Agenda

Board of Directors Meeting
08.30am – 12.30pm, Wednesday 25 September 2019
Seminar Room, Children's Centre, Dorset County Hospital

AGENDA
PART 1 (PUBLIC SESSION)

			Approx. timings	
1	**Patient Story** For discussion		**8.30**	
2	**Welcome and Apologies for Absence:**		**9.00**	Chair
3	**Declarations of Interest**			All
4	**Chairman's Remarks**	Oral	**9.05**	Chair
5	**Minutes of Board of Directors Part One 31 July 2019** To approve	Enclosure	**9.10**	Chair
6	**Matters Arising from those Minutes and Actions List** To receive	Enclosure	**9.15**	Chair
	QUALITY AND PERFORMANCE ITEMS			
7	**Chief Executive's Report** To receive	Enclosure	**9.20**	Patricia Miller
	BREAK		**9.45**	
8	**Integrated Performance Report** To receive and agree any necessary action **a. Workforce** **b. Quality** **c. Performance** **d. Finance** **e. ICS Update**	Enclosure	**10.00**	 Mark Warner Nicky Lucey Inese Robotham Paul Goddard Nick Johnson
	BREAK		***11.00***	
	GOVERNANCE ITEMS			
9	**Board Assurance Framework and Risk Register** To receive	Enclosure	**11.15**	Paul Goddard and Nicky Lucey

10	**Risk Appetite Statement Annual Review** To review	Enclosure	**11.35**	Nicky Lucey and Rebekah Ley
	WORKFORCE ITEMS			
11	**Safe Staffing Return** To approve	Enclosure	**11.45**	Nicky Lucey
12	**GMC Survey Results** To receive	Presentation	**11.50**	Audrey Ryan
13	**Guardian of Safe Working** Introduction to the Guardian	Oral	**12.05**	Kyle Mitchell
	CONSENT SECTION The following items are to be taken without discussion unless any Committee Member requests prior to the meeting that any be removed from the consent section for further discussion.			
14	**Annual EPRR Statement** To approve	Enclosure		Inese Robotham
15	**Cyber Operational Readiness Support Roadmap** To note	To Follow		Stephen Slough
16	**Any Other Business**		**12.10**	Chair

Date of Next Meeting (open to the public): Wednesday 27 November 2019, 8.30 a.m., Seminar Room, Children's Centre, Dorset County Hospital

Questions from the Council of Governors and Members of the Public – 12.15pm to 12.30pm. Fifteen minutes will be allowed for questions, with priority being given to **Governor questions submitted in advance of the meeting.**

Note: The Board will now adopt the resolution that "Governors, members of the public and representatives of the press are excluded from the next part of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business about to be transacted".

BOARD OF DIRECTORS
PART 1 (PUBLIC SESSION)

Minutes of the Meeting of Wednesday 31 July 2019
Seminar Room, Children's Centre, Dorset County Hospital

Present:
Mark Addison (Chair)
Sue Atkinson (Non-Executive Director)
Judy Gillow (Non-Executive Director)
Paul Goddard (Director of Finance)
Victoria Hodges (Non-Executive Director)
Alastair Hutchison (Medical Director)
Nick Johnson (Director of Strategy, Transformation and Partnerships)
Nicky Lucey (Director of Nursing and Quality)
Ian Metcalfe (Non-Executive Director)
Patricia Miller (Chief Executive)
Matthew Rose (Non-Executive Director)
Inese Robotham (Chief Operating Officer)
Stephen Slough (Chief Information Officer)
Mark Warner (Director of Organisational Development (OD) and Workforce)

In Attendance:
Liz Beardsall (Deputy Trust Secretary)
Andy Brett (ED Consultant and Clinical Lead) (item BoD19/102)
Ali Male (Patient and Public Engagement Lead) (item BoD19/102)

Apologies:
Alison Cooper (Divisional Director)
Rebekah Ley (Trust Board Secretary)

Observers:
Denise Eastaff (CQC Relationship Manager)
Meghan Hindley (Communications Officer)
Philip Jordan (member of the public)

BoD19/102 **Patient Story**

The Chief Executive welcomed Dr Andy Brett Emergency Department (ED) Consultant and Clinical Lead, and Ali Male the Patient and Public Engagement Lead, who introduced a short film regarding a patient's experience following the misinterpretation of an x-ray in the Emergency Department. After the film Andy explained the process by which the patient's complaint had been investigated and responded to. He explained the clinical reasons for the misinterpretation and confirmed that the outcome for the patient was unlikely to have been markedly different if the misinterpretation had not been made. He explained how the learning from the incident had been disseminated to the team and asked if the film could be used as a learning tool for the ED team. It was suggested by the Board that the film could be used for learning more widely across the Trust and may also be of interest to Poole Hospital who were also involved in the patient's care, and the Chair asked the Patient and Public Engagement Lead to take this forward.

ACTION: AMale

The Chair thanked Andy Brett and Ali Male for their presentation.

BoD19/103 Welcome and Apologies for Absence

The Chair welcomed everyone present to the meeting, especially Stephen Slough who was attending his first full Board meeting since commencing at the Trust. There were apologies from Alison Cooper and Rebekah Ley.

BoD19/104 Declarations of Interest

There were no declarations of interest in relation to items on the agenda. The Chair added that declarations could be raised at any time during the meeting.

BoD19/105 Chairman's Opening Remarks

The Chair paid tribute to the organisers of the Trust's Summer Spectacular event which raised over £2,500 for the DCH Charity Chemotherapy Appeal. He also acknowledged the continuing pressure which the hospital was under, which had not relented since the winter. He thanked the staff for their energy and commitment in the face of these challenges. The Chair announced that the Board would be joined for lunch by Nurse Consultant Natalie Harper, who had recently received a Queen's Nurse Award, in recognition of her work locally and nationally.

The Chair noted with great sadness the passing of Gloria Bill (formerly Moss) who died suddenly last week. The Chair said that Gloria had been a visible, cheerful, passionate and committed member of the hospital's team, notably in her most recent role recruiting and supporting nursing staff. The Board held a minute's silence to mark her loss and to think about her family and friends.

BoD19/106 Minutes of the Previous Meeting held on 29 May 2019

The minutes of the meeting were accepted as a true and accurate record.

BoD19/107 Matters Arising and Action Tracker

Action Tracker

BoD19/068 Sustainability Messaging: it was agreed that the communications team would work on improvements to the sustainability messaging on the website and intranet, but that substantive changes would not be undertaken until the Board's session with David Pencheon in December and conversations about a possible re-design of the website had been held. The Chief Executive asked the Board to consider the meaning of sustainability for the organisation in its broadest terms, rather than just in reference to finances. It was noted that the three pillars of sustainability are considered to be finance, environment and social factors.

BoD19/075 Demand and Capacity, and CIP Challenges: on the agenda. To be closed on the action tracker.

BoD19/075 ICS Performance Reporting: on the agenda under the Integrated Performance Report. To be closed on the action tracker.

BoD19/075 Review of other Trusts' coding and SHMI scores: The Medical Director reported that comparison of the Trust with the 11 other Trusts did not provide enough data for any correlations to be statistically significant. He underlined that the Trust knew there were coding inaccuracies impacting on the SHMI scores but it was important that this was not considered to be the only issue affecting the SHMI. He reiterated that he had found no evidence that safety was being compromised in relation to mortality. It was noted that the Mortality Action Plan was on the agenda. To be closed on the action tracker.

BoD19/080 Ophthalmology Risks: this issue was reviewed at the Quality, Finance and Performance, and Risk and Audit Committees in July. To be closed on the action tracker.

BoD19/086 Review of Chair and CEO Objectives by Board: this was confirmed as complete. To be closed on the action tracker.

Matters Arising
There were no matters arising that had not been included on the agenda or the action tracker.

QUALITY AND PERFORMANCE ITEMS

BoD19/108 Chief Executive's Report

The Chief Executive referred the Board to her previously circulated report, which was taken as read, and asked for questions.

The Chair asked for an update on the hospital's Brexit planning. The Chief Operating Officer confirmed that the messages from the centre were the same as in April and that the Trust had re-established its bi-weekly Brexit task and finish group. She explained the focus was on double-checking the hospital's providers, and any new providers, to ensure they had robust plans in place. She assured the Board that the hospital was ready for the recommencement of the required sit-rep reporting.

Victoria Hodges raised the question of the Being Fair Charter created by NHS Resolution and how the hospital would integrate and embed this. The Chief Executive asked for this to brought back to the Board for consideration once the supporting guidance was published.

ACTION: RL

Matthew Rose raised the issue of the resilience of the hospital's staff in the face of the unrelenting operational pressures. The Chief Executive confirmed that the Trust was continuing to do more work around staff well-being and encouraging non-clinical staff to undertake appropriate duties on the wards to relieve some of the pressure for the nursing teams.

Sue Atkinson drew the Board's attention to the publication of the Prevention green paper (which had not been published at the time of writing of the Chief Executive's report). The Chief Executive discussed the worrying focus on individualism in the paper and the challenges posed by the newly formed local authority in Dorset. The Director of Strategy, Transformation and Partnerships confirmed that the prevention agenda was covered in the Integrated Care System (ICS) performance summary report, and it was the ambition of the ICS to focus on the well-being challenge.

The Chief Executive was pleased to announce that the new Chief People Officer at NHS Improvement/England, Prerana Issar had accepted in principle an invitation to visit the Trust in November, with the date to be confirmed, as an opportunity to learn more about the realities of rural working.

The Chair thanked the Chief Executive for her report.

Break

BoD19/109 Integrated Performance Report

The Director of OD and Workforce introduced the workforce aspect of the performance report to the Trust Board. He reported that workforce numbers remained relatively static, and that the increase in agency and bank staff costs had been partially offset by a reduction in substantive staff costs. He reiterated that agency spend was directly linked to the number of nursing vacancies and the number of escalation beds which had now been open since winter. He reported that a task and finish group had been established to look at the drivers for the high agency spend, using the NHS Improvement Temporary Labour Tool Kit, and that a review of the nursing trajectories would be undertaken to take into account the amount of escalation activity at the

hospital. He reported that the partnership with Medacs for international nurse recruitment had led to a number of Skype interviews with good quality candidates and the first of these would be arriving at the Trust from the end of September. He highlighted that although this was very positive, the Trust needed to be mindful of the additional challenges the new recruits brought to the existing nursing teams and education team. He reported good progress was being made on job planning compliance; that appraisal and training rates remained steady but below target; that a review of the current eLearning software was underway and that there had been a good response to the recent offer of Mental Health First Aid training for staff.

The Chair of the Workforce Committee, Victoria Hodges added that the task and finish group had good senior staff and transformation team support, which was very encouraging. She highlighted that the committee had been looking at the timeline for reporting and acting on the outcomes of the staff survey so that improvements could be put in place in a timely fashion. She reported that good progress had been made with the Staff Survey listening events and divisional action plans. She highlighted to the Board good practice in the post room and transport teams, who had interns from Weymouth College in post as part of the college's initiative to enable students with learning difficulties to enter the workplace.

It was noted by the Board that a systematic review of agency spend was welcome; that the Mental Health First Aid training was an excellent initiative, but needed to take into account the cultural differences of staff at the organisation; that retention action plans were in place in the divisions and there had been some excellent work done on assessing the Allied Health Professional team's skill mix; and that the increase in the number and diversity of volunteers at the hospital was making a tangible difference on the wards.

The Director of Nursing and Quality introduced the quality aspects of the performance report to the Trust Board. She said that the quality indicators remained sustained. She reported that the Quality Committee had triangulated hospital mortality data with audit outcomes; received a deep dive into the Trans-Ischaemic Attack pathway; accepted the Infection Prevention and Control Annual Report; reviewed the new Patient Safety Strategy although the full guidance would not be available until November; and had a robust conversation about the key challenges of Venous thromboembolism (VTE) risk assessment, Electronic Discharge Summaries (EDS) completion and dementia screening. The Medical Director confirmed that a technological solution was being looked at in relation to EDS completion, including the possibility of forced completion prior to discharge. He explained that there had been concerns that a forced system would increase lengths of stay, but evidence from other hospitals suggested that this was not the case.

The Chair of the Quality Committee, Judy Gillow reported that the committee would be focusing on those areas where a plateau had been reached and would be inviting the clinical directors to work with the committee on 'hot spot' issues. She noted that some of these issues required a technological solution but others were about engagement and required overt work with the clinical teams. She also reported that the September committee would be undertaking a deep-dive regarding sepsis.

The Chair asked if there was a quality issue with EDS completion. The Director of Nursing explained that there was a portal where GPs could feedback on the EDSs they received, and whilst there were occasional minor queries there were no major themes relating to quality other than the timeliness of completion. The Medical Director reported that a random sample of EDSs were sent to the consultant under whose name they had been completed, so that feedback could be given to the junior doctors completing the summaries. He said that this had a positive impact on the quality of the summaries and created accountability.

The Chief Operating Officer presented the performance element of the performance

report. She said that the Trust was one of only a few who achieved the 95% target for the 4 hour emergency access standard in May, but that this had decreased to 93.3% in June. She reported that there had been an increase in the acuity of patients leading to higher number of admissions, and that this was being mirrored in East Dorset. She said the number of long length of stay patients had reduced in June, but had increased again in early July, and an executive led long stay review panel had been established. She reported that performance against the 18 week referral to treatment (RTT) standard was 76%, with two 52 week breaches predicted by month end. She reported that the July Finance and Performance Committee had received a paper outlining recovery plans for ophthalmology, trauma and orthopaedics, oral surgery and dermatology. She explained that for the trauma and orthopaedics, and ophthalmology services all internal options had now been exhausted and the recommendation had been to negotiate additional resources from the Clinical Commissioning Group (CCG). In relation to the cancer 2 week wait standard she reported that the rate of increase in referrals was down, but that overall referral numbers were still up and the pinch points were breast and dermatology. She reported that dermatology were increasing their workforce and that negotiations were underway with the private sector for 2 week wait breast appointments. She reported a step change in the cancer 62 days referral to treatment standard which was now above 80% having been in the 70s for the last year. She explained that the challenge remained the tertiary pathways. She reported that for the diagnostic 6 week wait performance was 90% in June, which was below the 95% standard but ahead of the Trust's improvement trajectory. She explained that the main pressure remained in endoscopy and there was ongoing insourcing of capacity for endoscopic procedures from an independent provider as the Trust had been unable to recruit to the department. She highlighted the positive news that the department had received its JAG accreditation for the next 12 months, which had been excellent for the team's morale.

Chair of the Finance and Performance Committee, Matthew Rose reported that the July meeting had dedicated significant time to the demand and capacity report. He praised the team for their clear paper on a complex issue. He suggested it would be important to know whether the internal recovery plans were having a positive impact before the end of the three month period suggested in the options paper, or whether some difficult decisions would need to be made.

