Board of Directors Meeting
08.30am – 12.15pm, Wednesday 27 November 2019
Seminar Room, Children's Centre, Dorset County Hospital

AGENDA
PART 1 (PUBLIC SESSION)

			Approx. timings	
1	**Welcome and Apologies for Absence:**		**8.30**	Chair
2	**Declarations of Interest**			All
3	**Chairman's Remarks**	Oral	**8.35**	Chair
4	**Minutes of Board of Directors Part One 25 September 2019** To approve	Enclosure	**8.45**	Chair
5	**Matters Arising from those Minutes and Actions List** To receive	Enclosure	**8.55**	Chair
	QUALITY AND PERFORMANCE ITEMS			
6	**Chief Executive's Report** To receive	Enclosure	**9.05**	Patricia Miller
	BREAK		**9.25**	
7	**Integrated Performance Report** To receive and agree any necessary action **a. Workforce** **b. Quality** **c. Performance** **d. Finance** **e. ICS Update**	Enclosure	**9.45**	 Mark Warner Nicky Lucey Inese Robotham Paul Goddard Nick Johnson
	BREAK		***11.00***	
	GOVERNANCE ITEMS			
8	**Board Assurance Framework and Corporate Risk Register** To receive	Enclosure	**11.15**	Paul Goddard and Nicky Lucey

WORKFORCE ITEMS

9	**Safe Staffing Return** To approve	Enclosure	**11.30**	Nicky Lucey
10	**Guardian of Safe Working** Introduction to the Guardian	Enclosure	**11.35**	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.

11	**Business Planning Guidance 2020/21** To approve	Enclosure		Paul Goddard
12	**Mortality Report Q2** To note	Enclosure		Alastair Hutchison
13	**Communications Activity Report July to September** To note	Enclosure		Nick Johnson
14	**Complaints Annual Report 2018/19** To note	Enclosure		Nicky Lucey
15	**Any Other Business**		**12.00**	Chair

Date of Next Meeting (open to the public): Tuesday 4 February 2020, 8.30 a.m., Seminar Room, Children's Centre, Dorset County Hospital

Questions from the Council of Governors and Members of the Public – 12.00pm to 12.15pm. 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 25 September 2019
Seminar Room, Children's Centre, Dorset County Hospital

Present:
Mark Addison (Chair)
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)
James Metcalfe (Divisional 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:
Sonia Gamblen (Divisional Lead Nurse)
Rebekah Ley (Trust Secretary)
Audrey Ryan (Director of Medical Education)
Kyle Mitchell (Guardian of Safe Working)

Apologies:
Sue Atkinson (Non-Executive Director)
Alison Cooper (Divisional Director)

Observers:
Meghan Hindley (Communications Officer)

BoD19/143 Patient Story

Sonia Gamblen was in attendance for this item. The Board were shown a short video of a patient story. The patient that attended the emergency department in April. She is a patient in her 70s. She has family but they do not live nearby and she presented to the department on her own. As an ex-nurse she knew that her symptoms needed attention and she was concerned because of her family history of cancer. She was seen and triaged in a reasonable time and had various tests. She was then asked to return to the waiting room in an undressed state and offered a blanket to preserve her dignity. She felt increasingly unwell and uncomfortable. She felt unsupported and decided she would be better off at home. She was admitted to Ilchester ward and eventually remained at the Trust for a week. She remains under the care of the gastroenterologists.

The patient complained to the Trust. When the Trust responded to her complaint the response missed the point of her complaint which became apparent when Trust staff met with her. On receipt of her letter the team did not telephone her to confirm the details of her complaint. Her complaint concerned her vulnerability and being left in the waiting area in an undressed state for a prolonged period with no contact or support. She felt that she needed to complain because she was concerned that other less articulate patients might be left in a similar situation. She found the complaints procedure and the

meeting stressful. However, at the meeting she was listened to and she felt a burden had been lifted.

The Board noted that that the patient had felt she was being processed rather than being cared for. Staff needed to put themselves in the place of the patient and understand the vulnerability they feel. It was noted that the video will be used as a learning tool for the department so that they can understand better the value of the patient's voice. The Director of Strategy said that the Trust's strategy is outstanding care for people in ways which matter to them and that the complaint illustrates how important it is to do this. Victoria Hodges said that she hoped the video and learning from it would enable people to take a moment to reflect and offer kindness. It was noted that there was more work to be done in terms of utilising local videos and also nationally available materials.

The Chair thanked the team for preparing the video and attending and requested a follow-up report in due course on the video usage.
Action: The Director of Nursing and Quality to provide an update regarding educational use of videos across the Trust.

BoD19/144 Welcome and Apologies for Absence
The Chair welcomed James Metcalfe (Divisional Director, Urgent and Integrated Care Division) to his first Trust Board meeting. Sue Atkinson (Non-Executive Director) and Alison Cooper, Divisional Director (Family Services and Surgical Division) had sent their apologies.

BoD19/145 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.

BoD19/146 Chairman's Opening Remarks
The Chairman noted the full agendas in both parts of the meeting and asked for his colleagues' assistance in managing the timings. The Trust's recent AGM had been a success and about a dozen members of the public attended. The presentations from Christian Verinder, Claire Hollingsworth and Hannah Robinson were well received.

The Chair reminded Board members that flu vaccinations would be offered to Board members during the lunch break.

BoD19/147 Minutes of the Previous Meeting held on 31 July 2019
The minutes of the meeting were accepted as a true and accurate record.

BoD19/148 Matters Arising and Action Tracker

Action Tracker
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: NL said this has been taken forward. Item to be closed on the action tracker.

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: post meeting note from RL had been added to the tracker. Item to be closed on the action tracker.

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 for Board sign-off in September: noted that this was discussed at the Board Development session in August and is an agenda item for Part 2 of the meeting. Item to be closed on the action tracker.

