to assess impact (R2).	Review effective of Medical Engagement Forum in 6 months. Consider engagement as part of the communication strategy review.
ISSUE 3		**ACTION**
C3	No clear metrics to determine appropriateness of support services, meaning assurance is limited (R3).	n/a
ISSUE 4		**ACTION**
C6	Gap in workforce reporting to highlight medical leadership vacancies (R6)	Include clinical leadership as part of talent management review

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
5	**Sustainable: Productive, effective and efficient.** We will ensure we are productive, effective and efficient in all that we do to achieve long-term financial sustainability			
		Strength of controls		A
		Strength of assurance		R

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not returning to financial sustainability, with an operating surplus of 1% and self sufficient in terms of cash	PG	2	5	10	12
R2	Failing to be efficient as outlined in the Model Hospital	PG	1	2	2	9
R3	Not generating 25% more commercial income with an average gross profit of 20%	NJ	1	5	5	5
R4	Not using our estate efficiently and flexibly to deliver safe services	PG	4	3	12	12
R5	Failure to secure sufficient funding to ensure financial sustainability	PG	4	4	16	12

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	The Board approved a financial sustainability strategy in Sept 17. The Director of Finance and Resources is leading on the implementation of the strategy. The Transformation Team is supporting the delivering of key work streams in the strategy. (R1)	R	The Better Value Better Care Group oversee the implementation of the financial savings. The Senior Management Team receive regular updates on the Transformation Programme. Regular reports received by the Finance and Performance Committee and the Board.	R
C2	Model hospital metrics accessible to service areas. Regular reports and opportunities identified by the Better Value Better Care Group (R2)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	G
C4	Commercial Board reviews income against metrics, overseen by Better Value Better Care Group (R3)	G	Financial reporting mechanisms at commercial board and the Better Value Better Care Group	A
C3	Model hospital will provide information on the efficient use of our estate. (R4)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	A
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	A	The Authorising Engineers which the Trust appoint, are independent and ensure that safe systems of work and inspection regimes are in place and carried out in accordance with the legislative requirements	G
C6	Six facet survey undertaken in Q2 of 19/20 to identify backlog maintenance levels and investment requirements. (R4)	A	Capital Planning Group review the 6 facet survey and capital investment required. This is reported to the Senior Management Team, Finance and Performance Committee and Board of Directors for approval.	A
C7	The Trust is part of the Dorset Finance Collaborative Agreement to ensure that funds and control totals are amended across the system (R5)	A	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	G
Overall Strength		A		R

D) We have actually received these POSITIVE ASSURANCES...

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	Internal audit reports on financial controls. (R1) and (R2).	BDO audit reports
C2	Model hospital information provides the information on our level of efficiency. (R2)	Model Hospital
C3	Estates Benchmarking (ERIC) return confirms efficient use of estate with opportunities in waste management (R2)	Estates Benchmarking (Eric) Return

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		ACTION
C1	(R1) No formal report discussed at the Better Value Better Care Group on the financial sustainability strategy or reported up to the Senior Management Team and Finance and Performance Committee.	(R1) Regular reports to the Senior Management Team and Finance and Performance Committee to be provided on implementation of the Financial Sustainability Strategy.
ISSUE 2		**ACTION**
C5	(R4) No independent assurance on compliance with statutory estates legislation	(R4) This was considered within the 2019/20 Internal Audit plan but not prioritised.
ISSUE 3		**ACTION**
C1	(R1) There is a risk we do not have the resource to make all of the transformation change happen timely.	An internal audit of the transformation programme was undertaken and reported to the November 2018 Audit and Risk Committee

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 4	Very low risk
5 - 9	Low risk
10 -14	Moderate risk
15 – 19	High risk
20 - 25	Extreme risk

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

A frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur 1 in 3 years	Do not expect it to happen/recur but it is possible it may do so 1 every year	Might happen or recur occasionally 1 every six months	Will probably happen/recur but it is not a persisting issue 1 every month	Will undoubtedly happen/recur,possibly frequently 1 every few days

Identifying Risks

The key steps necessary to effective identify risks from across the organisation are:

a) Focus on a particular topic, service area or infrastructure
b) Gather information from different sources (eg complaints, claims, incidents, surveys, audits, focus groups)
c) Apply risk calculation tools
d) Document the identified risks
e) Regularly review the risk to ensure that the information is up to date

Scoring & Grading
A standardised approach to the scoring and grading risks provides consistency when comparing and prioritising issues.
To calculate the Risk Grading, a calculation of **Consequence (C)** x **Likelihood (L)** is made with the result mapped against a standard matrix.