The Chair asked where the Trust sat nationally in regard to the 4 hour emergency access standard. The Chief Operating Officer confirmed that in April, the latest available benchmarking figures, the Trust was 28th out of 129. It was noted that the south west region was previously the top performing region, and was now fifth out of the seven regions. The Director of Strategy confirmed that work was underway with Public Health Insight to try and understand what was driving the increase in emergency department demand. The Chief Executive highlighted the closure of local seven day drug and alcohol services and the impact this was having on emergency attendances. The Director of Nursing confirmed that the South Western Ambulance Service Trust (SWAST) was reporting an increase in the acuity of patients, of adult drug and alcohol related cases and of paediatric mental health patients.

The Director of Finance introduced the financial element of the performance report to the Trust Board. He said that the Trust's year to date position was positive, being £400,000 ahead of plan. He highlighted however that £200,000 of this related to Provider Sustainability Funding (PSF) for the financial year 2018/19 which would therefore not count against the Trust's control total. He reported that the Trust had achieved its Sustainability and Transformation Funding (STF) and Financial Recovery Fund (FRF) funding for quarter one. He said that the Cost Improvement Programme (CIP) was close to plan year to date but that there was significant agency spend in excess of £500,000 for the third consecutive month. He stated that whilst the current position was positive there were concerns that the Trust was reliant on some non-recurrent benefits and that current spending levels were not sustainable.

He provided the Board with assurance that this had been reviewed in detail at the July Finance and Performance Committee meeting, and would be subject to further discussion in the Part Two Board meeting.

The Chair and Chief Executive confirmed that at the recent South West CEOs and Chairs meeting there has been a strong message from the centre that there would be no further funding at provider level to assist Trusts to meet a breakeven position, and that all available funding had already been distributed to the regions.

The Director of Strategy, Transformation and Partnerships introduced the ICS performance summary to the Trust Board. He highlighted the regional concerns over SWAST performance especially around call-stacking and handover delays. He also highlighted the comparative performance regarding SHMI and mixed-sex breaches. In terms of performance, he reported that there was pressure across the ICS but increasingly so in the West of the county. He drew the Board's attention to the fact that Dorset Health Care had given notice on the NHS111 service and reported that the ICS was working with Dorset Health Care to find a replacement solution. With regard to finance, he reported that the ICS had £13.9 million of unidentified cost savings but that overall the system was on plan year to date. He highlighted the progress being made by the Dorset Clinical Networks, as set out in the report. He explained that the new Primary Care Networks (PCNs) had now been established and that Christian Verrinder, Deputy Medical Director, would be working on engagement with the PCN clinical leads. He reported that the NHS Long Term Plan (LTP) Implementation Framework had been published in July, and each ICS was required to submit a local five year plan in draft in September with a final version in November. He said that the main challenges were integrating the local authorities into the production process and the ability to assess the impact of initiatives and interventions to date. He asked if the Board would consider the LTP at the August development session and sign off the plan at the September Board meeting. The Chief Executive said she and the Chair would need to consider whether there was space on the August agenda for this item.

ACTION: PM/MA/RL

Ian Metcalfe raised concerns that the Board had not seen any evidence that the ICS had efficiency plans in place to meet the £13.9 million gap, and stated that the organisation should not sign-up to an ambitious five year plan if it did not have assurance that the current financial problems could be solved.

The Board discussed the fact that although reports on amalgamated performance had been produced there was little intelligent, comparative, system wide demand and capacity work available. The non-executives sought assurance regarding the number of mixed sex breaches. The Director of Nursing explained that these were all in the critical care unit and all due to ward beds not being available when patients were ready for discharge from critical care. She said that the commissioners were aware, and that all patients concerned and their families had been spoken to individually and been understanding of the situation. The Chief Operating Officer added that the small size of the critical care unit meant that there was limited flexibility to move patients within the unit, which exacerbated the issue. The Board also discussed the potential negative impact on recruitment of the new PCNs, which would be in a position to offer attractive packages especially to pharmacists and physiotherapists. There was discussion regarding Prevention at Scale and how this would be integrated into the LTP, and the Director of Strategy confirmed that the approach would be for prevention to be integrated into the workstreams rather than be a separate strand.

The Chair thanked the executive team and committee Chairs for their reports.

Break

BoD19/110 **NHSI Mortality Governance Review**

The Medical Director presented the Mortality Governance Review report which had

been prepared by Paul Smith at NHS Improvement (NHSI). He said that the hospital's SHMI had been high for over four years, and that he had been working with NHSI since he came into post 12 months ago to understand this. He explained that whilst the report highlighted the issues with coding at the hospital leading to a high SHMI rate, he believed that this was not the complete picture. He gave an overview of the methodology, findings, examples of good practice and areas for improvement as detailed in the report. He explained that the previously circulated action plan reflected the recommendations made in the NHSI report.

Judy Gillow thanked the Medical Director for leading the cultural improvement which had led to the high levels of interest in the Medical Examiner roles at the Trust, and asked about how the new mortality data would be received by the Quality Committee. The Medical Director explained that he was working on pulling together triangulation data, including data from national audits such as the Intensive Care National Audit and Research Centre (ICNARC) and the National Emergency Laparotomy Audit (NELA). He said that 'RAG' rating reports often masked emerging trends and that he was in conversation with the information team about the presentation of the relevant data. The Director of Nursing confirmed that a quarterly Medical Director's report was now being received by the Quality Committee which would help to triangulate this date. She assured the Board that quality improvement work was underway at the Trust but that this needed to be articulated better through the reporting. The Chief Executive underlined that the organisation had work to do on understanding what the data trends were telling the teams and how the Trust could move from a culture of compliance to continuous improvement.

The Chief Information Officer confirmed that the information team were looking to spend more time out in the hospital talking to clinicians about data, to help the clinical staff spot trends and better understand the available information. The Director of OD and Workforce highlighted that there was a national shortage of clinical coding staff, and said this was one of the areas that the Trust were looking at in terms of longer term planning, e.g. recruitment of coding apprentices, to build a team with the necessary skills.

The Chair thanked the Medical Director for his report and for his personal commitment to the issue of mortality reporting. He asked the executive team to continue the discussion about embedding a quality improvement culture at the hospital.

ACTION: PM/Execs

[The Medical Director left the meeting to attend the junior doctor induction session]

BoD19/111 **Board Assurance Framework and Risk Register**

The Director of Finance introduced the previously circulated Board Assurance Framework (BAF) report. He explained that the July Risk and Audit Committee meeting had undertaken a deep-dive regarding the BAF, and what was now required was an holistic discussion with the executive team regarding whether the mechanism of the BAF was working for the organisation and how the BAF could be reviewed and refreshed. The Chief Executive confirmed that the August executives' meeting agenda was dedicated to a discussion of the BAF and the risk register. The Chair asked the Board if they felt it was right that the 'delivering outstanding services everyday' and 'productive, effective and efficient' objectives were the areas of highest risk. Judy Gillow highlighted that some of the RAG rating may not be an accurate reflection of the measures in place, and gave the example of hospital mortality reporting being rated green when there was still work to be done in this area (page 63/282) The Director of Finance confirmed that the accuracy of the ratings had been one aspect of the discussion at the Risk and Audit Committee meeting, and this would form part of the discussion at the executives' meeting.

The Director of Nursing introduced the previously circulated risk register, which

provided a summary of the full register which was reviewed by the Risk and Audit Committee. She confirmed that the corporate risk register reflected operational risks rather than the strategic risks reflected in the BAF. She highlighted that work had been undertaken to consolidate the risks on the register; that the risk rating for 'financial sustainability' had been increased; that 'recruitment and retention', 'workforce planning and capacity for nursing and Allied Health Professionals and Health Sciences staff' and 'personnel files (non-medical) not being stored centrally' had been added to the register; and the 'ED estate' was an emerging risk. Ian Metcalfe, Chair of the Risk and Audit Committee added that there had been a good discussion at the committee in July about the definition of extreme risks and what an extreme risk would look like for the organisation. He felt reassured by the fact that all the extreme risks were being discussed across all the relevant committees, with the exception of co-tag access which was however being addressed operationally. He informed the Board that the committee would be undertaking a deep dive regarding the risk register at the next committee meeting.

Victoria Hodges asked about the risk register at ICS and national level in relation to risk trends. The Director of Nursing confirmed that the risk matrix was a shared matrix, so that the system could compare ratings and although the organisational risks fed into a system wide risk register this was in its infancy. The Chief Executive confirmed that the Senior Leadership Team (SLT) had requested that an ICS risk register was developed, but she felt that there was a lack of recognition system-wide of how any given organisational risk could materially affect the ambitions of the ICS.

The Chair thanked the Director of Finance, the Director of Nursing and the Risk and Audit Committee Chair for their work and asked for the BAF and risk register to come back to the Board after the discussion at the August executives' meeting.

ACTION: RL

WORKFORCE ITEMS

BoD19/112 **Safe Staffing Return**

The Director of Nursing and Quality introduced the Safe Staffing Return for May which had been reviewed at the July Quality Committee meeting. She reported that there were two shifts with only one registered nurse on duty during the reporting period (elderly care and renal) and these were supported by adjacent wards areas and night sister presence. She confirmed that where Health Care Support Worker figures were over the fill rate this was to support increased demand. The Director of OD and Workforce reported that the future workforce planning for wards would review registered nurse pressure and look at redefining safe staffing within the new workforce model.

The Chair thanked the Director of Nursing and Quality for her report.

BoD19/113 **Annual Equality, Diversity and Inclusion Report, and Gender Pay Gap Report**

The Director of OD and Workforce presented two reports which had been reviewed at the July Workforce Committee meeting. Regarding the Equality, Diversity and Inclusion report, he highlighted the differences between the demographics of the hospital's workforce in comparison to the local population; the analysis of employee relations cases and tribunals to test whether the organisation had any inherent issues; the need to ensure a fair recruitment process and how training for recruitment needed to be expedited; the responses from BAME staff in the Staff Survey and how the issues raised needed to be addressed; concerns that many staff were not self-reporting their disabilities and the cultural issue that may underpin this; the positive attendance at listening events for BAME staff and staff with disabilities and how this could extend into the creation of staff networks.

Victoria Hodges, Chair of the Workforce Committee added that it was important for the Trust not to become too focused on simply reporting issues but the organisation

needed to make the shift into an action phase. She said it was a welcome development that the Board would be spending time looking more deeply at the equality, diversity and inclusion agenda later in the year.

In relation to the Gender Pay Gap report, Victoria said that the committee had spent time discussing how the organisation could commit more widely to flexible working for male and female employees. She said the committee also noted the challenge of making recruitment fully inclusive. The Director of OD and Workforce added that the gender pay gap reflected a national, structural issue but the way the organisation dealt with flexible working would be key in addressing this. He highlighted that the reference in the report to 'bonuses' related directly to the Clinical Excellence Awards, and that the challenge was equipping those who did not feel encouraged to put themselves forward to apply.

The Chair confirmed that there were two sessions on diversity and inclusion planned for the Board with Eden Charles, in October 2018 and January 2019. Both sessions would be on days already scheduled for the Board meeting, with a session the evening before. He said that the reports flagged some troubling issues but also some very positive points, and he believed the Trust was in a good position to drive this work forward.

The Chair thanked the Director of OD and Workforce and the Chair of the Workforce Committee for their report.

STRATEGIC ITEMS

BoD19/114 **Charity Annual Report and Accounts**

The Director of Finance and Resources presented the previously circulated report which had been reviewed by the Charitable Funds Committee. He confirmed that the Annual Report and Accounts had been subject to a full audit and had received a clean opinion from the auditors. He explained that the report was for the Board's approval and then for submission to the Charity Commission. He said that although submission was not required until January, it was good practice to submit early so that potential grant makers could view the Charity's accounts online.

The Chair thanked Peter Greensmith for the work he had undertaken as Chair of the Charitable Funds Committee before early departure from his non-executive director role at the Trust.

Victoria Hodges highlighted that the Charity still had a high number of restricted funds which was limiting the way in which the hospital could use the money donated. The Chair confirmed that the Charity was currently undertaking a refresh of its strategy and that this would be coming to the September Board meeting for information.

ACTION: RL

The Board unanimously approved the Charity Annual Report and Accounts.

[The Medical Director returned to the meeting]

BoD19/115 **Urgent and Emergency Care Patient Survey**

The Director of Nursing and Quality introduced the previously circulated report on the Urgent and Emergency Care Patient Survey which had been reviewed at the Patient Safety Group and the June Quality Committee meeting. She reported that the results placed the hospital in the top five nationally and, whilst there were always areas for improvement, the outcomes were a credit to the teams on the floor. She reported that the Trust was significantly better than average in a number of areas and significantly worse in only a few. She qualified this by saying that when the data was triangulated it did reveal some inconsistencies, often due to interpretation of the questions by respondents, but overall there were clear themes for improvement and celebration.

She said that the Patient Experience Group would oversee the resulting action plan, with reporting by exception to the Quality Committee and then on to the Board.

The Chair thanked the Director of Nursing and Quality for her report.

BoD19/116 **Guardian of Safe Working Report**

The Medical Director presented the previously circulated report which had been prepared by the outgoing Guardian of Safe Working, Jonathan Chambers. He confirmed that the Trust had applied for and been granted two doctors under the Priority Foundation Programme, which would help to improve the experience of the junior doctors at the hospital and to reduce the 11.3 training grade vacancies. He underlined that no fines had been levied on the Trust as a result of the exception reporting detailed in the report. He reported that two doctors at the hospital had been part of the junior doctor contract negotiating team, which was very positive for the image of the hospital. He also said that of 35 junior doctors attending induction at the hospital today, 32 had chosen Dorset County Hospital as their first choice. He noted the cluster of exception reports from orthopaedics and acute medicine, and assured the Board that the new Guardian of Safe Working would focus on these areas.

The Director of OD and Workforce reported that the details of the contractual changes for junior doctors were not yet known, but they would involve an increased number of rest breaks and greater constraints on rostering, which would have an impact on the resourcing challenges. He also stated that the implications for breaching the terms would be more severe than currently.

The Chair offered his thanks to Jon Chambers and said that the Board was looking forward to welcoming Kyle Mitchell into the role.

CONSENT ITEMS

The Chair confirmed that no questions or concerns had been raised about the consent items.

BoD19/117 **Annual Infection Prevention and Control Report**

The report provided the Trust Board with information regarding Infection Prevention and Control at the hospital from April 2018 to March 2019. The report was previously reviewed at the July Quality Committee meeting. Judy Gillow confirmed that the committee had been impressed with the report, and had praised the team for its production.