BoD19/110, the executive team to continue the discussion about embedding a quality

improvement culture at the hospital: the Board noted that this is an ongoing matter and NHS Elect is currently working with the Trust. The Quality Improvement strategy will be discussed at the November Board meeting. Action tracker to be updated with this date.

BoD19/111, the BAF and Risk Register to come back to the September Board meeting after discussion at the August executives' meeting: noted that these are agenda items. Item to be closed on the action tracker.

BoD19/114, Charity Strategy to be added to the agenda for the September Board meeting: noted that this is in the consent section for Part 2 of the meeting. Item to be closed on the action tracker.

BoD19/119, Non-executive director membership of the Responsible Officer Advisory /Revalidation Governance Group to be discussed by the Chief Executive 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: the guidance refers to a lay person not a Non-Executive Director. PM has made a suggestion for the Chair to consider. Item to be closed on the action tracker.

BoD19/122, the Head of Estates and Facilities to meet with Mr Jordan to talk through some of his suggestions regarding the Estates Masterplan: a meeting has taken place. Item to be closed on the action tracker.

BoD19/068, consider messaging around sustainability including accessibility of the Trust's intranet and web pages: there is a meeting with David Pencheon in December and the Executive team have a workshop planned on the 29th October that will inform how the development day is structured. The Chief Executive said that the development session would not just focus on the commitment to the Trust's environmental impact but its social value proposition as well. Item to remain on the action tracker.

The Chair noted that the visit for the Chief People Officer for the NHS, Prerana Issar has been fixed for the 29th November and a programme is being worked up for this. Item to be closed on the action tracker.

The Chair congratulated the Chief Operating Officer on her completion of the Great North Run and the funds raised for the Hospital Charity's chemotherapy appeal.

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

QUALITY AND PERFORMANCE ITEMS

BoD19/149 Chief Executive's Report

The Chief Executive said that she was taking the report as read. She said that the Trust has been very busy and this needs to be discussed when the Board reviews the Winter Plan. The Trust must ensure plans are as robust as possible and risks mitigated. The Chief Executive said that teams need to recognise that being busy is becoming the normal state of the Trust and that strong calm leadership is needed.

The Chief Executive highlighted the areas of her report that cover the work that the Trust is engaged with at a national level around rural hospitals. PM said that it is important to create the case for rural institutions and a media campaign will be part of that. A draft strategy will be sent for review by the Director of Strategy. The Chief Executive noted that GIRFT will compare the performance of smaller organisations against larger ones and also look at investment in seaside towns. The Chief Executive said that this is important work that the Trust must remain connected to.

The Chair noted the national figures and in particular emergency department

performance. The whole country appears to experiencing increasing demand and struggling to understand what the factors are that are driving this. The Chief Executive said that there are nuances with performance regionally and that there are differences in activity levels in the South West. The Chair asked about the increase in flu numbers in Australia and the Medical Director said that numbers had peaked earlier than anticipated but were now back to expected levels.

The Chief Operating Officer updated the Board on Brexit planning. Her update was in line with previous information and key messages. The Trust has complied with all national requests for information and was working with local partners as well. Sit' rep' reporting will still start from 1st October and run to the 29th December. Reporting is required every day. The Chief Operating Officer said that this will coincide with Winter Planning reporting. She said that there is anxiety around food supplies rather than clinical and non-clinical supplies. The Chair of the Risk and Audit Committee said that the Committee could not provide assurance to the Trust Board around national plans but confirmed that the Trust has done all that it can do in the circumstances.

The Chair reflected on a discussion at the Council of Governors meeting and their concerns about autistic spectrum disorder assessment times and waits. The Chief Operating Officer had been in attendance and provided valuable input into the discussion at the Council. The Chair said that the Governors are concerned about the system issues and he said that the Board should be aware of the deep anxiety they have in this area.

The Chair thanked the Chief Executive for her report and the Chief Operating Officer for her update.

BoD19/150 Integrated Performance Report

The Director of Organisational Development and Workforce introduced the workforce aspect of the performance report to the Trust Board. He highlighted that in respect of pension taxation, guidance has been received from NHS Employers. The Trust's policy is in line with current proposals. However, he said that the Board should review its policy once the present process is concluded.

The Director of Organisational Development and Workforce said that there had been a modest increase in workforce capacity due to the rotation of the junior doctors in August. He said that the increase in substantive workforce costs was due to the medical and dental pay award. He said that increases in agency costs continue to cause concern and this is primarily as a result of vacancies and escalation beds. The Director of Organisational Development and Workforce said that he is looking at the correlation of bank and agency fill rates as there appears to be conflicting information and he will be reporting to the Workforce Committee in due course.

The Director of Organisational Development and Workforce said that his team have identified the unmet staffing requirements of having escalation beds open and will be building these into nursing trajectories along with maternity leave cover requirements. This unmet need in staffing will be subject to a proposal for consideration by the Finance and Performance Committee in October.

The Director of Organisational Development and Workforce said that new agency rules came into effect in September that put greater restrictions on the use of agency staff. He is working with colleagues at Bournemouth and Poole in relation to the framework to ensure that all acute providers' processes are aligned. He said that staff turnover increased slightly as did levels of staff sickness and he will be tracking this closely. Mandatory training remained at 87% and he said that this is positive as the level has not dropped despite the pressures on the organisation.

The Director of Organisation Development and Workforce said job planning will be reviewed at the Workforce Committee and in due course the Trust Board. He wants to

ensure consistency across the Trust and agree revised trajectories with the divisions. He said that mental health first aid training has gone well and this is positive. The staff survey will be going out shortly and they will be trialling an online survey in some areas.

The Chair of the Workforce Committee asked the Board to note that successful recruitment leads to additional pressure on the education team and this was especially the case in September. She asked the Board to note that the Trust will be the first in the country to have thirty students on its introduction to medicine course in conjunction with the Duke of Edinburgh Award Scheme; this is a tribute to the Trust and the education team. The Chair of the Workforce Committee noted that all committees have a high workload and there is often too much to discuss and not enough time to do it in. Committee Chairs agreed with this. She commended the Executive team for their resilience and team working and thanked them for their contribution to the Trust.