Consequence score (C)
For each of the five main domains, consider the issues relevant to the risk identified and select the most appropriate severity scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. This provides five domain scores.

DOMAIN C1: SAFETY, QUALITY & WELFARE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage Short-term reduction in public confidence Elements of public expectation not being met	Local media coverage - long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) complaint Local resolution	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Inadequate/performance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

The average of the five domain scores is calculated to identify the overall consequence score

(C1 + C2 + C3 + C4 + C5) / 5 = C

Meeting Title:	Board of Directors
Date of Meeting:	26 May 2021
Document Title:	**Communications Activity Report – October 2020 to March 2021**
Responsible Director:	Nick Johnson, Deputy CEO/Director of Strategy, Transformation and Partnerships
Author:	Susie Palmer, Head of Communications

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
N/A		

Purpose of the Paper	This report gives an overview of communications activity for the Trust.							
	Note	*(✓)*	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	Included in the report is information about key campaigns, initiatives and events, and analytics for our social media channels and public website. There is also a summary of news releases issued and media coverage.							
Action recommended	The Trust Board is recommended to: 1. **NOTE** the report							

Governance and Compliance Obligations

Legal / Regulatory	Y/N	*No*
Financial	Y/N	*No*
Impacts Strategic Objectives?	Y/N	*No*
Risk?	Y/N	*No*
Decision to be made?	Y/N	*No*
Impacts CQC Standards?	Y/N	*No*
Impacts Social Value ambitions?	Y/N	*No*
Equality Impact Assessment?	Y/N	*No*
Quality Impact Assessment?	Y/N	*No*

Communications Activity Report

Quarters 3 and 4 (2020/21): October 2020 – March 2021

1. Introduction

This regular report gives an overview of communications activity for the Trust. It is not an exhaustive round-up of what the communications team has been involved with but covers key areas of our work and a summary of activity.

2. Key Campaigns, Initiatives and Events

Coronavirus Pandemic Response

The communications team continued to play a major role in the Trust's ongoing coronavirus response during this period. We continued to focus on ensuring staff, patients, visitors and the wider public have easy access to the latest information and guidance relating to hospital services as well as publishing 'good news' to celebrate successes and lift morale.

The team attends the Incident Management Team meeting and a host of regular meetings internally and externally to maintain an oversight on developments, offer advice and action comms related tasks.

Key regular staff publications are the Staff Bulletin, which was issued three times a week during this period, and the weekly CEO Brief. The Staff App has become an even more useful tool for sending out important news and alerts during the pandemic – we have now registered nearly 3,000 downloads of the app and content is refreshed on a daily basis.

The Trust's communications team has continued to work closely with system and regional comms colleagues to ensure public messaging is coordinated and consistent around key issues such as COVID vaccination, infection control measures and lockdown rules. The Trust has regularly fed into Dorset-wide campaigns with video content working well to strengthen key messages. Engagement continues to be high through the Trust's social media channels, enabling us to reach our audiences directly. Social media has also been hugely valuable in helping to lift staff morale, celebrating successes and positive news as well as the challenges we are facing.

Strong links have been built up with our local media outlets to support our public messaging, with our Chief Medical Officer continuing to give regular interviews to Radio Solent, Greatest Hits Radio (formerly Wessex FM) and the Dorset Echo to offer accurate updates and answer queries.

COVID-19 Vaccination Programme

There has been a huge amount of comms work involved in supporting the Dorset vaccination programme and the DCH COVID-19 Vaccination Centre.

The launch of the DCH Vaccination Centre received widespread local media coverage and a big ongoing focus has been getting regular, up-to-date, accurate information to DCH staff to encourage them to take up the offer of vaccination. Dedicated sections were created on the

intranet and Staff App and have been regularly reviewed and updated. Posters have also been created and regularly updated to encourage uptake. Social media has also been widely used to spread accurate and updated information to counter misinformation circulating online around vaccination.

COVID-19 Lateral Flow Testing
Another area of focus during this period was encouraging staff to take part in lateral flow testing and to report their results with an online reporting tool. The Staff App has been particularly well used for this, with many staff using the app to access information on how to do the tests and to link to the reporting tool which led to a surge in staff using the app to access other information.

Staff Flu Vaccination Campaign Success
The staff flu vaccination programme has been more challenging this year with the COVID restrictions in place and vaccine supplies arriving in several batches rather than all at once. There was widespread enthusiasm amongst staff for getting vaccinated and we were able to build on the success of last year's campaign and vaccinated 91% of all staff – a new record for DCH.