The report was accepted by the Trust Board.

BoD19/118 **Clinical Audit Plan**

The report detailed the Trust-wide Clinical Audit Plan for 2019-20. It was previously reviewed at the May Quality Committee and Risk and Audit Committee meetings.

The plan was accepted by the Trust Board.

BoD19/119 **Medical Revalidation Report**

The report provided the Board with assurance that the Trust was meeting its statutory duties in relation to medical revalidation. It covered the period 1 April 2018 to 31 March 2019. It was noted that the report referenced the inclusion of a non-executive director (NED) on the RO Advisory/Revalidation Governance Group. The Chief Executive said she would discuss this outside the meeting with the Medical Director to understand whether it was a requirement that this role was fulfilled by a NED or whether this could be undertaken by another lay member.

ACTION: PM/AH

The report was accepted by the Trust Board and the Statement of Compliance was approved.

BoD19/120 Communications Activity Update Quarter 1 April to July 2019

The report gave an overview of communications activity for the Trust. Included in the report was information about key campaigns, initiatives and events, and analytics for social media channels and the Trust's public website. There was also a summary of news releases issued over the quarter and associated media coverage. The Director of Strategy, Transformation and Partnerships highlighted the increased social media presence and the positive introduction of the DCH App which had been downloaded by 700 staff to date.

The report was accepted by the Trust Board.

BoD19/121 Any Other Business

The Chair announced that James Metcalfe had been appointed as the new divisional director for the Urgent and Integrated Care Division. The Medical Director confirmed that Mr Metcalfe was a vascular surgeon who had previously been the clinical lead for the renal unit. He said that Mr Metcalfe had been interviewed by the Medical Director, Chief Operating Officer and Director of OD and Workforce, and all three were very positive about his appointment. The Medical Director reported that there only remained a QI Lead to appoint and then all the clinical leadership roles at the hospital would be filled. The Chief Executive thanked the Medical Director for his proactive approach in ensuring these vacancies had been filled by the next generation of clinical leaders.

The Chair reported that Dorset Health Care had been awarded an 'outstanding' rating following their recent CQC re-inspection. The Board passed their congratulations to Dorset Health Care for this excellent result.

The Chair asked the Chief Information Officer for an update on the Dorset Care Record. The Chief Information Officer explained that the project has not progressed as hoped, with only 25 of 80 items in place. He said funding had been secured from the Wessex Care Record to progress the project and it was hoped by year end the gap would be closed to 60 or 70 out of 80 being in place. The Chief Executive stated that there needed to be understanding across the system that time needed to be released into the Dorset Care Record and that staff needed to be socialised to understand the benefits of using the system. The Chief Information Officer confirmed that once single sign-on was in place it would be easier to promote the system in the organisation. He also said that Dorset County Hospital had consistently been the best performing organisation throughout the process in terms of data quality and timeliness of delivery.

The Chair announced that the Chief Operating Officer would be completing the Great North Run in September to raise money for the DCH Charity Chemotherapy Appeal, and encouraged the members of the Board to support her. He also announced that the Director of Finance was getting married in August, and the Board gave him their congratulations.

BoD19/122 Questions from the Public

Mr Jordan, member of the public, said that work was being done on prevention via the Mid Dorset Locality Group and that he would forward their most recent newsletter to the Chair. He highlighted the issues of poverty and its impact on health, especially in relationship to Weymouth and Portland. He highlighted the issues of telephone scams, of which he had recently been a victim, and the negative impacts these could have. He said he had attended the recent engagement session about the strategic estates masterplan and was aggrieved to see that none of his suggestions regarding access had been included in the plans. He also said that the organisation seemed not to have taken a large number of items into consideration, including local travel plans. He suggested that the Trust consider building above the existing car parks, taking into account the natural slope of the site.

The Director of Strategy assured Mr Jordan that there was a large body of background

work which had been undertaken which was not presented on the day of the engagement session. He confirmed that a travel plan would form part of any planning application, and that the car park project was only one part of a wider solution. He suggested that Mr Jordan might like to spend time with the Trust's Head of Estates and Facilities to talk through some of his suggestions.

ACTION: NJ/AM

BoD19/123 **Date of Next Meeting (open to the public):** Wednesday 25 September 2019, 8.30am Seminar Room, Children's Centre, Dorset County Hospital.

The Board adopted the resolution that "members of the public, Governors and representatives of the press are excluded from the next part of the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business about to be transacted".

ACTIONS LIST – BOARD OF DIRECTORS PART ONE 31 JULY 2019

Minute	Action	Owner	Timescale	Outcome
BoD19/102	The Patient and Public Engagement Lead to take forward the patient film shown at the meeting being used as a learning tool for ED, trust-wide and at Poole Hospital if appropriate.	Ali Male	Sept 2019	
BoD19/108	The NHS Resolution Being Fair Charter and how the hospital would integrate and embed this, to be brought back to the Board for consideration once the supporting guidance is published.	PM/RL	TBA	*It is unlikely that there will be any guidance issued. The paper provides some useful evidence and examples but there will not be anything beyond this in terms of what hospitals should do. Suggest that the Workforce Committee considers this alongside any changes that are made to the Trust's disciplinary processes and procedures when reviewed.*
BoD19/109	The Chief Executive and Chair to decide whether the Long Term Plan will be added to the August development session agenda for discussion and return to Board for sign-off at the September meeting.	PM/MA/RL	August 2019	Added to August development session agenda and September Board meeting agenda.
BoD19/110	The executive team to continue the discussion about embedding a quality improvement culture at the hospital.	PM/execs	Ongoing	
BoD19/111	The BAF and Risk Register to come back to the September Board after the discussion at the August executives' meeting.	RL	Sept 2019	Added to September Board meeting agenda.

BoD19/114	Charity Strategy to be added to the agenda for the September Board meeting.	RL	Sept 2019	Added to September Board meeting agenda.
BoD19/119	Non-executive director membership of the RO Advisory/Revalidation Governance Group to be discussed by the CEO and Medical Director, to understand whether it is a requirement that this role is fulfilled by a NED or whether this could be undertaken by another lay member.	PM/AH	Sept 2019	
BoD19/122	The Head of Estates and Facilities to meet with Mr Jordan to talk through some of his suggestions regarding the Estates Masterplan.	NJ/AM	Sept 2019	**Complete.** Meeting held.

Carried Forward

Minute	Action	Owner	Timescale	Outcome
BoD19/068	Consider messaging around sustainability including accessibility of the Trust's intranet and webpages.	Executive Team and Communications Team	TBA	**Underway** July 2019: it was agreed that the communications team would work on improvements to the sustainability messaging on the website and intranet, but that substantive changes would not be undertaken until the Board's session with David Pencheon in December and conversations about a possible re-design of the website had been held.

Title of Meeting	**Board of Directors**
Date of Meeting	**25 September 2019**
Report Title	**Chief Executive's Report**
Author	**Chief Executive**
Responsible Executive	**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 includes reflections on how the Trust is performing and the key areas of focus for the coming year.

Key developments nationally are as follows:

ED waiting times

The number of patients kept waiting at A&E departments in England reached its highest level in a decade last year, prompting warnings that pressure on the NHS would rise this winter if it faced the "perfect storm" of high demand and a 'no deal' Brexit. Patients kept waiting at least four hours more than trebled in the past five years. According to NHS Digital's *Hospital accident & emergency activity 2018-19* report, last year only 88% of patients were seen within four hours compared with 98.3% ten years ago.

Separate NHS figures from NHS England and NHS Improvement show that last month was the busiest August ever. A&E attendances last month were up 6.4% on the same month last year. Although doctors treated an extra 1,200 patients within four hours, the percentage of people seen within that time dropped from 89.8% to 86.3%. About 24.8 million people attended A&E in 2018-19, a 21% increase on the 20.5 million who visited in 2009-10.

Capital investment

82% of NHS Trust leaders think that restrictions on access to capital funding are creating a medium or high risk to patient safety and could undermine plans to transform services. The Prime Minister's recent capital announcement can be considered only a first down payment, given a £6bn backlog maintenance bill that has left Trusts unable to fix or replace leaking roofs, broken boilers, ligature points in psychiatric facilities, and outdated technology - even before any investment can be made in new buildings and services.

New NHS staff 'passports

NHS England has urged all hospitals across the country to sign-up to its pass-porting agreement, which is designed to make it easier for staff to move between hospital sites and take on new roles. Those behind the initiative hope it will help to plug staffing shortages and improve patient care. The call follows a series of successful pilot projects across five hospitals. This was announced by NHS chief people officer Prerana Issar, who also confirmed £7m funding will be put into local services to support the nationwide introduction of e-rostering

Key local developments are as follows

DCH performance.

Although some improvements have been seen a number or risks continue to be evident which could compromise the ability of the Trust to deliver on its key commitments in the coming year:

- Growing elective waiting list
- 62 day referral to treatment cancer standard
- Staffing, in particular the use of temporary staff
- Waits for diagnostics
- Finances
- Mortality

Plans are in place to mitigate these in part, but further discussions are still required at a system level to avoid the escalation of risk. The Trust will need to make some key decisions in the coming weeks. These would include how to manage elective demand to ensure no further deterioration in the size of the waiting list and prevention of 52 week breaches, particularly in the context of increasing emergency demand, investment in further recruitment campaigns and making challenging decisions to meet our financial obligations.

From a strategic perspective it is important that the Trust continues to make progress with the delivery of its Transformation Programme, the development of the Damers site and the wider Estates Strategy as these programmes will play a key role in securing the Trust's long term future. Further work is required on the key programmes of work identified in the Trust's Finance Strategy and the Dorset ICS Transformation to ensure the Trust feels the full benefit of these programmes within the timescale required.

Paper Previously Reviewed By
Chief Executive.

Strategic Impact
In order for the Board to operate successfully, it has to 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 place 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.

Financial Implications
Failure to address key strategic and operational risks will place the Trust at risk.

Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided.

Chief Executive's report

Strategic Update

National Perspective

There have been a number of developments since the last report that will be of interest in terms of the national context or where there is a clear connection to challenges or developments locally.

Nursing recruitment

A study by the Royal College of Nursing (RCN) which suggests that the rise in hospital nurses in England has been dwarfed by a jump in patients. The research points to data showing the nurse workforce has increased by 4.6% in five years. However, hospital admissions have jumped by 12.3% - nearly three times the rate. The union says this shows more needs to be done to ensure safe staffing, but the government says the rising NHS budget will ensure high-quality care. RCN general secretary Dame Donna Kinnair said there needed to be a new law to ensure safe staffing, as has been introduced in Wales and Scotland. She also said she wanted a national body to be created to properly plan the nursing numbers needed in the future

Health minister changes

A new health minister has been appointed to the DHSC following a Cabinet reshuffle this week. Edward Argar, MP for Charnwood in Leicestershire, has replaced Chris Skidmore, who was appointed health minister in July this year, shortly after Boris Johnson became prime minister. Mr Argar's brief will include Brexit, finance, efficiency, commercial, capital and estates, operational performance, workforce, and transformation and provider policy. Before joining DHSC, he was a junior minister for the Ministry of Justice.

Local Relevance

Ruling on locum costs

The NHS potentially faces a bill for hundreds of millions of pounds after a court ruled that locum GPs were workers and eligible for holiday pay. The judgment could lead to self-employed locums, who earn on average about £140,000 a year, receiving back-dated holiday pay for up to six years - which could amount to tens of thousands of pounds each. The development comes after a tribunal backed a claim by a locum GP in Gateshead that she was entitled to holiday pay despite arguments that she was self-employed. Estimates suggest that the cost, excluding back payments, could be about £250m a year.

ED waiting times

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Separate NHS figures from NHS England and NHS Improvement show that last month was the busiest August ever. A&E attendances last month were up 6.4% on the same month last year. Although doctors treated an extra 1,200 patients within four hours, the percentage of people seen within that time dropped from 89.8% to 86.3%. About 24.8 million people attended A&E in 2018-19, a 21% increase on the 20.5 million who visited in 2009-10.

ED re-attendance rates

Almost one in ten A&E patients are returning to hospital within a week, amid growing difficulties getting to see a GP. The new figures from NHS Digital show that last year, almost 2 million patients who went to A&E were back again within seven days - a 72% rise from 1.1 million in a decade. In total, there were 24.8 million A&E attendances in 2018/19 - a rise of more than a fifth in a decade. Almost 9% involved patients who visited more than once in a week - up from 7% ten years ago.

Cancer survival rates in the UK

Cancer survival in the UK is are improving, but is still lag behind other high-income countries. Five-year survival rates for rectal and colon cancer improved the most since 1995, and pancreatic cancer the least. Advances in treatment and surgery are thought to be behind the UK's progress. However, the study in Lancet Oncology found that the UK still performed worse than Australia, Canada, Denmark, Ireland, New Zealand and Norway. The research looked at data on nearly four million patients with seven types of cancer - oesophagus, stomach, colon, rectum, pancreas, lung and ovary - from seven high-income countries.

Revised access standards

NHS England has confirmed that new mental health emergency care targets will be trialled across 11 NHS organisations and one social enterprise.
The 12 organisations will pilot new clinical standards for urgent and emergency mental healthcare, which include: a one-hour response by liaison psychiatry teams for patients with emergency mental health needs; assessments for emergency mental health referrals to be carried out 'within hours'; and patients accessing emergency mental health services in the community to be seen within 24 hours.

The organisations testing the standards, which largely match the sites of those testing the new acute accident and emergency standards, are listed in the article. The national commissioner has also revealed the 12 areas testing four-week waiting times for children and young people's community support teams

NHs Safety Standards

A recent review of CQC inspection reports has shown that patient safety is frequently at risk in NHS hospital Trusts in England, with 70% of them not meeting national safety standards, with staff shortages the biggest problem. Of 148 acute and general hospital Trusts, safety standards at 96 are rated as 'requires improvement' by CQC; six are rated inadequate. The others are rated good, with none outstanding. Of the 14 inspection reports published since the start of June, half raised concerns over inadequate staffing levels.

Artificial intelligence

Pioneering gene-based therapies and artificial intelligence are to be used to help people with cancer, dementia and Parkinson's with a £133m boost from the government. Ministers hope to enable faster, more accurate diagnoses and earlier interventions by investing £50m into NHS diagnostic services. A government spokesman said that the cash would help to "develop cutting-edge products using digital systems and artificial intelligence that could ultimately save lives". Research into improving adult social care will receive £7.5m and £14m will be spent on technologies for treating conditions such as osteoarthritis and developing new vaccines.

Capital investment

82% of NHS Trust leaders think that restrictions on access to capital funding are creating a medium or high risk to patient safety and could undermine plans to transform services. The Prime Minister's recent capital announcement can be considered only a first down payment, given a £6bn backlog maintenance bill that has left Trusts unable to fix or replace leaking roofs, broken boilers, ligature points in psychiatric facilities, and outdated technology - even before any investment can be made in new buildings and services.