The Chief Executive said that she was working closely with Dorset Council and she is discussing how the organisations can support each other and engage around education. The Chief Executive said that many children do not have clear career aspirations and there is a gap that can be filled around messaging and future careers in the NHS.

In response to a question regarding international nurse recruitment, the Director of Organisational Development and Workforce said that so far the international recruits that have joined the Trust have been of high calibre. The Trust is now working with Medacs to increase international nurse recruitment. Presently this is the only viable solution to recruiting qualified nurses until all the other work streams come on line nationally which is a five year programme of work.

The Director of Nursing and Quality introduced the quality aspects of the performance report to the Trust Board. She said that since the report was written, there has been a quality surveillance meeting and the Trust remains on routine surveillance which is positive. There were system issues for the Board to note: South West Ambulance Trust is on advanced surveillance for ambulance and handover times, the Priory remains closed to admissions and a hospice in Yeovil has closed. The Director of Nursing and Quality said that these may impact on the Trust.

The Trust received a positive GIRFT review for stroke services and the speech and language therapy team has undertaken some outstanding work around mouth care. She commended the infection prevention control results to the Board and said that they are a credit to all teams. Complaint responses are being maintained and the Quality Committee received the Annual Complaints report that now includes learning and themes. The Trust had inadvertently released information ahead of time about the Children and Young People's Survey the results of which are pleasing. The Trust has apologised for this error. The Quality Committee has received a report and action plan following a Human Tissue Authority inspection. Pressure ulcer guidance and changes to coding have been accepted by the Committee.

The Director of Nursing and Quality said that there are issues that remain a challenge: nutritional assessments, structured judgement reviews (SJRs) and electronic discharge summaries (EDS). She said that the Medical Director had led work on VTE assessments. The Medical Director said that a solution to improving VTE assessments had been found using the electronic prescribing software which can be used to force junior doctors to undertake the assessment before they can prescribe. This will be piloted on Ilchester and he hopes this will rectify the position by the end of the year.

The Chair of the Quality Committee said that the Trust is making good progress on challenging issues but she wanted to raise several points to the Board: (i) SJRs and the backlog; she said that there is a plan in place and the Committee has asked for a paper on the improvement plan to come to its next meeting. (ii) Sepsis; she said that there is no data at the present time for August. The Trust is not quite where it should be and there will be a deep dive on this at the next committee meeting. (iii) Dementia screening and

(iv) EDS, the Chair of the Committee said there are some cultural and process issues and the committee will be focussing on them to try to improve these areas. The Committee Chair said that the Director of Strategy had attended the last Committee meeting with the Head of Transformation and a good discussion about the framework for identifying and reviewing improvement priorities took place. The Director of Strategy agreed that there is a shared understanding of the journey required. The Chair of the Committee said that the plan is to link the transformation team and the quality improvement process with divisions and their hard to tackle issues.

The Chief Operating Officer presented the performance element of the performance report. Performance is discussed extensively at the Finance and Performance Committee and she said that issues to highlight are: the emergency department (ED) increased demand and the high bed occupancy. She said there is a direct link between these two metrics. A 1% increase in bed occupancy can have a marked effect on ED performance. The Chief Operating Officer highlighted the plans for expanding ED capacity in particular plans for a same day emergency care unit. She said the Trust is also looking at flexing hospital at home capacity. The Trust is working with system partners to improve out of hospital care provision. ED performance is above the national average with performance at 89.5% and September is on track for @90%. There have been no 12 hour breaches. She is looking at the resilience of teams and how they can maintain a calm and constructive approach to managing the organisation when busy.

The Chief Operating Officer said that referral to treatment (RTT) is deteriorating and this mirrors national performance. There is an RTT recovery programme and the Trust has work underway to validate the waiting list and a report and remedial plan will be submitted to the Finance and Performance Committee. There have been 52 week wait breaches in orthopaedics and plans for this specialty will be discussed in Part 2 of the meeting.

In terms of cancer waits, demand is up in respect of 2 week waits in dermatology, colorectal and breast. Dermatology has piloted super clinics that have been successful and the Trust has procured some additional capacity for breast two week waits in the private sector. Colorectal cancer 2 week waits are being prioritised and there will be a further discussion Part 2 of the meeting. The Chief Operating Officer said that diagnostic underperformance is driven solely by endoscopy.

The Chair noted it was encouraging that the Trust was continuing to seek innovative improvements, despite the huge day to day operational pressures.

The Chair of the Finance and Performance Committee said that there have been agenda challenges and while the Committee has been focussing on demand and capacity the point is now being reached where decisions will need to be made to alleviate demand. The Committee had an update on the theatre utilisation programme and he said that this had highlighted things that the Trust can resolve and make better and the full plan will be returning to the Committee next month.

The Director of Finance introduced the financial element of the performance report to the Trust Board. 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. This was debated at the Finance and Performance Committee.

The Chair of the Finance and Performance Committee said that it appeared that the Trust

would miss its control total by @£2m and there will need to be a careful narrative that sets out the complex reasons for this. The Chair of the Finance and Performance Committee had attended the CCG AGM and he said that messaging there was that the Trust had missed its CIP target when the reality is more complex than that. He said that messaging from the Trust needs to reflect all that the Trust has done that is in its control to meet its control total and that message needs to be consistent, simple and have impact.

The Director of Strategy, Transformation and Partnerships gave an update on the ICS performance. He said that the Senior Leadership Team (SLT) papers were delayed and so not included in the Board pack. He said that most things have been covered in the previous discussions. However, he said that quality of the CCG performance report is not robust and he believes that there is an opportunity for both business information teams to work together to prepare a report with more depth and meaning. The Chief Executive said that the CCG Performance Report should be subject to Chief Operating Officer sign off as part of a good governance process.

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

GOVERNANCE ITEMS

BoD19/151 Board Assurance Framework and Risk Register

The Vice Chair of the Trust Chaired this item on the agenda.