Site Development Comms and Engagement
The comms team have continued to support the strategic estates team with the comms and engagement requirements of the site development programme. Work starting on the multi-storey car park was celebrated with positive media coverage in January 2021. A newsletter for residents has been put together with the contractors and a community vote to choose the images for the artwork on the sides of the multi-storey car park attracted a lot of positive engagement, with over 1,000 local people voting for their favourite images. Scenes of Portland Bill, Durdle Door and Corfe Castle were the most popular images.

New Trust Website Launch – www.dchft.nhs.uk
Alongside the ongoing extra pressures on the communications team throughout the pandemic, we launched a new website for the Trust in February 2021.

This was a major piece of work to design, structure and populate an entirely new website and ensure the content was updated on the current website before being moved across. Staff and public users fed into the design to make sure the website suits their needs and offers the content they find most useful. Feedback following the launch has been very positive.

DCHFT Staff App
Working in partnership with the supplier we now have direct access to the content management system for our staff app which allows us to be much more responsive. We can now issue messages and alerts in real time ourselves whenever we need to so we have been making more use of this channel for urgent as well as routine staff updates and alerts.

We are actively encouraging staff to download the app and at the time of writing this report have registered nearly 3,000 downloads. We will be refreshing the content available through the app and adding more in response to the feedback we have gained from users to make it as useful to staff as possible. Download instructions are regularly included in the Staff Bulletin and are available on the intranet. We are working with the developers to further simplify the download process.

Recruitment
We continue to support recruitment, working closely with the Recruitment Manager to advertise 'hard to fill' posts. This has included being more creative with photo and video ideas, which have been well received. We are currently looking into a way of recording how many applications we receive because of social media posts. The next focus for supporting recruitment will be the 'relocation campaign' and the Kickstart Scheme.

Home First
The comms team have been working closely with colleagues across the hospital and the Dorset-wide system to provide consistent and key messages about the newly launched 'Home First' service which aims to help reduce the length of patient stays in local hospitals.

Other Design and Video Work
The comms team have been working with the Advanced Nurse Practitioner (Dementia/Frailty) to create a dementia booklet for staff. The booklet concentrates on the key priorities for dementia care and actions needed in the acute hospital setting. Posters were also distributed to staff rest rooms to highlight the five dementia statements.

Issue 22 of The DCH Way was published in December 2020. A main focus of the newsletter was thanking the community for their support during the coronavirus pandemic. The newsletter also focused on the 2020 Governor Election, as well as updates on Arts in Hospital and the DCH Charity.

3. Social Media

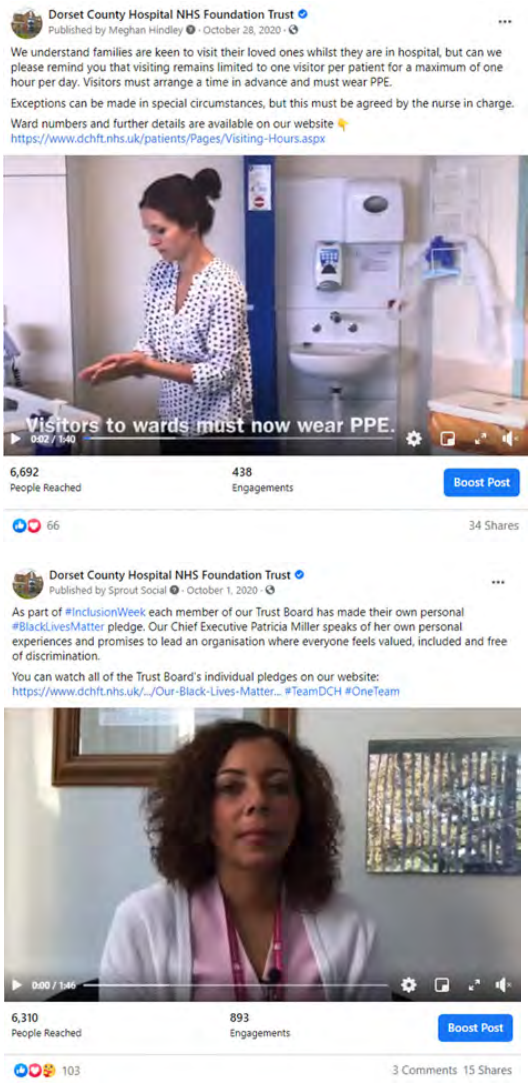
The statistics below demonstrate how many people we are reaching each quarter through each channel. Also included is a small selection of the most popular posts for each month.