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Small, rural hospitals

Following the first meeting of small, rural DGHs with NHSI colleagues a number of work streams have now been identified:

Future vision - The future vision theme relates to the unique offer of small and rural hospitals, their role within local systems and economies, and the differing expectations of all system partners. The theme also relates to support for hospitals
delivering changes in their operations to build sustainability and resilience

Workforce - The workforce theme relates to options for small and rural hospitals to maintain and grow their workforce, and ensure the right skill mix to provide safe and high quality care

Finance and funding - The finance and funding theme relates to funding models that support hospitals and systems in rural areas, and the drivers of small or rural financial challenges at hospital level (including capital)

Digital and Technology - The digital and technology theme relates to the adoption and spread of digital solutions to address key challenges facing small and rural hospitals

Safe and high Quality Patient Pathways - The safe and high quality patient pathways theme relates to clinical service models within existing services within hospitals, as well as transformation along the care continuum. The theme also relates to quality and safety guidelines

Trusts have also been asked to self-identify into one of four groupings:

- Small hospital near a next hospital, both part of the same Trust
- Number of small hospitals all within relatively close geography to one another
- Small hospital near a large hospital; not part of the same Trust
- Isolated small hospital with significant distance to nearest hospital

The Trust Board will receive regular updates as this work progresses.

NHS Providers Rural Network

The first meeting of the network was held at the beginning of September. Senior representatives from a round 20 providers attended. Colleagues from the NHSI team leading the national work under the NHS LTP, focussed on a sustainable operating model for small, rural DGHs were also in attendance alongside Nigel Edwards, Chief Executive from the Nuffield Trust. A number of areas of future focus were agreed by the network:

- Creating the social value case for rural hospitals as anchor institutions. This was considered to be critical to developing business cases for capital funding that would be considered more favourably by HMT.

- Creating a positive narrative about small and rural hospitals. Often small hospitals perform very well against national standards as highlighted in DCH's GIRFT reviews but this is very rarely given the focus it deserves.

- The remaining two areas of focus agreed were workforce and finance. The network was clear that its work programme would complement that of NHSI to provide maximum opportunity to influence the national conversations around policy relating to rural providers.

DCH Performance

The Trust has continued to face challenges in meeting increasing emergency demand. We are continuing to see the consequences in terms of agency costs and cancellations of elective admissions, leading to further growth in the waiting list. This is continuing to poses challenges in a number of areas:

- Inability to meet the NHS operating standards for RTT, cancer and the waiting list size. Although we have recently seen improvements in cancer performance and have agreed some investment in Ophthalmology, cancellations of elective surgery due to emergency pressures remains a risk

- The significant risk of 52 week breaches and harm being caused to patients where waits are excessive. We are currently negotiating with the CCG additional funding to mitigate this risk.

- Increasing numbers of stranded and super stranded patients. The Urgent and Emergency Care Board has this as a high priority with a particular focus on seven day services for out of hospital care and increasing the capacity to discharge patients from hospital at weekend.

- Increasing agency costs and a run rate above plan places a risk on the achievement of the Trust control total. Our domestic and overseas recruitment will mitigate some of this. But the run rate remains a risk.

My biggest concern remains the resilience of our staff who have not seen a decrease in these pressures since January and we will very soon be approaching winter.

As stated last month, 'no deal' Brexit remains a risk and whilst comprehensive approach to planning for this scenario in the NHS continues, there are unknowns in terms of the consequences. We will be testing our business continuity plan in terms of interruption of service in the next couple of weeks.

Dorset Integrated Care System

The Dorset ICS has completed the first draft of the Dorset LTP which is on the Board agenda for comment and agreement.

Patricia Miller, Chief Executive
September 2019

Balanced-Score Card Performance Report

Report to Board: 25 September 2019

Performance Summary:

August performance against the four hour Emergency Access Standard (EAS) declined when compared to July. The type one performance for August was 77.2%, the combined types one and three performance was 89.5%. Whilst this performance is below the national standard of 95% it remains above the national average. Crowding in the Emergency Department remains an ongoing risk to patient outcomes and experience. The number of attendances increased by over 5% compared to August 2018; similarly ambulance conveyance rates increased by 4%.Whilst the number of admissions remained comparable with August 2018 there was a 154% increase in the in the number of breaches due to bed availability. Exit block is a well-recognised cause of ED crowding as delays with releasing physical capacity have a significant impact on the ability to assess and treat incoming patients. Ambulatory Emergency Care activity in August increased back to 28% of the emergency medical take during service hours which compares very well with the national average of the number of patients admitted as an emergency being managed through the Same Day Emergency Care type approach. The RTT constitutional standard was not achieved and the performance was below the trajectory (73.3% versus trajectory of 77.7%) and there were 4 breaches of patients waiting over 52 weeks for treatment in Trauma and Orthopaedics. A 50:50 cost sharing agreement has been agreed in principle with the Commissioners in order to mitigate potential future 52 week breaches and additional Orthopaedic capacity has been agreed with Yeovil hospital. Performance against 62 day cancer standard has declined compared with Q1; the latest finalised performance is for July 2019 at 72.70%. The decline in performance is driven by a significant increase in 2ww referrals; the size of the total cancer PTL has increased by 300 compared with August 2018, however the 62+ day backlog has decreased from 80 to 58 as a result of increased diagnostics and treatments. Performance against 6 week diagnostic standard decreased to 85.46% as there has been a further deterioration in Endoscopy due to significant staffing shortages. A Quality Impact Assessment has been undertaken and a short term fixed duration service prioritisation proposal is being progressed through the appropriate governance route. Insourcing arrangements with independent provider continue and provide marginal mitigation to the underlying capacity gap.

Main Performance Risks facing the Trust in 2019/20

Quality and Access risks:

- RTT overall waiting list and backlog continues to grow, there are four confirmed 52 week breaches as at the end of August 2019 in Orthopaedics with a risk of further breaches in Orthopaedics and Ophthalmology.
- The number of 2 week wait referrals continues to be above the levels of previous financial years.
- Increased demand and capacity gaps continue to impact overall delivery of performance standards and present a financial risk to the Trust
- Underperformance against 6 week diagnostic standard in Endoscopy remains a significant concern
- Crowding in Emergency Department presents a risk to patient outcomes and experience

Financial risks:

- The Trust has a shortfall of identified schemes against the annual CIP target of £1.8m which threatens the deliverability of the financial plan.
- Agency spending in August is £550k and the run rate has been consistently over £500k since the start of the financial year.
- This high level has been absorbed in the year to date, due to non recurrent slippage but this is not sustainable over the remainder of the year and places the financial control total at risk without corrective action.

Items from the Workforce Committee:

- The Trust will be the only NHS Trust working with the Duke of Edinburgh Gold Award Scheme.
- The volume of clinical learners and the pressures in September.
- The review of the Freedom to Speak up Guardian roles.
- The development of the Trust's microsite as part of the Trust's recruitment strategy.
- The GMC Survey results.
- Long term plan in respect of workforce.
- Pension consultation and proposed changes.
- There is a review of Whistleblowing arrangements and the role of the Freedom to Speak Up Guardian role is being considered as part of this.

Items from the Quality Committee:

- The positive GIRFT result for stroke.
- The SALT team and national recognition of changes to mouth care.
- Sustained results for infection prevention control.
- Sustained performance on complaints.
- DCH was the only Trust to achieve a 100% rating for the question relating to staff talking to children about their worries in the Children and Young People National Survey Results
- The Committee received the Trust's annual complaints report.
- The Committee received the results of the HTA review and action plan.
- Pressure ulcer guidance was accepted by the committee.
- There is more work to be done on completion of nutritional assessments, electronic discharge summaries and dementia screening.

Items from the Finance and Performance Committee:

- Work has been undertaken in key performance areas under pressure, ophthalmology, dermatology, max fax and orthopaedics.
- The Dorset long term plan and key timescales for submission and approvals were considered.
- The Committee reviewed the Trust's Winter Plan.
- The Committee reviewed changes to the Performance Oversight Framework.

Items from the Risk and Audit Committee:

- The committee reviewed the Trust's annual Emergency Preparedness, Resilience and Response Report.
- The BAF and Risk Register were reviewed.
- The Trust Board will receive an update on informatics later in the year.

Are we on track to deliver the 9 Must Dos?

	Metric	Met?
1	Produce a sustainability and transformation plan for the health economy	Yes
2	Return to "aggregate financial balance", deliver savings through the Lord Carter productivity programme and cap agency spend	Partially
3	Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.	N/A
4	Achieve waiting time targets for A&E patients and ambulance response times.	No
5	Improve and maintain performance against 18 weeks RTT target.	No
6	Deliver the 62 day cancer waiting time target including two week referral and 31 day treatment targets and make progress in improving one year survival rates by increasing the proportion of cancers diagnosed early.	No
7	Achieve and maintain the two new mental health waiting time targets.	N/A
8	Improve care for people with learning disabilities including improved community services and reducing inpatient facilities.	Yes
9	Develop and implement an affordable plan to make improvements in quality. In addition, providers will be required to publish avoidable mortality rates annually.	Partially

Key Performance Metrics Summary

	Metric	Standard	Jul-19	Aug-19
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	0	0 (0.0)	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	50% reduction by 2021	3 (0.3)	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	16	1 (0.1)	1 (0.1)
	Never Events	0	0	0
	Serious Incidents declared on STEIS (confirmed)	51 (4 per month)	3	0
	SHMI - Rolling 12 months, 5 months in arrears (Apr-18 to Mar-19)	<1.12	1.19	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Jun-18 to May-19)	100	108.7	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	92%	76.3%	73.3%
	RTT Incomplete Pathway Waiting List size	11,991	15,797	16,291
	All cancers maximum 62 day wait for first treatment from urgent GP referral	85%	71.3%	69.2%
	Maximum 6 week wait for diagnostic tests	99%	89.2%	85.5%
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	95%	91.6%	89.5%
Finance	Elective levels of contracted activity (£)	2019/20 = £30,721,866 £2,560,155/month	2,431,310	2,431,310
	Surplus/(deficit) (year to date)	2019/20 = Breakeven YTD M5 = (3,434)	(2,418)	(3,064)
	CIP - year to date (aggressive cost reduction plans)	2019/20 = 7,130 YTD M5 = 1,794	1,353	1,852
	Agency spend YTD	2019/20 = 2,929 YTD M5 = 1,087	2,043	2,619

Rating Key

Achieving Standard

Not Achieving Standard

INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain

Safe

- There have been no Never Events year to date
- Infection Prevention and Control indicators have been sustained
- Falls and Pressure Ulcer risk assessments have been above the standard required
- **MRSA Screening** –Non- Elective Elderly Care and Cardiology.
- **Falls –** There were 2 falls reported during this month which resulted in severe harm. 1 was an unwitnessed fall of a patient known to be high risk of falls (all action were in place). The second fall related to a patient who mobilised out to the toilet with crutches and bent to pick something up off the floor.
- **Sepsis:** Data not available for ED August.
- **VTE Risk assessment:** The standard has not been achieved. Medical Director is leading a piece of Quality Improvement to implement changes in prescribing to enable sustained improvement
- **Nutritional Assessments –** The standard has consistently not been achieved. This has now been identified as a key area requiring focus from the ward leaders and matron team. Director of Nursing & Quality is leading a piece of Quality Improvement work to enable a sustained improvement. QI group to be established in October post some initial baseline analysis.

Effective

- Sepsis screening and antibiotic administration has improved in inpatient areas
- The number of home births has consistently achieved higher than the standard required and the national average
- **SHMI:** Hospital Mortality Group monitors unpublished SHMI. The dashboard reflects the nationally published SHMI data, next available at the end of September.
- **Stroke & TIA**: Further information in Divisional report.
- **Fracture Neck of femur** – Improvement noted compared last month. Further Information in Divisional Report
- **Dementia**: Standards required are consistently not being achieved. Medical engagement and support by the medical director with daily exception reports to the Medical Director from the Specialist nurse resource.
- **EDS:** Remains below the standard required. Medical Director leading with the Divisional Director Quality Improvement to meet this standard

Caring

- Timeliness of complaint responses has been sustained above the standard required
- **Mixed sex breaches** – All breaches relate to the timely discharge of patients from the Critical Care area to suitable ward beds. This standard has been discussed with the CCG, a further paper will be taken to the Quality Surveillance Group for discussion.
- **Friends and Family Test** – There has been a slight deterioration in the recommendation rates for the Emergency Department; general theme relates to waiting times.

Responsive

The access standards for August 2019 remained challenging with increased emergency activity including trauma, increased elective cancellations and sustained high levels of fast track referrals.

The following standards were met:

- Cancer 31 day diagnosis to first treatment
- Cancer 31 day from decision to treat to anti-cancer drug treatment
- Cancer 31 day Subsequent treatment

Standards not met:

- ED- 4 hour standard combined with MIU
  - Reduction in the numbers of stranded and super stranded patients; executive led long stay PTL meetings have been established
  - System wide work ongoing on demand management and expediting of complex discharges
  - Recruitment to key posts in Emergency Department to improve out of hours resilience
  - Embedding of Integrated Urgent Care and Same Day Emergency Care
  - Implementation of recommendations from peer reviews
- Cancer 62 days referral to treatment
  - Urology, Lung and Colorectal remain the main underperforming specialties
  - Weekly tracking meeting taking place chaired by COO
- Cancer 2 week wait - all cancers and breast symptomatic
  - Significant month on month growth in fast track referrals, in particular breast, skin and colorectal
  - Private sector capacity for 2week wait breast appointments has been identified and utilised
  - Following a successful pilot super clinics have been established in Dermatology
  - Daily capacity escalation
  - Additional ad-hoc clinics and conversion of routine capacity to fast track
- RTT
  - 50:50 cost share agreed in principle with commissioners to resource additional capacity for potential 52 week breaches
  - Agreement reached for 20 Interprovider transfers per month between DCH and Winterbourne in Ophthalmology
  - RTT recovery programme launched on 12/09/19
- Diagnostic 6 week wait
  - Significant improvement in performance for audiology, DEXA scanning and neurophysiology
  - Ongoing insourcing of capacity for endoscopic procedures from an independent provider
  - Service prioritisation proposal progressing through the appropriate approval route

Well Led

The Trust delivered a year to date deficit in the five month period to August of £3.1m which is £0.4m better than plan, although £0.2m of this variance relates to additional Provider Sustainability Funding received in relation to last year, which will not count against the current year control total. Agency spend levels increased in month to over £550k for the first time, and the arrears of the recent medical pay award has contributed to the overall pay budget now over performing by nearly £0.6m. Current levels of demand continue to be high and have led to extra capacity provision which is driving over performance on patient care contracts which has ensured that the Trust remains close to the financial plan in total.