The Vice Chair asked the Board if the documents accurately reflect risks and mitigations that have been identified in the framework and register. The Chair of the Risk and Audit Committee said that this had been reviewed in depth at the last committee meeting. The Board Assurance Framework (BAF) reflects the risks associated with the Trust achieving its strategic objectives; the financial and workforce risks are the most challenging. All the changes have been highlighted in red in the document and the Chair of the Risk and Audit Committee said that there have been technical changes and considerations to the RAG rating of these elements. There had been a debate at the committee regarding the risks associated with the ICS and it was agreed that these risks are captured in other documents. Board members noted the changes and felt that it was an accurate reflection of the Trust's position. The Chair of the Finance and Performance Committee said that the test of the BAF is whether the identified risks are reflected in Committee and Board agendas and he said that this is the case.

The Board accepted the revised BAF.

The Director of Nursing and Quality said that the executive team need to review the risk register and said that there are risks in the paper that are not yet due for review. She said that the discussion at the Risk and Audit Committee is moving away from a technical discussion of what we call things to focussing on what the consequences of the risks might be using the Trust's risk scoring matrix. She said that the top rated risks relate to subjects already discussed. She said that mitigations have been updated around financial sustainability, workforce planning and the emerging risks around pension taxation.

The Chair of the Quality Committee said that she felt there should be a specific risk relating to mortality as she believes that this risk, linked to clinical coding, the medical examiners service and structured judgement reviews (SJRs) is quite high. The Medical Director said that the surgical division has an efficient and effective method of reviewing their SJRs but this is not working well in the urgent and integrated care division. The Medical Director said that of the 750 deaths at the Trust annually, 150 are in surgery and 600 in medicine. The Divisional Director for the Urgent and Integrated Care Division said that he has ideas on how this will be addressed and in the next few weeks he plans that reviews will be done regularly and in a timely fashion with assistance from his clinical colleagues.

Action: The Chief Executive will discuss with executive colleagues the specific issues around mortality when reviewing the Risk Register.

The Medical Director said that the medical examiner system is in place and is working well. Medical Examiners will review every death and there should be much greater clarity from them as the service progresses.

The Director of Nursing and Quality said that partner organisations are looking at potential changes to the risk scoring matrix and having one matrix across all local organisations. If changes are proposed she will review and a paper will be submitted to the Risk and Audit Committee for consideration and approval before any changes are made.

BoD19/152 Risk Appetite Statement Annual Review

The Director of Nursing and Quality said that the risk appetite statement should be reviewed annually by the Board and in conjunction with the BAF and Risk Register. In response to a question, the Director of Nursing and Quality said that proposals at committees should be reviewed against the matrix and drive decision making. She said it would be helpful to frame any discussions in Part 2 of the meeting against the framework.

The Chair of the Risk and Audit committee did not think that the statement in respect of commercial risk was correct as the Trust had not demonstrated significant appetite for commercial risk. The Director of Strategy felt that the statement was accurate up to a point and that the Trust has taken some commercial risks e.g., Pharmacy Sub. Co. The Director of Strategy said that if the statement should drive decisions there should be an indication on cover sheets to papers. The Director of Nursing and Strategy said that the statement is specifically for Trust Board use rather than all staff. The Chief Executive said that the statement should be used in the business planning round. It was noted that none of the domains could be taken in isolation.

Action: Executives to advise on changes to the Board paper covering reports/front sheets to reflect risk appetite assessment.

WORKFORCE ITEMS

BoD19/153 Safe Staffing Return

The Director of Nursing and Quality introduced the Safe Staffing Return which is for submission nationally. There were two shifts with only one registered nurse on duty during this reporting period (elderly care and renal); these were supported by adjacent ward areas and night sister presence on all occasions. The Director of Nursing and Quality said that currently approximately 75% of requested temporary cover for shifts is filled by temporary staffing. She asked the Board to note that many areas are showing as greater than 100% due to additional staff required for extra capacity beds due to demand and activity.

The Board noted the return and approved it for submission.

BoD19/154 GMC Survey Results

Audrey Ryan (Director of Medical Education) gave a presentation to the Trust Board.

The Director of Medical Education said that the Trust has a mix of consultants, doctors in training (almost exclusively from the Wessex Deanery), and non-training grades (Staff Grades, Specialty Doctors, Trust Doctors, 'F3s', Associate Specialists, 'WAST' doctors). AR said that Deanery trainees are at the Trust for between 6 months and 2 years. DCH has no input into the length of their placement.

The rotas are designed around a certain number of doctors but that nationally lower levels of doctors training in some specialties plus increased numbers of less than full time workers mean rotas are not filled. There are also geographical recruitment challenges for DCH.

The Director of Medical Education said that this year the Trust has a full complement of F1s and F2s. The Trust had limited success in F3 recruitment although this is something that the Trust is getting better at for example by continuing access to an educational supervisor, which has been developed locally at DCH. New Widening Access to Specialist Training doctors (WAST) have been encouraged to fill vacancies in psychiatry and general practice and have been targeted at regions with hard to fill vacancies. The Trust has taken three WAST trainees who will be with at the hospital for three years and are currently working at F2 level.

The Trust had good fill rates with Deanery training posts, but problems with some trainees who arrived without completion of the necessary visa process. This is being addressed with the Deanery. The new Dean is Dr Paul Sadler.

The junior doctor contract has been renegotiated and this has presented an opportunity to revisit rotas. The Trust has signed up to the BMA Fatigue and Facilities Charter, aimed at improving and increasing facilities for rest breaks for junior doctors and £30k has been made available for this and the junior doctors forum will decide how to spend it. The Trust's allocation for doctors undertaking supervision should be 0.25PA for each doctor supervised but at the present time the Trust allocates half of this. The Dean believes that the CQC will be interested in this metric and this was also a recommendation from the GMC visit in February 2018.

The Director of Medical Education said that in terms of key individuals, Kyle Mitchell is now the Guardian of Safe Working. Dr Lucy Pearce alongside Paul Murray 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 the new Chief Registrar.