Facebook Analytics – www.facebook.com/DCHFT

The organic reach of FB posts (how many people see your post without paid advertising) is cut after reaching 10,000 followers. This means the number of engaged users will dramatically decrease (as demonstrated in the table below). The comms team will therefore be exploring further options, such as paid for advertising and utilising other community pages, to further the success of the Trust's page and ensure key messages and updates are seen widely.

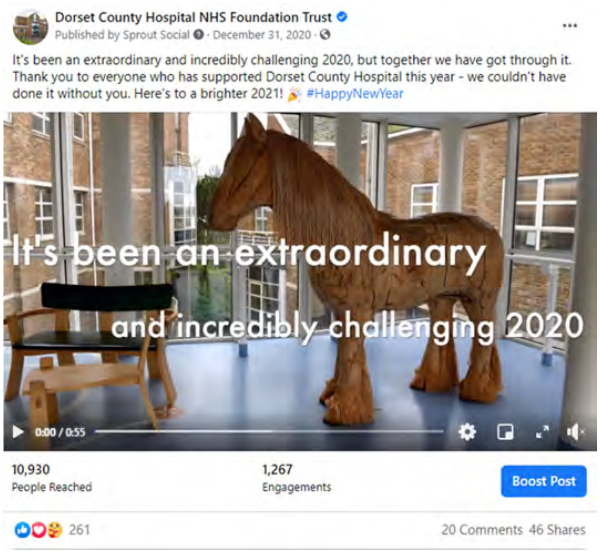
	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Engaged users	230,847	84,790	75,105	65,137
Number of posts	237	110	115	86
Number of followers	10,111	10,206	10,761	11,207

Facebook Highlights for October 2020



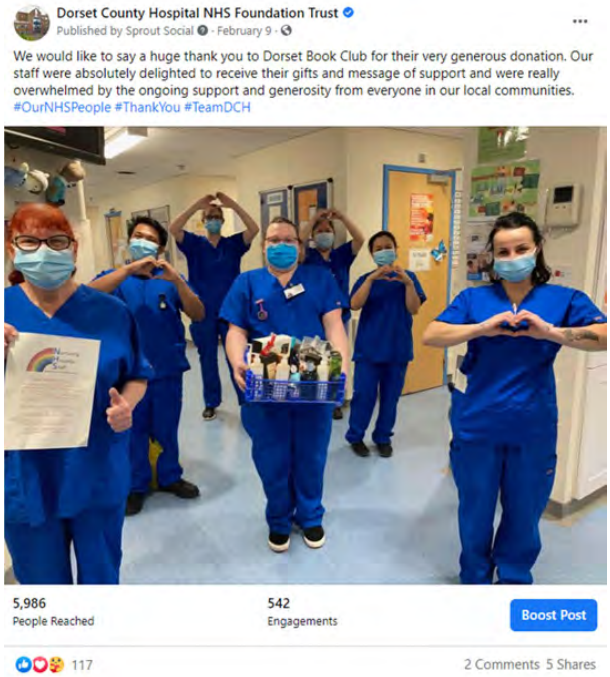
Facebook Highlights for November 2020

Facebook Highlights for December 2020

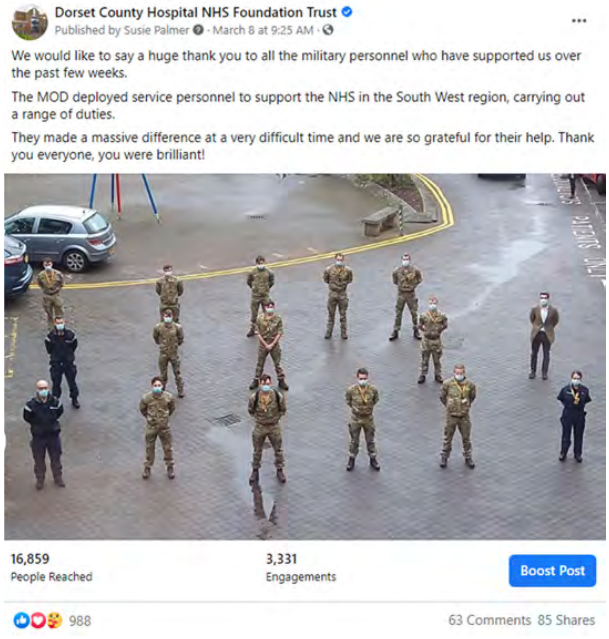


Facebook Highlights for January 2021

Facebook Highlights for February 2021



Facebook Highlights for March 2021



Twitter Analytics - @DCHFT www.twitter.com/DCHFT

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Tweets	320	166	211	121
Tweet impressions	699,000	253,900	421,200	427,200
Profile visits	10,167	4,612	8,679	12,761
Mentions	1,778	1,170	1,363	1,040
Number of followers	5,120	5,265	5,489	5,726