There was an increase of 38 FTE in the substantive workforce capacity in M5, which was primarily a result of junior doctor rotation timing. Additionally we saw an increase of 6 FTE in bank usage. There has been a corresponding increase in substantive workforce cost; up £326 which primarily relates to increases in the specialty trainee medical staff group as a result of deanery rotations. Agency spend increased by £30k in M5. This increase was primarily attributable to increased usage of RNs which was required due to reduced take up of bank shifts. The overall costs were offset by a £34k reduction in consultant agency spend. Sickness levels increased by 0.43% in M4 with increases in both long and short term absence. There was a 1% decrease in appraisal rates and essential skills training compliance remained at 87% for the 7th consecutive month.

Metric	Threshold/ Standard	Type of Standard	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Q1	Q2	YTD	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)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff hospital acquired post 72 hours - Due to lapses in care (Rate per 1000 bed days)	**13**	Contractual (National Quality Requirement) 2018/19	0 (0.0)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	Contractual (National Quality Requirement) 2019/20	N/A	1 (0.1)	**2 (0.2)**	1 (0.1)	1 (0.1)	1 (0.1)	4 (0.2)	2 (0.1)	5 (0.1)	↔	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	97.5%	**94.1%**	**93.4%**	96.0%	95.4%	**93.6%**	**94.4%**	**94.3%**	**94.4%**	↓	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	1	0	0	1	1	0	1	1	2	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	0	1	0	0	0	0	1	1	1	**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	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	**3**	**4**	**5**	**5**	**5**	**12**	**12**	**22**	↔	
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)	**2 (0.2)**	0 (0.0)	0 (0.0)	**2 (0.2)**	2 (0.1)	**2 (0.1)**	4 (0.1)	↓	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.0)	↑	
Emergency caesarean section rate			14.1%	11.2%	13.6%	14.3%	16.4%	20.8%	13.2%	18.7%	15.5%	↓	
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)	**75.6%**	92.5%	**71.7%**	91.9%	**70.9%**	N/A	**84.6%**	**70.9%**	**80.3%**	↓	
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)	**84.0%**	92.2%	94.4%	97.4%	93.4%	100%	94.4%	95.9%	95.1%	↑	
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)	**87.0%**	91.3%	**86.2%**	**87.5%**	**77.5%**	N/A	**77.6%**	**77.5%**	**77.6%**	↓	
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)	**73.2%**	**78.0%**	**75.0%**	**85.3%**	**85.7%**	**87.9%**	**79.6%**	**86.4%**	**83.0%**	↑	
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)	**1**	N/A	N/A	N/A	N/A	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]	**<1.12 (ratio between observed deaths and**	Contractual (Local Quality Requirement)	**1.19**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**112.2**	**109.9**	**108.7**	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**105.9**	**102.2**	99.1	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	C	N/A	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)	**60.5%**	**62.8%**	**64.3%**	**47.0%**	**38.7%**	**28.4%**	**57.9%**	**33.2%**	**53.3%**	↓	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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)	**51.2%**	**86.4%**	**62.9%**	**62.5%**	**73.3%**	**40.0%**	**68.5%**	**65.0%**	**69.2%**	↓	
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	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	28	30	29	24	26	40	83	66	149	↓	
Complaints - Percentage response timescale met (1 month in arrears)	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	97.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	99.5%	98.4%	98.5%	98.7%	97.8%	**95.2%**	97.8%	96.8%	97.5%	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	85.0%	**82.3%**	84.5%	**83.0%**	**82.8%**	**80.4%**	**82.5%**	**81.5%**	**82.2%**	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	94.6%	**91.7%**	94.5%	**93.9%**	94.4%	94.1%	**93.8%**	94.3%	**93.9%**	↓	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**18**	**22**	**18**	**14**	**17**	**10**	**54**	**27**	**81**	↓	

Metric	Threshold/ Standard	Type of Standard	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Q1	Q2	YTD	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)	**76.1%**	**75.1%**	**76.6%**	**76.0%**	**76.3%**	**73.3%**	**76.0%**	**73.3%**	**73.3%**	↓	
RTT Incomplete Pathway Waiting List size	**11,991**		**14,532**	**15,179**	**15,189**	**15,135**	**15,797**	**16,291**	**15,135**	**16,291**	**16,291**	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**80.2%**	**68.8%**	**61.8%**	**75.5%**	**65.0%**	**59.0%**	**68.2%**	**61.9%**	**65.6%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**21.9%**	**3.6%**	**4.5%**	**37.5%**	**0.0%**	-	**8.6%**	**0.0%**	**8.5%**	↓	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**96.0%**	**94.7%**	97.6%	98.7%	**95.9%**	97.7%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	**88.9%**	100.0%	100.0%	100.0%	**81.8%**	**62.5%**	100.0%	**73.7%**	**88.1%**	↓	
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%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	-	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**79.5%**	**84.0%**	**81.6%**	**81.7%**	**71.3%**	**69.2%**	**82.4%**	**70.4%**	**82.4%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	100.0%	94.1%	92.9%	**72.7%**	**69.6%**	**56.3%**	**88.1%**	**64.1%**	**88.1%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**89.9%**	**88.2%**	**89.0%**	**90.3%**	**89.2%**	**85.5%**	**89.2%**	**87.4%**	**88.5%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**82.8%**	**78.3%**	**90.4%**	**85.9%**	**82.1%**	**77.2%**	**84.8%**	**79.7%**	**82.7%**	↓	
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)	**91.5%**	**89.5%**	95.5%	**93.3%**	**91.6%**	**89.5%**	**92.8%**	**90.6%**	**91.8%**	↓	
Well Led													
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		50.86%	36.21%	46.55%	43.97%	46.55%	N/A	N/A	N/A	N/A		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	3.1%	3.2%	3.0%	3.1%	3.55%	N/A	3.10%	3.55%	3.20%	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	87%	88%	88%	88%	87%	86%	88%	87%	87%	↓	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.5%	8.8%	8.8%	8.9%	9.3%	9.7%	8.8%	9.5%	9.1%	↓	
Total Workforce Capacity	**2,650.8**	Internal Standard reported to FPC	2,376.4	2,392.9	2,423.1	2,430.4	2,455.0	2,442.9	2,415.5	2,448.9	2,428.8	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	3.0%	**6.1%**	4.9%	**7.6%**	**6.3%**	**7.8%**	N/A	N/A	N/A	↓	
Total Pay Cost	**10,442.1**	Internal Standard reported to FPC	9,991.1	9,583.1	9,287.4	9,181.3	9,391.5	9,717.9	9,350.6	9,554.7	9,432.2	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	0	2	0	0	0	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	87%	87%	87%	87%	87%	87%	87%	**87%**	87%	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		2,512	**2,328**	**2,378**	**2,350**	**2,406**	**2,180**	**7,056**	**4,586**	**11,642**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		£2,573,187	**£2,220,576**	**£2,331,554**	**£2,429,480**	**£2,431,310**	**£2,233,744**	**£6,981,610**	**£4,665,054**	**£11,646,664**	↓	
Surplus/(deficit) (year to date)	**2019/20 = Breakeven YTD M5 = (3,434)**	Local Plan	**(8,029)**	(879)	(1,536)	(1,972)	(2,418)	(3,064)	(1,972)	(3,064)	(3,064)	**N/A**	**N/A**
Cash Balance	**2019/20 - 1303 M5 = 6,553**		3,536	7,738	8,348	7,700	10,988	12,714	7,700	12,714	12,714	↑	
CIP - year to date (aggressive cost reduction plans)	**2019/20 = 7,130 YTD M5 = 1,794**	Local Plan	**5,060**	379	**692**	**971**	**1,353**	1,852	**971**	1,852	1,852	**N/A**	**N/A**
Agency spend YTD	**2019/20 = 2,929 YTD M5 = 1,087**		**4,160**	**482**	**970**	**1,502**	**2,043**	**2,619**	**1,502**	**2,619**	**2,619**	**N/A**	**N/A**
Agency % of pay expenditure	**2019/20 = 2.3%**		**5.5%**	**4.5%**	**4.7%**	**4.8%**	**4.9%**	**4.9%**	**4.8%**	**4.9%**	**4.9%**	↔	

Movement Key

Favourable Movement ↑
Adverse Movement ↓
No Movement ↔

Achieving Standard
Not Achieving Standard

Title of Meeting	Board of Directors
Date of Meeting	25 September 2019
Report Title	Board Assurance Framework
Author	Paul Goddard, Director of Finance and Resources
Responsible Executive	Paul Goddard, Director of Finance and Resources

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

Summary

1. 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.

2. The principle risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix.

3. The summary position of the BAF continues to highlight the Sustainable and Outstanding Services strategic objectives as the two which are most at risk of delivery.

4. A comprehensive review of the BAF was undertaken in July 2019. The attached BAF has been through a further review by the collective Executive Management team to consider the current risk rating and whether the controls and assurances are still current and relevant.

5. The following section outlines the material changes made to the BAF (but all changes are marked in Red text):

1. **Outstanding: Delivering outstanding services every day.**

   The specific Risk on SHMI has been subsumed into Risk 2 and the wording changed to reflect this.

2. **Integrated: Joining up our Services.**

   Some refreshes to the risk scores of Risk 1 and Risk 6 and some wording changes to some risks and controls.

3. **Collaborative: Working with our patients and partners.** Some wording changes to some risks and controls and the Dorset Care record risk has been transferred in from Strategic Objective 4 (see below). 4. **Enabling: Empowering Staff.** The Dorset Care record risk has been transferred to Strategic Objective 3 (Collaborative). A new control has been included (C6) identifying the clinical leadership programme which mitigates the clinical leadership risk. 5. **Sustainable: Productive, effective and efficient.** Changed the RAG rating of the strength in the reporting mechanisms to reflect the strength of delivery.
Paper Previously Reviewed By Executive Management Team Risk and Audit Committee, 17 September 2019
Strategic Impact 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 Evaluation Each risk item is individually evaluated using the current Trust Risk Matrix.
Impact on Care Quality Commission Registration and/or Clinical Quality It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Governance Implications (legal, clinical, equality and diversity or other): 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.
Financial Implications The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.

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

Recommendations	The Board are requested to: • review the Board Assurance Framework; and • note the high risk areas and actions

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: September 2019

Summary Narrative

The most significant risk which could prevent us from achieving our strategic objectives is not being **SUSTAINABLE.**

Whilst the current financial position is marginally better than plan, delivery of the year end control total is at risk given current run rates and the CIP gap of c£2m. The strength of assurance for this objective continues to be Red.

There is also a high risk in ensuring we have **OUTSTANDING** services as we may not have the appropriate workforce in place to deliver our patient needs. We have seen an increasing risk due to the increased dependancy on the use of temporary clinical staff and the difficulties in keeping within the regulator ceiling for agency staff.

There is a moderate risk in the strength of controls on ensuring we have **INTEGRATED** services that ensure the redesign of the discharge pathway for complex patients and demand for secondary care services does not 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.	**6-12**	**G**	**G**
4. Enabling: Empowering Staff. We will engage with our staff to ensure our workforce is empowered and fit for the future.	**4-12**	**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.	**9-16**	**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	NL	3	3	**9**	6
R2	Failing to be in the top quartle 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	3	**9**	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 worforce in place to deliver our patient needs	MW	4	5	**20**	12
R6						

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
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	Quality Committee reports on CQC, CQC Provider Information Collection & Insight data, CQC quarterly meetings. Dorset Quality Surveillance meeting in place that reviews hard and soft intelligence	G
C2	Performance monitoring and management of key priorities for improvement in quality and safe care (R2)	G	Divisional exception reporting and monitoring of quality improvement plans, SHMI and KPIs via The Quality Committee, alongside safety visits (NEDs) 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 .	G
C3	Quality improvement plans within Divisions and key workstreams 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	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 to be presented at July 2019 Trust Board.	G
C5	Emergency Preparedeness 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 aginst EPRR core standards ratified by Local Health Resiliance Partnership.	G
C6	Establishment of a Resourcing Operations Group. Monthly review of vacancies at Workforce Committee and SMT and tracking of junior doctor exception reports. (R5)	A	We review safe staffing through Board reports; junior doctor workforce issues through the GOSW reports; vacancy levels through the Workforce Committee and Board workforce reports; develop strategic solutions through the Resourcing Operations Group.	A
C7	People Strategy published May 2018. (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 gap - plan to address with increased resources. Dorset Workforce Action Board partner and	A
C7	Scrutinising other care quality indicators to assure standards of care (R6)	A	Regular reports to Hospital Mortality group , Quality Committee and Board	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 recevied that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	Internal Audit of CQC action plan and assurances. November 2018 CQC rating as 'Good'.	KPMG audit report and published CQC report
C2	Internal Audit of Medicines management	KPMG audit report
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
C8	NHSI regular scrutiny and support (R6)	NHSI visit and report April 2019

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...

E.g. No surgial safety checklist in place (gap in control) or hand hygene 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, which may result in some services not being reviewed to enable an 'outstanding' rating	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.
ISSUE 2		**ACTION**
	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.
ISSUE 3		**ACTION**
C5	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.
ISSUE 4		**ACTION**
	Inconsistent application of the Performance framework within the Divisions leading to failure to pick up early warnings of deteriorating performance	
ISSUE 5		**ACTION**
	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.
ISSUE 6		

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
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. (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 recevied 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 surgial safety checklist in place (gap in control) or hand hygene 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		G
		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	MW	3	2	**6**	4
R5	Not achieving a Dorset wide integrated electronic shared care record	SS	3	4	**12**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
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	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)	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 pplicable	G
C5	Investment in DCH workforce planning team. DWAB resourced Dorset wide workforce planning capacity to co-ordinate (R4).	G	Regular reports considered at DWAB and escalated to Workforce 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 Dorset CCG Director of Transformation. (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		A

D) We have actually received these POSITIVE ASSURANCES...		
Add actual assurances recevied 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 surgial safety checklist in place (gap in control) or hand hygene 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	Communciaiton 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	MW	2	4	**8**	6
R2	Not benefitting from the successful delivery of our People Strategy	MW	4	2	**8**	6
R3	Failure to deliver flexible and appropriate support service models	Exec team	3	4	**12**	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	MW	4	1	**4**	4
R6	Lack of medical leadership in senior management positions	AH	3	4	**12**	9

B) We will CONTROL these risks by...		**Strength**	**C) The REPORTING MECHANISM...**	**Strength**
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	Appointment of OD Manager to focus on Organisational Culture. Diversity and Inclusion/ Wellbeing Manager appointed to provide a dedicated resource to this agenda. Divisional champions to be identifed to ensure local action plans developed and discussed. (R1)	A	Quarterly Family & Friends test results reported to the Workforce Committee. Staff Survey action plan presented to Board. Review of Equality & Diversity associated issues at Equality & Diversity Steering Board.	A
C2	People Strategy approved at May 2018 Trust Board. (R2)	G	Workforce committee formed October 2018 to consider and report progress against people Strategy.	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 clincal 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 FPC as necessary. (R5)	G	Medical Education update provided at Workforce Commitee. GMC junior doctor survey presented to board annually.	G
C7	Ensure a clinical leadership program is in place and appropriate delegates attending. (R6)	G	Reporting through Workforce Committee	G
Overall Strength		G		A

D) We have actually received these POSITIVE ASSURANCES...