In terms of the GMC survey results, the Director of Medical Education said they can be broken down by specialties or by programme. There are eighteen fields relating to topics such as clinical supervision, rota design etc. In terms of results, the Trust is second only to Jersey of the acute Trusts in Wessex in terms of overall results. There have been improvements in some areas that flagged as problems in the previous survey.

Anaesthetics does well each year and continues to do so. Paediatrics and GP foundation trainee results have improved. Cardiology was a problem but the results are better this year. Emergency Medicine got great results overall. General surgery is better than last year as is care of the elderly. Obstetrics and gynaecology has seen a significant improvement and are now top in Wessex. However, hot spots are in core medical training (doing more ward work rather than attending clinics) and this is being worked on, paediatrics in higher training, issues with emergency medicine workload, F2s in surgery and issues in gastroenterology and urology.

The Director of Medical Education said that 100% of F2s completing the survey said that they worked beyond their rostered hours in emergency medicine with 75% describing this workload as very heavy. There is an action plan for recruitment for F3s, a new rota design and the introduction of specialty trainees. Done some work looking at local induction and staffing levels at night. PM mentioned the theatre efficiency work that FPC have reviewed and the stress that surgeons and juniors are under.

In paediatrics overall the department scored well but specialty trainees flagged red in five different areas. Claire Hollingsworth has done exit and incoming interviews and met with her consultant body and management team. The issues are multi- factorial including communication and issues with their rota which was a particular problem for doctors commuting long distances. They have created a new rota and there is protected training time with exposure to management skills and more preparation and training in respect of safeguarding and preparing for a consultant role.

The red flags in gastroenterology were around rota design and clinical supervision out of hours. In urology, issues persist despite the move to a consultant of the week system and support from nurse specialists. This is the fourth year that the department has flagged red. The question remains whether there should be junior doctors in urology. The Chief Executive said there are embedded cultural team issues that the Trust should consider as a factor in whether there should be trainees in urology. The situation is being monitored closely.

All the recommendations from the GMC visit have been addressed and are being worked upon.

The Medical Director said that overall the GMC report is good and the challenges are not unique; urology is an exception to that. The Divisional Director commended the energy the Director for Medical Education brings to the role enabling a stable and improving picture to be maintained which he said is hugely valued by all his clinical colleagues. He said that with better leadership in the Division the issues in urology may be addressed. The Chief Executive asked the senior team to consider what further steps the Trust should take in respect of training posts in this service.
Action: The Senior Team to consider what further steps the Trust should take in respect of training posts in this service.

BoD19/155 Guardian of Safe Working
Kyle Mitchell was in attendance as the new Guardian of Safe Working and gave an overview of the approach that he is going to take to the role. He said that he was motivated to take on the role because he has a passion for fostering sustainability in his profession. He said there are subtle intergenerational challenges but he recognises the brilliance of junior doctors and wants to foster engagement and enthusiasm in partnership with the trainees. He noted the independence of his role and his accountability directly to the Trust Board. His aim, through careful review of exception reports, is to identify risks early and address them making the Trust safer. He said that his is concerned about the level of reporting which he believes is low and he said that he looked forward to providing the Board with regular quarterly updates.

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

BoD19/156 Annual EPRR Statement
The Trust Board approved the statement.

BoD19/157 Cyber Operational Readiness Support Roadmap
The roadmap would be circulated to the Board following the meeting.

BoD19/158 Any Other Business
There was no other business.

BoD19/159 Questions from the Public
No members of the public were present and there were no tabled questions.

BoD19/160 Date of Next Meeting (open to the public): Wednesday 27 November 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 25 SEPTEMBER 2019

Minute	Action	Owner	Timescale	Outcome
BoD19/143	The Director of Nursing and Quality to provide an update regarding educational use of videos across the Trust.	Director of Nursing and Quality	TBA	
BoD19/151	Executive team to consider the issues around mortality and SJRs when reviewing the Corporate Risk Register.	Executive Team	ASAP	
BoD19/154	The Senior Team to consider what further steps the Trust should take in respect of training posts in this service.	Senior Team	ASAP	

Carried Forward

Minute	Action	Owner	Timescale	Outcome
BoD19/110	The executive team to continue the discussion about embedding a quality improvement culture at the hospital. The quality improvement strategy to be discussed at the November Trust Board.	Executive Team	November	
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	**27 November 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:

Number of over 85s in UK

The number of over 85s in the UK is set to double within the next 25 years, new data reveals, amid fears of the social care crisis escalating. The Office for National Statistics (ONS) has published data showing national population projections. Researchers found that the UK population is set to rise by 3 million (or 4.5%) in the next decade, from around 66.4 million in mid 2018 to around 69.4 million in mid 2028. However, the ONS also reported that the number of 85 year olds is set to double within the next 25 years.

DCH Performance

The hospital has continued to find itself under pressure during the last quarter. ED attendances and emergency admissions remain higher than planned. The consequences are reductions in planned care, longer waits for surgery and winter escalation beds remaining open since January this year leading to higher than planned staff costs. There are however some improvements to celebrate. Performance against the 6 week diagnostic standard has shown a marked improvement, together with the breast symptomatic standard. Although referrals under the 2 week referral standard for cancer continue to grow. Performance against the majority of the quality standards remains good.

Although some further improvement in performance against some constitutional standards is expected this year, full recovery to national performance levels will not be achieved. The Trust is continuing to work with the CCG to agree trajectories for the coming year coupled with associated funding levels.

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. The first phase of this strategy relating to the construction of a multi storey car park has commenced with the submission of the planning application. 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

Private surgery for NHS patients

The number of NHS patients having surgery in private hospitals has nearly trebled since 2010. NHS figures obtained by the Guardian show that it paid for 214,967 people in England to have an operation in a private hospital in 2009/10. The figure soared to 613,833 last year, a 185% rise in nine years. The sharp rise in outsourcing has coincided with the waiting-list for non-urgent operations increasing to 4.6m, the highest figure since records began in 2007. The privatisation of healthcare has emerged as a key issue in the general election campaign.