Twitter Highlights for October 2020

Top media Tweet earned 3,335 impressions

As part of #InclusionWeek each member of our Trust Board has made their own personal #BlackLivesMatter pledge. Our Chief Executive @P_MillerNHS promises to lead an organisation where everyone feels valued, included and free of discrimination. #TeamDCH #OneTeam
pic.twitter.com/R1xHAJfoJy

2 14 46

Top Tweet earned 4,549 impressions

We are so proud of our CEO @P_MillerNHS for her role in influencing positive change! 👏
twitter.com/HSJnews/status…

6 12 55

Twitter Highlights for November 2020

Top Tweet earned 84K impressions

We are delighted to be one of the first NHS Trusts to trial the use of reusable PPE gowns. Each reusable gown replaces the need for up to 75 disposable gowns and will significantly reduce the amount of single use products put into clinical waste each day. @NHSEngland pic.twitter.com/uk3MtMN6r5

35 107 830

Top mention earned 753 engagements

Nicky Lucey (She/Her)
@DCH_DoN · Nov 28

A call out for passionate experienced senior nurses - I have a secondment opportunity for my deputy @DCHFT. Interviews 7th Jan, so get in quick and be part of #TeamDCH - Go on - you know you want to! pic.twitter.com/X2SBs5whww

1 20 48

Top media Tweet earned 4,603 impressions

A massive thank you to Ali from @waitrose in #Dorchester for another generous donation of #Christmas-inspired goodies for our international nurses who will be joining shortly. #ThankYou #TeamDCH pic.twitter.com/a7Heecm8hZ

1 1 22

Twitter Highlights for December 2020

Top Tweet earned 33.3K impressions

A momentous day @DCHFT as we successfully held our first #COVID19Vaccine clinic as a hospital hub. A huge thank you to our incredible staff who have worked around the clock to safely roll out the vaccination programme. #TeamDCH #OurNHSPeople @NHSEngland @DorsetCCG pic.twitter.com/HbxZ9Bfzam

4 44 295

Top mention earned 2,352 engagements

A momentous day @DCHFT as we successfully held our first #COVID19Vaccine clinic as a hospital hub. A huge thank you to our incredible staff who have worked around the clock to safely roll out the vaccination programme. #TeamDCH #OurNHSPeople @NHSEngland @DorsetCCG pic.twitter.com/HbxZ9Bfzam

4 44 295

Top media Tweet earned 9,422 impressions

'It's the start of a hugely significant and exciting period in DCH's history.'

The New Year will see work begin on DCH's much anticipated multi-storey car park and will kick-start a major expansion of clinical facilities. Read more here 👇
dchft.nhs.uk/about/news/Doc…
pic.twitter.com/2NM4sAj4TY

2 10 42

Twitter Highlights for January 2021

Top Tweet earned 123K impressions

A huge thank you to everyone at #TeamDCH who has worked incredibly hard to book and run extra vaccination clinics this weekend to vaccinate hundreds more frontline #NHS staff as the national COVID-19 vaccination programme significantly ramps up. 👏 #OurNHSPeople #COVID19vaccine
pic.twitter.com/5MeSeJzLSc

12 30 320

Top mention earned 1,528 engagements

Gary Spracklen
@Nelkcarps · Jan 22

Rainbow is coming literally out of the NHS Key Workers at @DCHFT right now.

#ThankYouKeyWorkers #InspiredToLearn
pic.twitter.com/JVISetgpdQ

4 43 230

Top media Tweet earned 12K impressions

Our hospital is currently extremely busy. Please only attend our Emergency Department for serious or life-threatening situations. If you are unsure about where to go please call NHS 111 or visit 111.nhs.uk
pic.twitter.com/QII65H2Wd3

1 49 54

Twitter Highlights for February 2021

Top Tweet earned 9,281 impressions

We are delighted to have launched our new Trust website today! The new site has been developed in consultation with staff and public users to give people easy access to a wealth of useful information about the hospital and our services.