Add actual assurances recevied 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 guage. Recently formed Medical Engagament Forum too early to assess impact (R2).	Review effectivement 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	4	4	**16**	12
R2	Failing to be efficient as outlined in the Model Hospital	PG	3	3	**9**	9
R3	Not generating 25% more commercial income with an average gross profit of 20%	NJ	2	5	**10**	8
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
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 financial sustainability strategy requires updating in line with Long Term Plan and Financial Recovery Funding requirements.	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.	A
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.	A
C4	Commercial Group reviews income against metrics, overseen by Better Value Better Care Group (R3)	A	Financial reporting mechanisms at commerciaL group 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.	R
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 due to be 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 which governs the allocation and management of funding across the system	A	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	R
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 report 17/18 gave significant assurance with minor improvements. (R1) and (R2).	KPMG audit report
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) 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 >1 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 breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required inadequateperformance 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

Title of Meeting	Board of Directors
Date of Meeting	25 September 2019
Report Title	Corporate Risk Register
Author	Mandy Ford, Head of Risk Management and Quality Assurance
Responsible Executive	Nicky Lucey, Director of Nursing and Quality

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

Summary

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 monthly by the Service Manager and the Head of Risk Management.

The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.

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 monthly with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.

Risks were categorised as 'managed or within tolerated risk appetite' as detailed in the previous two Risk and Audit Committee have now been closed.

RISK RATING:
Financial Sustainability – NO CHANGE (This risk is not due to be reviewed again until the end of QTR 2).

Previous update: July 2019.
There is a gap of £2m from the full year CIP target and current agency spend levels, whilst affordable currently given non recurrent benefits, it is not expected that this will continue. Remedial actions are being considered.

Recruitment and retention of Medical staff across specialities - NO CHANGE (This risk is not due to be reviewed until 30.10.19)
Previous update: July 2019

To mitigate this we have:

- *We have proactively recruited F3 posts, and WAST posts to mitigate risk of gaps in Foundation Doctors.*
- *We now provide training for undergraduate physician associates which we hope will provide a source of future recruitment.*

- *We have reopened the associate specialist grade.*
- *We are reviewing skill mixes to reduce pressure on medical workforce.*
- *We also subscribe to LocumsNest to provide medical bank staff*

Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff - NO CHANGE (This risk is not due to be reviewed until 30.10.19)
Previous update: July 2019

To mitigate this we have:

- *We have contracted with a new supplier to deliver international registered nurses.*
- *We have increased resources for temporary staff and bank team*

- *We have increased recruitment events, participating and arranging.*
- *Developed different recruitment marketing tools including a Trust micro site and greater use of social media.*
- *Reviewed employer branding.*
- *We have invested in a workforce planning capability to consider longer term actions to mitigate staff shortages, actions.*

EMERGING:

- Availability of medical workforce resulting from pension taxation pressure

Reviewed with Mark Warner 30.08.19 – Established current risk level is Low (6)

Risk Statement:
*'*Changes in pension taxation rules came in to force 3 years ago. However the effects of these are now being seen across high earners within the NHS. This relates to lifetime allowance and annual allowance Regulations, and impact staff members earning above certain thresholds. The implications of this have been that consultants have indicated a desire to reduce their working commitments and a reluctance to accept additional work. This has impacted our workforce capacity and has the potential to create further capacity pressures.'

Supporting information:
This is a national issue and has become very high profile across the NHS and within Government.

Progress as at 30.08.19:
In 2018 the Trust agreed an alternative pension contribution policy, which allowed staff members breaching pension thresholds to opt out of the NHS pension scheme and receive a cash alternative in relation to the employer contributions. Nationally, a number of options are being consulted on, including one similar to the policy we have agreed.

Individual requests from consultants to reduce work capacity are being considered on an individual basis in line with Trust policy for changes to contractual terms and conditions (e.g. hours of work).

DIVISIONAL LEVEL EMERGING RISKS
Urgent and Integrated Care Division

- ED Estate (Currently rated as 20 (EXTREME) on the Divisional risk register and unlikely to be managed at Divisional Level).

Details of Risk:
Insufficient physical capacity within the ED to meet activity levels, including insufficient resus capacity, insufficient treatment/assessment capacity, and non-compliant mental health assessment area, leading to delays in offloading patients, breaches due to lack of assessment/treatment space, risk of patients being treated in inappropriate spaces (i.e. resus in majors, majors in minors).

Despite works completed in 2018/19 to increase treatment capacity by 1-2 spaces plus one additional triage space and improved compliance with mental health assessment requirements, the department remains significantly too small to meet the activity levels currently seen. (Built for c. 22,000 attendances per year, currently at c. 47-48,000 p.a.).

We are seeing an increasing number of incidents reported, and investigations via the Corporate Learning from Incident Panels to evidence that the space issue and patients being seen in inappropriate spaces is impacting on patient and staff safety.

The service is seeing over double volume of patients (48K). Currently we are able to manage between 100 and 135 patients per day through the service, however, we are consistently seeing more patients via ED and we remain escalated in almost all areas.

Plans have been made to extend the space which is currently out for consultation.

MITIGATION:

Escalation protocol linked to seasonal and surge planning
Start Date: 25.07.19 Due date: 13.09.19
Review of existing Departmental and Divisional policies, to include clear guidance related to surge and capacity management in the ED, including: Queuing out, queue management, rapid transfer to identified beds, FAB bay, escalation capacity management, use of SDEC capacity, and Stranded/Super-Stranded patient management.

ED capacity and Demand modelling
Start date: 25.07.19 Due date: 30.09.19
Working with ECIST, review Capacity and Demand modelling for the ED looking at a) Decision Maker capacity, b) physical capacity, and c) (potential) nurse staffing.

Ensure that ED Rebuild remains part of Estates Masterplan
Start date: 01.03.19 Due date: 31.03.20
Full departmental rebuild is likely the only way to fully resolve these risks. Manager to continue to liaise with colleagues in Estates to lobby for departmental rebuild to remain a priority in the estates masterplan for the Trust.

Awaiting updates of actions due for completion 30.08.19:

- Cross divisional management of patient pathways through ED
- Review of Risks associated with ED capacity, to triangulate risk rating of "extreme"

Family Services and Surgical Division
None additional identified to those previously reported.

MITIGATING ACTIONS:

It should be noted that many of the mitigating actions have had to be aligned to the strategic Board Assurance Framework as being able to mitigate a number of the risks is reliant on achieving financial sustainability to ensure that we have enough staff to deliver services to meet the demands on the services, both within the wards and in specialities. Recruitment and retention of permanent staff, thus reducing the amount spent on agency and locums, will be reliant on the success of recruitment and retention programmes.

In order to be realistic with our risk register, many of the dates for mitigating the risks, or accepting them within our risk appetite, will be longer term rather than shorter term plans.

FOR NOTE:

This is the first review of this paper, when this is discussed with the Executive Team it is likely to be subject to change. The Executive Team are currently reviewing and reframing the Board Assurance Framework, which when finalised will need to be reflected within the Risk Registers. This report details where we are as an organisation as at 06.09.19.

Paper Previously Reviewed By
Risk and Audit Committee, 17 September 2019

Strategic Impact
The Risk Register 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 Evaluation
Each risk item is individually evaluated using the current Trust Risk Matrix.

Impact on Care Quality Commission Registration and/or Clinical Quality
It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.

Governance Implications (legal, clinical, equality and diversity or other):
The Risk registers highlights that risks have been identified and captured, that have been escalated from within the Divisions or affects the Trust's strategic objectives. The Document provides an outline of the work being undertaken to manage and mitigate each risk.

Financial Implications The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	The Board are requested to: • review the current Corporate Risk Register ; and • note the high risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances

Corporate Risk Register

The Risk Items on the Corporate Risk Register have been reviewed by the appropriate risk leads and the Executive Team.

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31/03/2020	Extreme (20)	Extreme (20)	Very low (2)	474	Review of Co-Tag system and management of issuing/retrieving tags to staff	The door access system is unstable and due to its age and condition is at the end of its useful life. The Trust is experiencing regular failures of the system causing operational disruption to users and Information Governance concerns.	30/08/2019	Matt Chivers 22/08/2019 15:50:35	Finance	Estates Department	**Strategic Objective 5**: **Sustainable** Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** Tender process underway. Technical details for electrical supplies being finalized ready for imminent tendering (separate work package).
31/03/2020	Extreme (20)	Extreme (20)	Low risk (6)	641	Clinical Coding	Poor clinical coding can result in:- - Failure to optimize legitimate income - lack of adequate information to support resource management and business planning - inaccurate reflection of Trust performance and quality of care (e.g. SHMI)	31/08/2019	Mandy Ford 18/07/2019 13:56:19	Finance	Information	**Strategic objective 1: outstanding** failing to be in the top quartle 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. **MITIGATION:** Recruitment of new coders has taken place and they are currently receiving their training which is due to be completed by September 2020. The longer term plan is for coders to sit with clinicians to complete the coding to ensure that the coding is correct and that

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
											we can maximise legitimate income to assist with the financial sustainability.
31/03/2020 	Extreme (20)	Extreme (20)	Moderate risk (12)	468	Recruitment and **retention** of Medical staff across specialities	Recruitment and retention of Medical staff across specialities	31/10/2019	Mandy Ford 28/06/2019 15:36:25	Workforce and Human Resources	Across all specialties	**Strategic Objective 4** : **Enabling:** Failure to deliver flexible and appropriate support service models, Loss of training status for junior doctors, Not achieving a Dorset wide integrated electronic shared care record, Not achieving a staff engagement score in the top 20% nationally, Not being an exemplar site for clinical research and innovation, Not benefitting from the successful delivery of our People Strategy **Mitigation:** We have proactively recruited F3 posts, and WAST posts to mitigate risk of gaps in Foundation Doctors. We now provide training for undergraduate physician associates which we hope will provide a source of future recruitment. We have reopened the associate specialist grade. We are reviewing skill mixes to reduce pressure on medical workforce. We also subscribe to LocumsNest to provide medical bank staff.

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31/03/2025	Extreme (20)	Extreme (20)	Low risk (9)	709	Failure to achieve constitutional standards (elective Care)	The Trust is current not achieving constitutional standards in : 18 Week RTT Diagnostic standards - 6 weeks Cancer Standards (2 week wait and 62 day standard) ED standards	31/10/2019	Mandy Ford 12/07/2019 15:34:49	Director of Operations		**Strategic Objective 1** : **Outstanding:** Failing to be in the top quartle 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% **Mitigation:** The relevant service have individualised management plans to mitigate the risks for meeting standards, however, without appropriate staffing and service capacity to deliver these, it will be difficult to achieve in all areas. These are being monitored by service, caregroup and divisions.

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31.03.2025	Extreme (20)	Extreme (20)	Low risk (9)	710	Follow up waiting list backlog	Failure to ensure that patient's are followed up according to their clinical needs and presentation.	31/10/2019	Mandy Ford 12/07/2019 15:37:31	Director of Operations	Across all specialties	**Strategic Objective 1 : Outstanding** Failing to be in the top quartle 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. **Mitigation:** The relevant service have individualised management plans to mitigate the risks for meeting standards, however, without appropriate staffing and service capacity to deliver these, it will be difficult to achieve in all areas. These are being monitored by service, caregroup and divisions.

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31.03.2025	Extreme (20)	Moderate risk (16)	Low risk (9)	449	Financial Sustainability	An unsustainable financial position could result in a reduced quality of both clinical and support services and reduce the autonomy the Trust has in providing high quality services to its population.	31/10/2019	Mandy Ford 10/07/2019 14:12:02	Finance	Finance	**Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital, Failure to secure sufficient funding to ensure financial sustainability, Not generating 25% more commercial income with an average gross profit of 20%, Not returning to financial sustainability, with an operating surplus of 1% and self-sufficient in terms of cash, Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** There is a gap of £2m from the full year CIP target and current agency spend levels, whilst affordable currently given non recurrent benefits, it is not expected that this will continue. Remedial actions are being considered.
31/03/2020	High risk (16)	High risk (16)	Moderate risk (12)	450	Emergency Department Target, Delays to Care & Patient Flow	Inconsistent achievement of the 4-hour standard, caused by crowding, high attendance numbers, insufficient bed/assessment unit capacity, and staffing challenges, leading to external regulator scrutiny, impact on overall performance (linked to PSF package), ambulance handover delays, and patient safety risks.	30/08/2019	Jennifer Frampton 2 5/07/2019 17:04:41	Unscheduled Care (A3)	ED - Majors Service	**Strategic Objective 1: Outstanding** Failing to be in the top quartle 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% **Mitigation:** FAB Bay – formal project due for completion 30.09.19 Improved time to initial assessment, improved ability to direct patients to assessment areas following rapid senior

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
											assessment, improved clinical outcomes. 1) proposal to be developed re: fixed term trial, to include staffing required and clearly defined metrics, for a 4-6 month trial; 2) costings to be established; 3) consideration given to using slippage while Divisional business developments are implemented to fund the trial
31/03/2025	High risk (15)	High risk (15)	Moderate risk (12)	463	Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff	Inability to source appropriately skilled and competent staff to meet requirements for Nursing, Allied Health Professional and Health Science staffing	31/10/2019	Mandy Ford 12/07/2019 15:46:33	Workforce and Human Resources	Across all specialties	**Strategic objective 1 : Outstanding** Not having the appropriate worKforce in place to deliver our patient needs **Mitigation:** We have contracted with a new supplier to deliver international registered nurses. We have increased resources for temporary staff and bank team We have increased recruitment events, participating and arranging. Developed different recruitment marketing tools including a Trust micro site and greater use of social media. reviewed employer branding. We have invested in a workforce planning capability to consider longer term actions to mitigate staff shortages, actions.