Medical staffing

The UK has fewer doctors and nurses serving its population than many other countries in the developed world and spends less money on its health service. The study, from the Organisation for Economic Co-operation and Development (OECD), found that the UK had 2.8 doctors and 7.8 nurses for every 1,000 people, ranking it below Costa Rica, Russia and Hungary, but slightly above the US and Canada. The average across the OECD's 36 member countries was 3.5 doctors and 8.8 nurses. Health spending in the UK was significantly lower than most other western European countries, at 9.8% of its GDP. This was about 1% higher than the OECD average, but lower than spending in Switzerland, Germany, France and Sweden.

Review of access standards

NHS England appears increasingly likely to recommend a major overhaul of the four-hour A&E target. A progress report by NHS England's clinical review of standards review team said a trial of new metrics designed to "remove the four-hour cliff edge" had been "promising". However, NHS England medical director Stephen Powis said it was too early for us to draw conclusions.

Seven in ten A&E patients are waiting longer under the new targets. A review of the measures found that the vast majority of patients were forced to wait longer, by an average of nine minutes. Waiting times fell for the one in three A&E cases admitted to hospital, by an average of three minutes, to five hours 12 minutes. The remainder saw average waiting times increase by nine minutes, to three hours and 10 minutes.

Pilot of standing appointments

GPs are to pilot standing-up appointments to "set an example" to patients about the perils of a sedentary lifestyle. Backed by the Royal College of General Practitioners, the study will also investigate whether doing so will shorten the length of consultations. Starting in the Midlands, the pilot scheme will see family doctors equipped with £2,000 desks that can switch from sitting to standing formats at the push of a button.

Antibiotic usage

There has been a 17% drop in the number of prescriptions for antibiotics written by GPs in England over the past five years. However, antibiotic-resistant infections are still rising - up 9% between 2017 and 2018, to nearly 61,000. Public Health England's annual report on antimicrobial resistance for 2018-19 found that the most potentially serious infections rose by a third between 2014 and 2018.

Local Relevance

Diabetes

More than 10% of all NHS drug spending is now devoted to diabetes. The statistics from NHS Digital reveal that the bill for antidiabetic medication has risen by more than 220% in a decade. The report shows that the overall bill for all types of medication and devices to treat the disease has now reached more than £1bn.

Obesity

NHS figures show that the number of hospital admissions for conditions linked to obesity has exceeded a million in a year for the first time. NHS figures show that there were 442,000 obesity-related admissions in 2013/14. There were 1,086,266 last year. In 2018/19, almost 1.1 million patients in England were admitted to hospital as a direct result of their obesity or with a condition caused or exacerbated by being very overweight. The NHS Digital data shows that in 12,000 cases obesity was noted as the primary reason for a hospital admission, including cases in which people were struggling to breathe or had too much carbon dioxide in the blood. Almost two cases in three were women, with an average age of 54. The figures also showed a large rise in the number of children receiving treatment. More than 9,000 of the admissions involved someone who was under 18, a number that has doubled in five years. More than 600 cases involved children aged under five

Mental Health

A report commissioned by the Royal College of Psychiatrists found that patients were forced to travel 555,000 miles in a year because there were no locally available beds. The college estimated the figure by analysing NHS data on a range of distances travelled by patients subject to 8,640 inappropriate placements active between August 2018 and July 2019. On 31 July this year there were 745 people were being treated inappropriately out-of-area, according to official figures.

The college has estimated that the NHS needs more than 1,000 extra mental health beds to end the practice of sending patients hundreds of miles for treatment.

Racism in the NHS

Following recent media coverage of the racism that NHS staff sometimes face from patients the Secretary of State for Health and Social Care, Matt Hancock, has told NHS staff that patients who ask to be treated by a white doctor should be told 'no'. In a letter sent to all NHS staff he adds that: "Your management must and will always back you up." It instructs "those of you in senior management positions" to ensure "all appropriate steps are taken by organisations to ensure their staff know they can come to a workplace that is free from abuse and harassment".

Medical workforce

A recent report by the General Medical Council shows that around 9,100 medics who were trained abroad joined the medical register in the 12 months up to June 2019, compared to just over 8,100 in the preceding 12 months. By contrast, the number of new starters trained in Britain remains static at around 7,100 each year. The widening difference - now 28%, up from 12% the year before - has prompted calls to boost the number of home-grown doctors. NHS Providers praised the contribution of staff who have trained abroad, but added: "We know that a longer-term approach to meeting our workforce needs for the future must encourage higher number of locally trained staff over the next five to 10 years. We need to do more to attract young people into NHS careers as well as doing more to make sure the NHS is seen as a great place to work." Overall, there are now 164,525 licensed doctors in the UK, a 4.1% increase since 2017.

NHS estate

Recent reports concerning the latest NHS estate condition figures will make sobering reading for hospital bosses across England. The Estates Return Information Collection (ERIC) statistics for 2018/19, which were published last week, show that the NHS collective maintenance backlog has increased to £6.5bn. While this figure is less than some experts had feared, the number is still a big jump on the £6bn recorded in the previous year. More than half of the backlog is accounted for by maintenance issues that are deemed to pose a "high" or "significant" risk. To eradicate "high-risk" problems would cost NHS providers £1.1bn, more than twice the level just three years ago. The effect of the backlog can be seen in the 25% increase in the number of clinical service incidents in the past year, according to the Eric statistics. Poor maintenance – leading to power failures, sewage blockages and risk of fires – is often to blame for such incidents. A survey carried out recently by NHS Providers showed more than 80% of hospital executives believe that continued capital underinvestment is putting patient safety at risk.

Private providers

A new database to track doctors working in the independent sector is being developed as part of wider reforms to improve the clinical governance of those providers. The secure system will allow information to be shared between hospitals including a mandatory dataset about where doctors work and their scope of practice.