Visit the site at dchft.nhs.uk
pic.twitter.com/14xbIOxAgJ

3 8 43

Top mention earned 751 engagements

Megan Hughes
@mhughesphysio · Feb 26

Offically two weeks in my new role as a bank therapy assistant at Dorset county hospital! And im loving it!!!!
Working along side my physiotherapy degree is hard work but such an amazing oppotunity✨ @DCHFT
pic.twitter.com/PLnAhHb87j

1 2 53

Top media Tweet earned 6,534 impressions

Today we're celebrating International Day of Women and Girls in Science and we're proud to showcase some of the amazing staff working here at #TeamDCH.
#WomenInScience
pic.twitter.com/jZ8RJ41uLk

2 10 46

Twitter Highlights for March 2021

Top mention earned 483 engagements

Josh Naylor
@joshuajnaylor · Mar 9

This #hcsweek21 we @HCS_PooleNHS begin work w/ #SGRT from @VisionRTLtd @SGRTCommunity installed on all @VarianMedSys linacs @UHD_NHS & @DCHFT

Numerous benefits to patients: next steps are tattoo-less, quicker & safer treatments thanks to support from @RobertWhiteLF pic.twitter.com/GBdv9aWRDT

6 14 57

Top media Tweet earned 5,917 impressions

We would like to say a huge thank you to all the military personnel who have supported @DCHFT over the past few weeks. They made a massive difference at a very difficult time and we are so grateful for their help. Thank you everyone, you were brilliant! #OneTeam #TeamDCH pic.twitter.com/xtao9RidK3

2 23 146

Top Tweet earned 6,746 impressions

We are absolutely thrilled to see our Chief Executive @P_MillerNHS recognised in the @HSJnews top 50 chief executives 2021. Well done Patricia!👏👏👏

Read more below 👇
guides.hsj.co.uk/top-chief-exec...

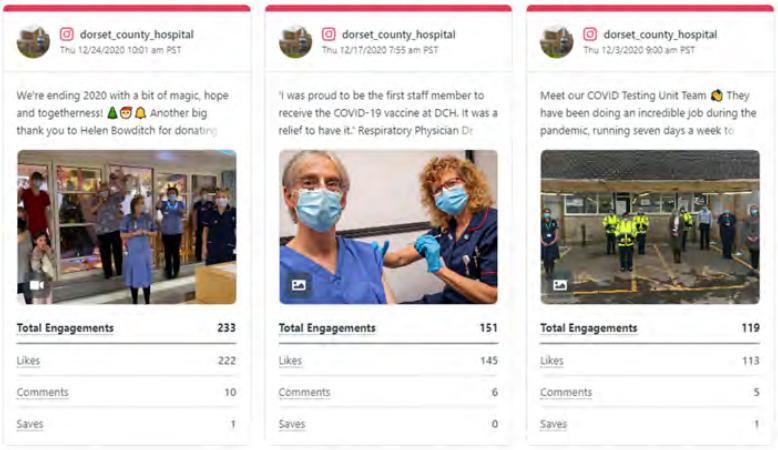
8 10 83

Instagram Analytics - www.instagram.com/dorset_county_hospital/

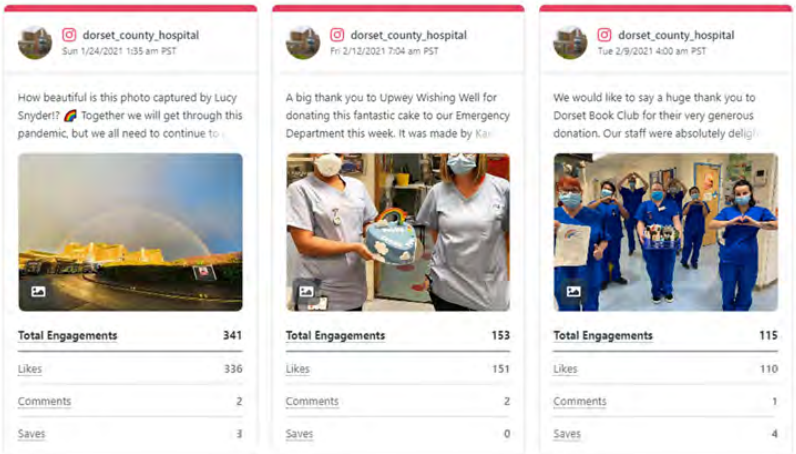
Instagram Impressions

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Total impressions	63,207	27,813	22,495	19,533
Average impressions per day	695	302	244	217
Average daily reach per profile	367	205	167	113
Number of followers	2,019	2,161	2,245	2,360