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31/03/2020 ↑	Moderate risk (10)	Very low (4)	Very low (4)	682	Personnel files (Non Medical) not being stored centrally	There is a risk that the personnel files for non medical staff are not being maintained and stored centrally. There is a risk to the files being lost or misplaced when staff or managers move or being stored securely which is a risk to confidentiality. There are potential inconsistent standards to which the files are being maintained.	31/10/2019	Mandy Ford 18/07/2019 13:47:19	Workforce and Human Resources	Human Resources	**Strategic objective 1 : Outstanding** Not having the appropriate worKforce in place to deliver our patient needs **Mitigation:** There is guidance available on how to maintain a personal file. The alternatives are to centrally store personal files which would require space and facilities. The preferred option would be to move to electronic personal records. We will include this in the business planning process as it was hoped this could be covered through the DPR project, however this is now not possible.
31/03/2020 ↓	Moderate risk (12)	High risk (15)	Very low (4)	470	Fire Door Maintenance	A significant number of fire doors throughout the site are no longer compliant and may not perform as designed in the event of a fire.	31/10/2018	Matt Chivers 22/08/2019 15:37:57	Finance	Estates Department	**Strategic objective 5: Sustainable** Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** Recent works have concentrated on revalidation of previously surveyed and repaired fleet. Repair works to continue according to surveys.

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31/03/2020 	Moderate risk (12)	High risk (15)	Low risk (6)	698	Maintaining Business Continuity Management Arrangements	Risk Event - any issues that affects buisness continuity without adequate BC plans in place to mitigate or minimise the disruption. Cause - as above Impact - Significant impact on health systems being unable to cope with the disruption.	04/07/2020	Mandy Ford 29/07/2019 14:42:24	Director of Operations	Emergency Planning	**Strategic objective 1: Outstanding**: Not having effective Emergency Preparedness, Resilience and business continuity plans **Mitigation:** A number of revised BCPs have been updated and submitted for review. The list is kept up to date on SharePoint.
31/03/2020 	Moderate risk (12)	Low risk (9)	Low risk (9)	464	Mortality Indicator	An increased Summary Hospital Mortality Indicator (SHMI) may indicate increased in-patient mortality, and/or a failure to code correctly patients admitted to DCH or a combination of the two.	31/10/2018	Mandy Ford 17/05/2019 14:28:51	Medical Director		**Strategic objective 1: Outstanding** : Failing to be in the top quartle of key quality and clinical outcome indices for safety and quality **Mitigation:** Clinical coding has had difficulty in recruiting for experienced level posts. After failing to do so four times, a decision has been made to take on an increased number of high caliber trainees. Due to the long training time for coders, even with higher caliber candidates, this still means that improvements to quality of coding will not come in to play for anything up to a year. The first benefit of an increased workforce will be the increase in number of cases that can be coded from full case notes. (This leads to increase in co-morbidity capture which tends to have a beneficial impact on relative risk). We may also see an improvement in terms of allocation of cases to diagnostic groups through work with the new Medical Examiners

TARGET DATE TO MEET TARGET RISK LEVEL:	Risk level (current)	Previous current risk level	Risk level (Target)	ID	Title	Risk Statement	Review date	Last updated	Care Groups	Service of responsibility	Principle Risk - Collaborative: Joining up our services
31/03/2020	Moderate risk (12)	Extreme (20)	Low risk (8)	454	Quality and Timeliness of Electronic Discharge Summaries	Potential for impact on post-DCH patient care and reputational impact due to incomplete, inaccurate or delayed electronic discharge summaries arising from lack of embedded EDS process	01/09/2019	Mandy Ford 19/01/2019 14:16:18	Director of Nursing	Across all specialties	**Strategic objective 1: Outstanding** Failing to be in the top quartle 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 **Mitigation:** The challenges to clear the backlog remain the same. Capacity across all areas, including administration resource to go through the backlog and order notes, super-user/ICE system manager capacity to cleanse the data of user errors, medical records capacity to provide the notes and Junior Doctor capacity to complete, which is especially challenging in times of operational pressures. Whilst there are still some process issues being worked through, the quality and risk impact continues to be reduced as a result of the work to date.

Table 1 Consequence Scores (C)

Choose the most appropriate domain for the identified risk from the left hand column on the table. Work along the columns in the same row to assess the severity of the risk on a scale of 1-5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**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/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution 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 Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) 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 Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
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
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
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
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

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
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
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?
The 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 **Not expected to happen for years**	Do not expect it to happen/recur but it is possible it may do so **Expected to occur at least annually**	Might happen or recur occasionally **Expected to occur monthly**	Will probably happen/recur but it is not a persisting issue **Expected to occur weekly**	Will undoubtedly happen/recur,possibly frequently **Expected to occur daily**

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	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

Risk	Remedial Action Lead	Decision to Accept or Close a Risk	Risk Register level	Risk Register Type
V.Low	Ward sister	Senior Sister / Matron	Care Group	Ward/Department
Low	Ward sister	Senior Sister / Matron	Care Group	Ward/Department/ Directorate
Moderate	Senior Sister / Matron	Service Manager / Divisional Head of Nursing and Quality / Divisional Manager	Care Group / Division	Care Group/ Division
High	Service Manager / Divisional Head of Nursing and Quality / Divisional Manager	Reviewed by Patient Safety Group	Divisional / Corporate	Divisional / Corportae/ Board Assurance Framework
Extreme	Service Manager / Divisional Head of Nursing and Quality / Divisional Manager	Reviewed by Patient Safety Group	Divisional / Corporate	Divisional / Corportae/ Board Assurance Framework

Title of Meeting	**Board of Directors**
Date of Meeting	**25 September 2019**
Report Title	**Risk Appetite Statement Annual Review**
Author	Rebekah Ley, Trust Board Secretary
Responsible Executive	Nicky Lucey, Director of Nursing and Quality

Purpose of Report (e.g. for decision, information) For approval.	
Summary The Board is required to annually review the Trust's Risk Appetite Statement. It was last reviewed by the Board in September 2018. The Board should consider whether changes are necessary in light of the recent review of the Board Assurance Framework and Risk Register.	
Paper Previously Reviewed By Board of Directors, September 2018	
Strategic Impact	
Risk Evaluation	
Impact on Care Quality Commission Registration and/or Clinical Quality	
Governance Implications (legal, clinical, equality and diversity or other):	
Financial Implications	
Freedom of Information Implications – can the report be published?	No

Recommendations	To review and approve the Risk Appetite Statement.

RISK APPETITE STATEMENT

The Trust Board of Dorset County Hospital NHS Foundation trust is committed to adopting the best practice in the identification, evaluation and cost effective control of all forms of risk to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practicable. The Board aims to maximise opportunities to achieve the Trust's objectives and the delivery of core services, by the recognition and effective response to risks. The Trust acknowledges that some risks will always be present and never fully eliminated. It accepts responsibility for the mitigation of this residual risk as far as possible, along with practical plans to control and mitigate risk and provide assurance to the Trust Board.

THE TRUST'S 7 RISK APPETITE FOCUS AREAS

QUALITY AND SAFETY	COMPLIANCE & REGULATION	INNOVATION & TRANSFORMATION	FINANCE	COMMERCIAL	REPUTATION	WORKFORCE
The Board will provide high quality services and in delivering this it will take low appetite position in its decisions that have consequential effects upon patient safety, quality of care or clinical outcomes. The Board have no appetite and are strongly adverse to decisions that result in poor quality of care; unacceptable clinical risk; non-compliance of CQC standards; and poor clinical or professional practice.	*The Board has a low risk appetite in decisions that relate to compliance to regulatory issues. In addition, it has no appetite and is strongly adverse to risks that impact upon any legal regulatory standard. It has a moderate appetite and will mitigate wherever possible to meet expectations set by regulators, which fall outside any legal framework, unless there is strong evidence to challenge them.*	*The Board has a significant appetite for innovation, depending upon the nature of the innovation being proposed. For transformation or innovation that supports quality, safety and operational effectiveness the Board has a high appetite. For innovation and transformation that has been tested elsewhere and proven to be transferable and will enable the board to meet its quality, safety, financial, operational and reputational objectives the Board has a significant appetite. The Board has a moderate appetite for untested innovation or transformation that affects quality, safety and operational effectiveness and efficiencies objectives.*	*The Board has a low risk appetite for financial commitments that do not relate to delivering quality and safe patient care or delivering a more efficient, effective service. It is prepared to have a high appetite to investments and its flexibility in resources when the decision relates to ensuring quality and safe services are provided to patients or service efficiencies can be delivered. The Board has no appetite to proceed with any financial decision that does or could negatively impact on quality and safe care, unless a robust quality impact assessment has been completed and provides assurance on the perceived risk and mitigations of the risk.*	*The Board has a high to significant appetite for commercial risk. It will be open and willing to consider commercial delivery options and service models which contribute towards improving the safety and/or quality and/or patient and/or staff experience, either directly or indirectly, and which provides an acceptable level of reward and value for money.*	*The Board has a moderate appetite for decisions that have the potential to impact upon the Trust's reputation. Decisions that could expose the Trust to additional scrutiny of its reputation need to be considered carefully and cautiously with strong mitigations and management in place to counter any potential repercussions. The Board has no appetite for decisions which risk causing reputational damage because they conflict with the Trust's high standards of professional conduct, values and ethics.*	*The Board aims to maximise the potential of its staff and are committed and eager to recruit and retain staff that meet our values, standards and support our strategic objectives. There is a low appetite to decisions that could negatively impact upon this. The Board accepts a significant risk appetite with regards to innovation in our workforce and encourages workforce redesign within the framework of our values; recruitment and retention; and staff engagement strategy as long as there is no compromise to our quality, safety risk appetite. With regard to the financial implications of the current and future workforce sustainability the Trust has a moderate appetite. This is intended to support the innovation of workforce models, and anticipate workforce demand and trajectories*

Measure any proposal against each of these focus areas:

Is there a quality impact – positive/negative?

Are there Compliance and/or Regulatory Issues - CQC/NHSI?

Is the proposal innovative and/or transformative?

What is the financial impact – the risk and reward?

What is the commercial opportunity, now and/or in the future (for each of those elements the impact might be positive or negative?

What are the reputational risks – positive/negative?

Wil there be any impact on the Trusts' workforce?

Summarise the position:

1. What is the nature of the risk(s) being assumed?
2. The amount of risk being taken on?
3. Is there the desired balance of risk versus reward when set against the Trust's Risk Appetite Statement?

MAKE A DECISION

Safe Staff Return July

	Day				Night				Day		Night					
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff									
Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Abbotsbury Short Stay Surgical Unit	1774	1571	1112	1439.25	682	1026.75	682	693	88.6%	129.4%	150.5%	101.6%	770	3.4	2.8	6.1
Barnes	1297.5	1158.5	1534.5	1452	682	693	858	1012	90.3%	94.6%	101.6%	117.9%	706	2.6	3.5	6.1
Critical Care Unit	2283.5	2238.75	355.75	179	2138	2120.75	0	23	98.0%	50.3%	99.2%	-	186	23.4	1.1	24.5
Day Lewis	1488	1383	1149.25	1418.5	682	671	682	684	92.9%	123.4%	98.4%	100.3%	707	2.9	3.0	5.9
Fortuneswell	919.5	1069.5	748	837.75	682	684.5	341	429	116.3%	112.0%	100.4%	125.8%	463	3.8	2.7	6.5
Ilchester Intergrated Assessment Unit	1423.75	1752.08	1471.67	1819.42	1069.5	1442.75	1066.5	1562.25	123.1%	123.6%	134.9%	146.5%	859	3.7	3.9	7.7
Kingfisher	1501.5	1456.5	618.75	616.75	1069.5	1046.5	355.5	308.5	97.0%	99.7%	97.8%	86.8%	182	13.8	5.1	18.8
Lulworth	1876.98	1800.67	1506	1516.25	1023	1023.58	1023	1099.75	95.9%	100.7%	100.1%	107.5%	887	3.2	2.9	6.1
Maternity	3028.5	2579.33	1543.5	956.67	2099	2004.6	682	609	85.2%	62.0%	95.5%	89.3%	377	12.2	4.2	16.3
Maud Alex	1218.75	1261	809	819.25	1069.5	1080.5	356.5	436.5	103.5%	101.3%	101.0%	122.4%	460	5.1	2.7	7.8
Moreton	1412.5	1333.25	1515.5	1484	682	691	1021.5	1009.5	94.4%	97.9%	101.3%	98.8%	689	2.9	3.6	6.6
Prince of Wales	1444	1408.17	759.5	626.75	682	682	341	330.5	97.5%	82.5%	100.0%	96.9%	419	5.0	2.3	7.3
Purbeck	1676	1603.92	1523.68	1486.7	682	682	680	735	95.7%	97.6%	100.0%	108.1%	797	2.9	2.8	5.7
Ridgeway	1288.5	1249.8	1062.5	1421	682	682.5	682	682	97.0%	133.7%	100.1%	100.0%	696	2.8	3.0	5.8
SCBU	759.8	812	372	300	682	708	341	319	106.9%	80.6%	103.8%	93.5%	200	7.6	3.1	10.7
Stroke Unit	1507.5	1489.7	1119	1395	682	682.5	682	814	98.8%	124.7%	100.1%	119.4%	575	3.8	3.8	7.6

Exception report: Abbotsbury shifts were all supported by the supervisory ward leader. Maternity staffing levels reflect changing demand. There were 2 shifts with only 1 RN on duty during this reporting period (Elderly Care, Renal); these were supported by adjacent ward areas and night sister presence on all occasions. Currently approximately 75% of requested temporary cover for shifts is filled by temporary staffing.

Note- Many areas are showing as greater than 100% due to additional staff required for extra capacity beds due to demand and activity. Staffing for this extra capacity has relied on temporary staffing and is currently being reviewed.