If any concerns are raised this should be shared with everywhere they work, including in the NHS, under the scheme. The framework, developed by former NHS England medical director Sir Bruce Keogh with the Independent Healthcare Providers Network, is designed to head-off concerns over governance and the ability for clinicians to operate without providers being fully aware of their activities.

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My biggest concerns at present are twofold; firstly, the resilience of our staff who have not seen a decrease in these pressures since January. Secondly, the escalating costs associated with urgent and emergency activity.

Other news

The Trust welcomed visits from a number of partners during November:

Saffron Cordery, Deputy Chief Executive NHS Providers and Adam Brimelow, Director of Communications NHP visited to review our capital constraints in support of the media campaign NHSP are running on the NHS needing more capital. The teams in the Emergency Department and Critical Care welcomed Saffron and Adam with their usual positive approach to ensuring patient safety in challenged environments.

Owen Williams, Chief Executive of Calderdale and Huddersfield NHS Foundation Trust, visited the Trust with some of his senior team. They have made good progress with embedding inclusive leadership so it was to hear more about their approach. They wanted to learn more about our approach to population health management and our acute hospital at home service, which they are thinking of replicating.

Later in the month we welcomed both Nigel Edwards, Chief Executive of the Nuffield Trust and Elizabeth O'Mahoney, Regional Director for the South West for NHSI/E.

Finally, on 29 November we are looking forward to welcoming Prerana Issar, Chief People Officer for NHSI/E.

Patricia Miller, Chief Executive
November 2019

Balanced-Score Card Performance Report

Report to Board: 27 November 2019

Performance Summary:

October performance against the four hour Emergency Access Standard (EAS) remained on par with September 2019. The type one performance for October was 79.5%, the combined types one and three performance was 90.2%. 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 7.8% compared to August 2018; similarly ambulance conveyance rates increased by 16%.This translated into a corresponding increase in the number of admissions of 6% compared with August 2018. The aforementioned pressures were partially mitigated by a decrease in super-stranded patients (as at 04/11/19 the Trust had achieved 31% reduction against the national ambition of 40% for beds occupied by patients with a length of stay of 21 days or more) and reduction in Delayed Transfers of Care to 3.5%. Ambulatory Emergency Care activity in October saw a further increase to 35% (for comparison August 2019 was 28% and September 2019 was 34%) of the emergency medical take during service hours and continues to compare 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 (70.22% versus trajectory of 76.16%) and there were five breaches of patients waiting over 52 weeks for treatment. Four of these were in Trauma and Orthopaedics and one in ENT. The 50:50 cost sharing agreement with the Commissioners has been clarified to cover all patients waiting 40 weeks and over and a number of insourcing/outsourcing arrangements are in train in order to mitigate potential future 52 week breaches. Performance against 62 day cancer standard has improved compared with Q2; the latest non-finalised performance for October stands at 79.2% compared to Q2 average of 72.3%. Performance remains challenging following the significant increase in 2ww referrals during Q1 and Q2; the size of the total cancer PTL has decreased by 250 compared with August 2019, however the 62+ day backlog has increased from 58 to 88. There has been a marked improvement in performance against the 6 week diagnostic standard to 93.25% which is 3% ahead of the monthly improvement trajectory. The main improvements have been in Audiology, Neurophysiology and Sleep Studies. Insourcing arrangements for endoscopic procedures are continuing with an independent provider to mitigate 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 five confirmed 52 week breaches as at the end of October 2019.
- 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:

- Achievement of the CIP target for the year of £7.130 million. To date schemes and opportunities totalling £5.748 million have been identified, leaving a gap of unidentified CIP of £1.382 million. Of the schemes identified £0.283 million relates to high risk schemes.
- The Agency metric is a 4 with Agency spend to date of £3.793 million against a target of £1.471 million. The annual ceiling is £2.9 million. Spend remains especially high for nursing agency and is also increasing on medical staffing.
- The level of uncoded spells has increased in month and now stands at 2,128 (compared with 2,027 last month). An estimate of the associated income has been included in the underlying Dorset, Somerset, Dental and NCA positions. If activity is not coded on a timely basis there is a risk to income collection for that being generated outside the Dorset CCG contract.

Items from the Workforce Committee:

- Linked to the long term plan: the recruitment of AHPs, nursing and midwifery posts are subject to system wide discussions.
- Nursing trajectories and international nurse recruitment are positive.
- Agency spend remains a challenge.
- The library services strategy was approved.
- Consultant job planning is now being led by the Chief Executive and plans will be in place and completed by the beginning of April.
- There has been a positive take up of substantive contracts by Estates and Facilities staff who were on as and when contracts.
- There are challenges in recruiting to health informatics using Agenda for Change pay bands.
- The number of apprenticeships at the Trust is positive.

Items from the Quality Committee:

- Mortality reporting and the structured judgement review backlog and ongoing discussions with NHSI.
- A never event.
- The positive GIRFT report for endocrinology.
- Discussions around stroke services.
- CAMHS services and ongoing work in this area.
- Complaints response rates remain at 100%.
- Norovirus outbreak and assurance on actions being taken.
- Venous thromboembolism (VTE) assessment, electronic discharge summaries (EDS), dementia screening and MUST (screening tool to identify adults who are malnourished) remain key areas of focus for the comittee.
- The committee received a deep dive on sepsis.

Items from the Finance and Performance Committee:

- Improved performance in diagnostics.
- Performance and winter pressure funding.
- There are ongoing projects around theatre utilisation, patient flow and RTT that are being closely monitored by the Comittee.
- International nurse recruitment and the recommendation to the Trust Board.

Items from the Risk and Audit Committee:

- The BAF and Risk Register were reviewed. There is synergy between items contained in each and the work undertaken by the board sub-committees and Trust board.
- Two information governance breaches were reviewed. No further action was required by the Trust.
- The committee received a deep dive into the risks associated with the emergency department.
- The internal audit report in respect of medical devices.
- Board resilience and planning for winter.