Instagram Highlights – October to December 2020



Instagram Highlights – January to March 2021



LinkedIn Analytics - www.linkedin.com/company/dorset-county-hospital-foundation-trust

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Total impressions	8,330	9,472	3,903	6,487
Total engagements	534	595	185	438
Organic followers gained	180	184	179	154
Number of followers	1,999	2,174	2,346	2,487

4. Public Website

The analytics below show general usage of the website and the most visited pages:

Website Analytics – www.dchft.nhs.uk

	Q1 2019/20	Q2 2019/20	Q3 2020/21	Q4 2020/21
Page Views*	174,937	172,206	212,744	219,518
Unique Page Views**	127,270	126,449	156,211	166,482
Users	42,287	42,549	54,408	54,732
Average Session Duration	00:00:57	00:00:57	00:01:01	00:00:59

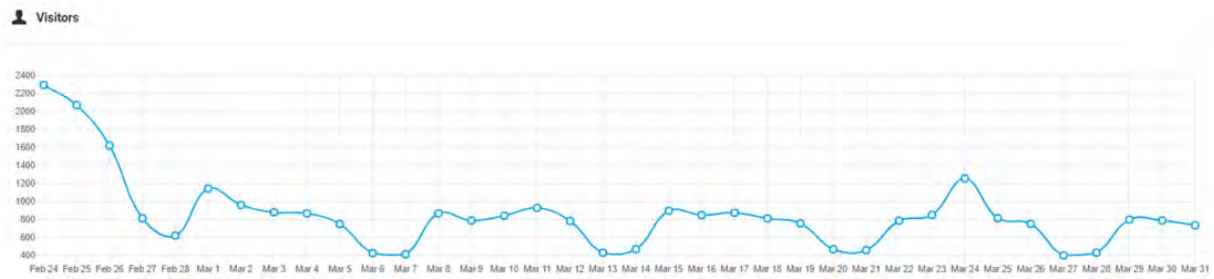
*In Google Analytics, a page view is a single viewing of a web page. This means that any time the page is loaded by the user's browser, the number of page views is incremented. If a user visits the same page multiple times within a single session, each viewing of the page will add to its page view count. Also, if the user refreshes the page in their browser, this counts as a new page view. For this reason, page views are sometimes seen as being of limited significance. For example, if the same user views the same page five times as part of a single session, this is different from five users viewing that page independently.

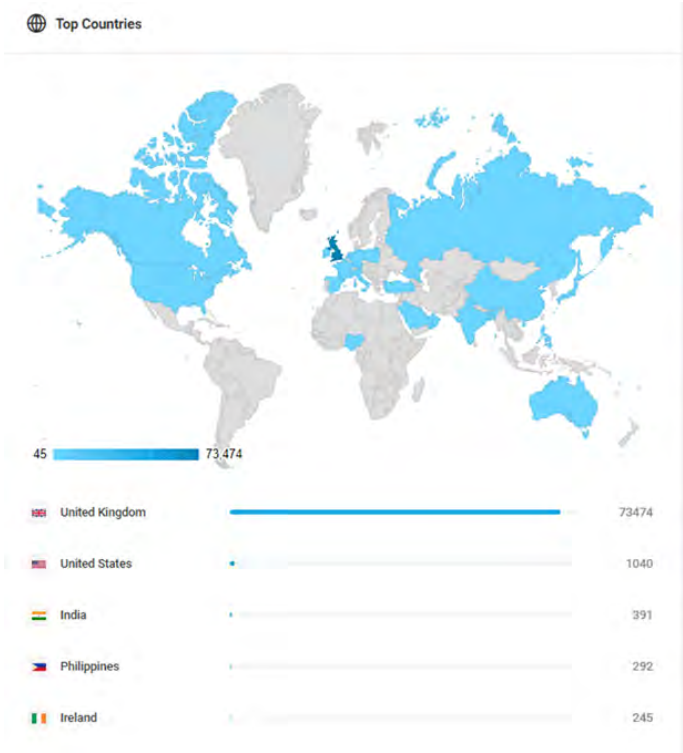
**Unique page views provide a useful alternative to basic page views. With unique page views, you eliminate the factor of multiple views of the same page within a single session. If a user views the same page more than once in a session, this will only count as a single unique page view. For this reason, unique views can be understood as user sessions per page, with each session potentially representing multiple views of the page but a minimum of one view per session.