Director of Medical Education Overview

September 19

Miss Audrey Ryan

Our doctors

- A mix of consultants, doctors in training (almost exclusively from Wessex Deanery), and non-training grades (Staff Grades, Specialty Doctors, Trust Doctors, ‘F3s’, Associate Specialists, ‘WAST’ doctors)
- Deanery trainees are here for between 6 months and 2 years
- Rotas are designed around a certain number of doctors but lower levels of doctors training in some specialties around the nation plus increased numbers of LTFT working mean rotas are not filled
- Recruitment challenges
- Small percentage working less than full time

Education Update

- **Staffing update**
- **National and regional changes**
- **Local changes**
- **GMC Survey – highlights and hotspots, with Action plans**

Staffing update

- Full complement of F1s and 2s
- Limited success in F3 recruitment
- New WAST doctors
- New Specialty Trainees in Emergency Medicine
- Good fill rates in Deanery training posts, but problems with nationally recruited Trainees who arrived without completion of Visa process – this is being addressed with the Deanery

National and Regional Changes

- New Dean, Dr Paul Sadler
- National reorganisation of boundaries at Health Education England, recognising that Dorset sits within the South West region for NHSE and NHSI; this does not affect Medical Education
- Junior Doctors Contract 2016 has been renegotiated. This has led to the need to review rotas and work schedules to ensure compliance
- BMA Fatigue and Facilities Charter,
- Increasing work being around International Medical Graduates
- HEE document ‘Enhanced Supervision of Doctors in Postgraduate Training’

GMC Visit Feb 2018

- **Requirement 2:** **'Trust must continue to develop clear and transparent systems to monitor how educational resources are allocated and used'**

- HEE guidance recognises that Supervisors should have 0.25 PAs for each doctor supervised
- Increasing CQC interest in this area
- DCH's current job planning policy allocates 0.125 PAs

Local changes

- WAST doctors: 2 overseas doctors, recruited nationally as part of the Widening Access to Specialist Training initiative. Supported by the Deanery, these doctors are working at F2 level. They are funded in the same way as Trainees, and receive Educational and Clinical Supervision. We hope to continue this in 2020/1

- Dr Lucy Pearce has taken over from Dr Adeel Ghaffar as Foundation Programme Director for F1s. Dr Ghaffar has taken the role of Pastoral Lead for the WAST doctors

- Dr Kathryn Barr is our first Less Than Full Time Training Champion, acting as a point of contact for those who are, or who are considering, training LTFT

- Dr Heather Deall is our new Chief Registrar

- Following funding cuts in HEE, we are now providing Refresher courses for Educational and Clinical Supervisors locally

The Survey

- Annually, March-May
- No longer compulsory
- 18 sets of questions relating to work in and out of hours
- Results can be broken down by Specialty (eg for all doctors at all grades in Surgery) or by Programme (eg only the higher Specialty Trainees in Paediatrics)
- Results are measured against a national mean score and flagged accordingly: Green = national ‘above’ outlier, Red = national ‘below’, light green = tending above, pink = tending below

Overall Trust Survey Results

- In line with national averages in all 18 categories
- Second only to Jersey of the Acute Trusts in Wessex for Trainees, highest scoring for Trainers
- Visible improvements in some areas that flagged problems last year
- In other areas issues persist

Highlights

- Anaesthetics =
- Paediatrics overall >
- GP Foundation >
- Cardiology >
- Emergency medicine >
- General Surgery >
- Geriatric medicine >
- Obstetrics & Gynaecology >>

Hotspots

- Core medical training <
- Paediatrics higher trainees <
- Emergency medicine workload =
- Surgery F2s =
- Gastroenterolgy =
- Urology =

Emergency Medicine F2s – 1 Red for Workload

- 100% of F2s worked beyond their rostered hours, and 75% described their workload as ‘very heavy’ for both day and night-time

Action plan:

- Recruitment – attracting F3s
- New rota design
- Introduction of Specialty trainees

Paediatrics

- Overall specialty scored well, with greens for Workload, Supportive environment and Teaching
- But Specialty Trainees flagged Reds for Overall Satisfaction, Induction, Adequate experience, Curriculum coverage and Rota design

Action plan:

- New rota; protected teaching time; allocation of new clinical sessions; exposure to management skills; trainee involvement in new induction

Gastro

- 3 reds for Clinical Supervision out-of-hours, Educational Supervision and Rota design

Action plan:

- New rota design
- Change in staffing

Core Medical Training

- Reds for Rota design, Regional teaching, Clinical Supervision plus 5 pinks
- Last year's results had been much better after a downward trend for some years

Urology

- Reds for Overall satisfaction and Clinical Supervision. Also Pinks for Educational Supervision and Clinical Supervision out-of-hours

Action plan:

- New Consultant-of-the-week system; Sharepoint visibility of nurse-led clinics; addressing issue of Consent in Induction

Surgery F2s

• Reds for Overall satisfaction, Clinical Supervision in and out of hours, Rota design

• GMC Visit Feb 2018 raised a Serious Concern about this group of doctors and required us to '**review and monitor out-of-hours supervision for F2 trainees and ensure F2s working at night in the specialty for the first time are appropriately supported'**

Action plan:

- Data analysis of Surgical activity
- Extra doctor on duty from 5pm to midnight
- Review of Hospial@night team activity
- Review of Induction

Recommendations

- review the structure for local induction for postgraduate learners.
- review and monitor processes for implementing less than full-time training.
- review the system for granting annual leave and study leave and ensure clear communication to trainees.

What happens next?

- Results are reviewed by Education Faculty and Director of HR, Medical Director, Divisional Managers and Directors
- Action plans for Red outliers; departments with Green outliers are asked to share good practice
- Board presentation
- Action plans are fed back to Health Education England and monitored through the year

Thankyou

For your ongoing commitment to teaching, training and supervising

Title of Meeting	**Board of Directors**
Date of Meeting	**25th September 2019**
Report Title	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Submission 2019/120**
Author	**Tony James, Head of Emergency Planning & Resilience**

1. Introduction

1.1 As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of the NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

1.2 The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

2. Relevant legislation and guidelines

2.1 The Civil Contingencies Act 2004, and the NHS Act 2006 as amended by the Health and Social Care Act 2012 underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England.

2.2 Additionally, the NHS Standard Contract Services Conditions require providers of NHS funded services to comply with the EPRR Framework and other NHS England guidance.

3. EPRR annual assurance process

3.1 As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients.

3.2 NHS England has an annual statutory requirement to formally assure its own and the NHS in England's readiness to respond to emergencies. To do this, NHS England and NHS Improvement ask commissioners and providers of NHS funded care to complete an EPRR annual assurance process. This process incorporates four stages:

1. Organisational self-assessment against NHS Core Standards for EPRR
2. Local Health Resilience Partnership (LHRP) confirm and challenge
3. NHS England and NHS Improvement regional EPRR confirm and challenge
4. NHS England and NHS Improvement national EPRR confirm and challenge

3.3 Based on this process, National EPRR will submit an EPRR assurance report to the NHS England and NHS Improvement Board. The report is then shared with the Department of Health and Social Care (DHSC) and the Secretary of State for Health and Social Care.

4. Core Standards for EPRR domains

4.1 The NHS England Core Standards for EPRR are split into 10 domains.

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN) and Hazardous Materials (HAZMAT)

Further detail can be found in Appendix C.

5. NHS EPRR Core Standards 2019/20

5.1 The Trust was notified on 8th July 2019, by NHS England & NHS improvement of the process for the 2019//20 EPPRR assurance process. The letter, from Stephen Groves, National Head of EPRR, included the latest version of the Core Standards which have remained as they were in the 2018-19 with only minor clarifications made.

5.2 Organisations are asked to undertake the self-assessment, against individual core standards and rate their compliance for each as not compliant, partially compliant or fully compliant. See definition below:

Compliance level	Compliance definition
Not compliant	Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months.
Partially compliant	Not compliant with core standard. However, the organisation's EPRR work programme

	demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
Fully compliant	Fully compliant with core standard.

5.3 An overall assurance rating is assigned based on the percentage of Core Standards being fully compliant. The thresholds for each rating are shown in the table in Appendix B.

6. Assurance Deep Dive 2019/20

6.1 Each year NHS England use the core standards assurance process to undertake a 'deep dive' to look at a specific topic relating to emergency preparedness, resilience and response.

6.2 This year's EPRR assurance deep dive topic focusses on 'Severe Weather and Climate Adaptation'. This is as a result of a request from the Government's Environmental Audit Committee (which has responsibility for assessing adaptation to climate related issues). The self-assessment of these deep dive statements does not contribute to the Trust overall EPRR assurance rating as these will be reported separately.

7. NHS EPRR Core Standards Self-Assessment

7.1 As part of NHS England's EPRR assurance process for 2019/20, Dorset County Hospital was required to self–assess against a total of 64 core standards.

7.2 The self-assessment was completed by the Trusts Head of Emergency Planning & Resilience and Chief Operating Officer (Accountable Emergency Officer) and submitted to the Accountable Emergency Officer at Dorset Clinical Commissioning Group on Friday 13th September 2019.

7.3 The outcome of the self-assessment showed that of the 65 applicable standards the trust was:

- Fully compliant with 62 of the standards
- Partially compliant with 2 of the standards
- Non-compliant with 0 of the standards.

7.4 The results of the 2019/20 self-assessment enable the Trust to provide **'substantial' compliance** to NHS England and Dorset Clinical Commissioning Group with respect to its emergency preparedness, resilience and response arrangements.

8. EPRR Work Programme

8.1 To accompany the EPRR core standards self-assessment, the Trust is required to submit an Action Plan detailing how it plans to address the 2 standards for which full compliance has yet to be achieved. See Appendix A

8.2 The Core Standards Action Plan has been added to the EPRR Work Programme 2019/20 which is overseen by the Trust Accountable Emergency Officer (COO) and Emergency Resilience & Planning Group.

9 Next Steps

7.1 The next steps for the assurance process are:

- The Trust Board to approve the 'Statement of Compliance' and Action Plan following the recommendation ratified by the Risk and Audit Committee on 17th September 2019.
- The Trusts Accountable Emergency Officer and Emergency Planning Lead are required to meet with Dorset CCG's Accountable Emergency Officer and NHS England (South West) EPRR representative on 14th October 2019, to discuss the Trust EPRR assurance submission and agree a compliance position.
- It is the intention of Dorset CCG to agree the overall EPRR compliance level for Dorset NHS at the Local Health Resilience Partnership (LHRP), Executive Group meeting on 19th November 2019.

10 Conclusions and Recommendations

10.1 During the last 12 months, the Trust has continued to invest in developing and improving its emergency preparedness, resilience and response arrangements.

10.2 This investment has resulted in the Trust being able to provide 'substantial compliance' to NHS England and Dorset Clinical Commissioning Group with respect to emergency preparedness, resilience and response for 2019/20.

10.3 The Trust Board is asked to approve the Statement of Compliance and Action Plan.

Appendix A: Statement of Compliance and Action Plan

Emergency Preparedness, Resilience and Response (EPRR)

Statement of Compliance 2019 / 20

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The accountable emergency officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for 2019/20, Dorset County Hospital NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 64 of the core standards which are applicable to the organisation, Dorset County Hospital NHS Foundation Trust:

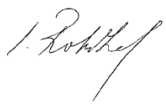
- is fully compliant with 97% of these core standards; and
- 3% of the core standards were not full addressed by the date of submission.

Therefore, based on the table in tab one of the Core Standards Self-Assessment, Dorset County Hospital NHS Foundation Trust is submitting an overall compliance rating of substantial compliance level with the core stands.

In response to the 2019/20 deep dive for severe weather and climate adaptation, Dorset County Hospital NHS Foundation Trust:

- Is fully compliant with 15 of the 20 standards.

The Action Plan tab of our EPRR Core Standards Self-assessment spreadsheet sets out actions against all core standards where full compliance has yet to be achieved.



Inese Robotham
Accountable Emergency Officer

6th September 2019

NHS EPRR Core Standards 19/20 Action Plan - Version 1.0 **September 2019**

Dorset County Hospital NHS Foundation Trust has assessed itself against the NHS Core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2019/20. This action plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance. This is a live document and it will be reviewed and updated as actions are completed. The plan will be monitored by the Trusts Emergency & Resilience Planning Group and NHS Dorset Clinical Commissioning Group.

Ref	Domain	Standard	Detail	Evidence Required	RAG	Action to be taken	Timescale
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Mass Countermeasure Plan on the Dorset LRF Work Plan 2019/20. Awaiting national guidance to be issued by Ministry of Housing, Communities and Local Government. In the meantime Dorset LHRP Business Management Group to adopt a similar approach to the London Region's Mass Prophylaxis Centres framework. Work steam led by NHS England. DCH plan will be revised following publication of the Dorset plan.	March 2020
19	**Duty to maintain plans**		The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion,	Arrangements should be: • current • in line with current national guidance • in line with risk assessment	Partially compliant	Current arrangement not formulated to address the requirement regarding non sequential numbering of major incident patients.	March 2020

			using a non-sequential unique patient identification number and capture patient sex.	• tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required		Safer temporary identification criteria for unknown or unidentified patients to be implemented in line with Alert reference number: NHS/PSA/RE/2018/008 . ED Consultant KS (12/6/19) has requested guidance from NHS England NHS Improvement on pre-prepared MI packs that would be dependent on our IT systems.	

Appendix B: Organisational Assurance Ratings

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix C: Core Standards for EPRR domains

1. **Governance**

A policy statement, outlining the organisation's commitment to deliver EPRR, must be in place. This statement should be supported by an annual EPRR work programme to ensure all NHS England Core Standards for EPRR are delivered.

Organisations must have an appointed Accountable Emergency Officer (AEO) who is a board level director and responsible for EPRR in their organisation. This person should be supported by a non-executive board member.

2. **Duty to risk assess**

Organisations should have provision in place to regularly assess the risks to the population it serves. This process should consider the community and national risk registers.
A supporting risk management system must be in place to ensure a robust method of reporting, recording, monitoring and escalating EPRR risks.

3. **Duty to maintain plans**

Appropriate and up to date plans must set out how the organisation plans for, responds to and recovers from major incidents, critical incidents and business continuity incidents. These should be developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.

4. **Command and control**

A robust and dedicated EPRR on call mechanism should be in place to receive notifications relating to EPRR. This facility should be 24 hours a day, 7 days a week, and provide the ability to respond or escalate notifications to executive level.

Personnel performing the on call function should be appropriately trained in major incident response.

5. **Training and exercising**

EPRR training should be carried out in line with a training needs analysis to ensure staff are competent in their role.

Planning arrangements must be exercised through a:

- communications exercise every six months
- desktop exercise once a year
- live exercise every three years
- command post exercise every three years.

6. Response

Staff trained in incident response should be available to respond to incidents from within an Incident Coordination Centre (ICC). This includes having processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings. These arrangements should also include an alternative ICC, should the primary location be affected by the incident itself.

7. Warning and informing

Demonstrable processes to communicate with partners and stakeholders, and warn and inform public and staff should be in place for use during major incidents, critical incidents and business continuity incidents.

Organisations should also have an appropriate media strategy to enable communication with the public. This should include identification of and access to a trained media spokespeople able to represent the organisation.

8. Cooperation

Arrangements should be in place to share appropriate information with stakeholders. This includes participation in Local Health Resilience Partnerships (LHRPs) to demonstrate engagement and co-operation with other responders.

9. Business continuity

Up to date business continuity plans setting out maintenance of critical activities when faced with disruption should be in place within each organisation. These planning arrangements should be aligned to current nationally recognised business continuity standards.

10. Chemical, Biological, Radiological, Nuclear (CBRN) and Hazardous Materials (HAZMAT)

Acute, specialist, mental health and community healthcare providers are required to have planning arrangement in place for the management of CBRN incidents.