Top 10 Most Popular Webpages (October 2020 to 23 Feb 2021)

Page	Page Views	Unique Page Views	Average Time on Page
Site Homepage	56,747	43,571	00:00:45
Coronavirus Information	12,451	9,912	00:01:32
Staff Homepage	12,267	8.409	00:00:38
Patients Homepage	10,799	7,609	00:00:25
Departments A-F Homepage	7,891	5,096	00:00:23
Getting Here	7,393	5,135	00:02:21
E-rostering Links	7,351	5,248	00:02:19
Departments P-Z Homepage	7,294	4,854	00:00:27
Visitors Homepage	6,890	4,742	00:00:22
Contact Us	6,650	5,532	00:01:42

Stats since launch of new public website (24 Feb 2021)
Total of 30,698 sessions from 24 Feb to 31 March





5. News Releases

A round-up of the news releases issued by the communications team with links to the full releases on our website. The reduction in releases proactively issued demonstrates how we are making better use of our own channels to reach our audiences directly:

Dorset County Hospital's Diagnostic Imaging Department granted QSI accreditation – 17 March 2021
Dorset County Hospital's Diagnostic Imaging Department has been received national recognition for the quality of its services.

NHS Staff Survey results published – 11 March 2021
Dorset County Hospital NHS Foundation Trust has pledged to do more to ensure it is a fully inclusive employer following the publication of the latest NHS National Staff Survey results.

Public invited to have their say on artwork for new hospital multi-storey car park – 8 February 2021
Local people are being invited to choose the images which will be used as artwork on the sides of Dorset County Hospital's new multi-storey car park.

Work set to begin on hospital's multi-storey car park – 21 December 2020
Work will begin on Dorset County Hospital's much anticipated multi-storey car park in January 2021 to kick-start a major expansion of clinical facilities.

Dorset County Hospital staff switch on Weymouth's Christmas lights – 2 December 2020
Weymouth Town Council celebrated the official switching on of the town's Christmas lights with a virtual event, and it featured special guests from Dorset County Hospital.

7. Media Coverage

Each of our news releases generated positive local media coverage. Further coverage was prompted by events, national statistical reports, announcements and public meetings. The charts below show the balance of positive, negative and neutral stories, and the table shows each quarter.

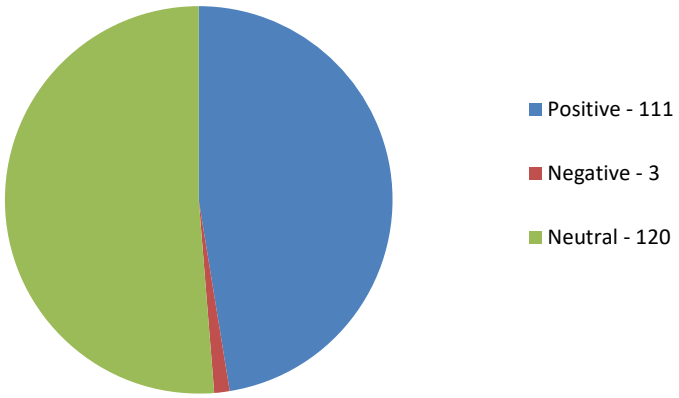
	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
Media stories	203	180	234	247
Positive	156	136	111	94
Negative	0	0	3	5
Neutral	47	44	120	148

October to December 2020 - Coverage to note included:

- Frink Dog sculpture loaned to German museum
- 'Unmasked' exhibition unveiled at Dorset County Hospital

- ICS thank you to volunteers
- Dorset County Hospital Charity launch Christmas Appeal
- Coronavirus: Dorset hospitals death total exceeds 200
- DCH confirmed as COVID vaccine hub
- £2.4million boost for hospital facilities
- Nearly £14m in damages paid out last year
- Coronavirus: More than 100 admissions in a week at Dorset hospitals
- Medical couple receive COVID vaccine on wedding anniversary

Media Coverage October to December - 234 Stories



January to March 2021 - Coverage to note included:

- Open Letter from the NHS in Dorset
- Coronavirus: Dorset hospitals experience spike in cases
- Hospital services in Dorset 'close to being overwhelmed'
- Cost of parking at Dorset County Hospital
- Waiting times at DCH increase as hospital responds to pandemic
- Dorset County Hospital grateful for the support of service personnel
- COVID: More than 200,000 vaccine jabs given in Dorset
- Negligence claim against Dorset County Hospital
- DCH chief calls for gradual easing of lockdown restrictions
- COVID patients at DCH in single figures
- CEO Patricia Miller recognised in HSJ's top 50 chief execs 2021
- Waiting list backlog at DCH

Media Coverage January to March - 247 Stories