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	Sep-19	Oct-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	1 (0.1)	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	16	2 (0.2)	1 (0.1)
	Never Events	0	0	0
	Serious Incidents declared on STEIS (confirmed)	51 (4 per month)	2	1
	SHMI - Rolling 12 months, 5 months in arrears (Apr-18 to Mar-19)	<1.12	1.18	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Jun-18 to May-19)	100	114.4	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	92%	71.5%	70.2%
	RTT Incomplete Pathway Waiting List size	11,991	16,248	16,442
	All cancers maximum 62 day wait for first treatment from urgent GP referral	85%	73.5%	79.2%
	Maximum 6 week wait for diagnostic tests	99%	90.7%	93.3%
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	95%	90.4%	90.2%
Finance	Elective levels of contracted activity (£)	2019/20 = £30,721,866 £2,560,155/month	2,194,701	2,514,683
	Surplus/(deficit) (year to date)	2019/20 = Breakeven YTD M7 = (3,716)	(3,528)	(3,402)
	CIP - year to date (aggressive cost reduction plans)	2019/20 = 7,130 YTD M7 = 2,613	2,227	3,005
	Agency spend YTD	2019/20 = 2,929 YTD M7 = 1,471	3,130	3,793

Rating Key

Achieving Standard

Not Achieving Standard

INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain

Safe

- **Sepsis:** Data not available for ED October. Inpatients met the required standard for antibiotic administration. Deep Dive on Sepsis separate agenda item presented at Quality Committee.
- **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 –** Data not accurate as part of the Nutritional Quality Improvement project, data is moving from data based to VitalPac. Reports form VitalPac are not available Trust wide. To provide assurance, the Board is asked to note that training levels in the pilot areas is: Purbeck 90% - Day Lewis 97% -Stroke 95%. A snap audit of VitalPac Must assessments shows Purbeck ward at 100% compliance with Nutritional assessments.

Effective

- **SHMI:** Hospital Mortality Group monitors unpublished SHMI. The dashboard reflects the nationally published SHMI data, which is only available 6 months in arrears.
- **Fracture Neck of femur** – Further deterioration within month observed. Further detailed 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. Improvement noted; Medical Director leading with Divisional Director support.

Caring

- **Mixed sex breaches –** All breaches relate to the timely discharge of patients from the Critical Care area to suitable ward beds. A proposal to support the new guidance provided by NHSE/I will be taken to the Quality Surveillance Group by the CCG. Further details will be supplied to the Quality Committee.
- **Friends and Family Test –** The standards for ED/Outpatients and Maternity have not been achieved during this reporting period.

Responsive

The access standards for October 2019 remained challenging with increased emergency activity including trauma, corresponding impact on 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 (radiotherapy/other)
- Cancer 31 day from decision to treat to surgery

Standards not met:

- ED- 4 hour standard combined with MIU
  - Reduction in the numbers of stranded and super stranded patients; executive led long stay DPTL meetings continue weekly
  - System wide work ongoing on demand management and expediting of complex discharges
  - 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
  - Referral volumes remain above previous financial years
  - Breast 2ww capacity has been aligned to demand and bookings made within the 14 day standard
  - 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 agreement with the CCG clarified to include treatment of any patient waiting 40 weeks or over
  - Transfer of 60 ophthalmology patients to Winterbourne has been agreed with the Commissioners
  - Additional insourcing/outsourcing capacity being explored with the independent sector for ENT and Gynaecology
  - Tender waver in place for utilisation of Orthopaedic capacity at Yeovil
  - ASD improvement trajectory agreed with the Commissioners
- Diagnostic 6 week wait
  - Significant improvement in performance for audiology, DEXA scanning, neurophysiology and sleep studies
  - Ongoing insourcing of capacity for endoscopic procedures from an independent provider

Well Led

Dorset County Hospital NHS Foundation Trust has delivered an income and expenditure deficit of £3.402 million to the end of October 2019 against a planned deficit of £3.716 million, a favourable variance of £0.314 million. The favourable position to plan is mainly as a result of increased levels of clinical income from Specialist Commissioning and Non-Contracted Activity as well as an additional £0.233 million of Provider Sustainability Fund related to 2018/19. The position in month is marginally worse than planned as a result of a further increase in agency spend.

Total workforce capacity increased by 14 FTE in month with a growth of 18 FTE in substantive workforce and a reduction of 4 FTE with Bank staff. Total workforce costs increased by £365 in M07. Agency costs in month rose by £152k in M07 and were £238k above last year's figure for M07. The increase in agency spend was primarily attributable to staff grade and consultant medical staffing and qualified nurses with the primary reasons for spend recorded as sickness and vacancy cover. This was the highest agency spend this financial year and work continues through a task and finish group to address agency costs. Sickness levels rose in M07 to 3.66%, which as sighted was a contributory factor to increased agency costs. This represents the highest level of sickness in 2019/20.

As at 5th November, 55% of all staff had received the Flu vaccination and 63% of front line staff. This represents an increase on take-up of the vaccination against the same period last year.

Metric	Threshold/ Standard	Type of Standard	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-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)	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	N/A	N/A	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	1 (0.1)	**2 (0.2)**	1 (0.1)	1 (0.1)	1 (0.1)	**2 (0.2)**	1 (0.1)	4 (0.2)	4 (0.2)	9 (0.2)	↑	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	**94.1%**	**93.4%**	96.0%	95.4%	**93.6%**	95.1%	**91.8%**	**94.4%**	**94.5%**	**94.1%**	↓	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	0	1	1	0	0	1	1	1	2	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	1	0	0	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	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	**3**	**4**	**5**	**5**	**6**	**6**	**2**	**12**	**12**	**29**	↑	
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)	**2 (0.2)**	0 (0.0)	0 (0.0)	**2 (0.2)**	**3 (0.4)**	0 (0.0)	2 (0.1)	**5 (0.2)**	**7 (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)	1 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.0)	1 (0.0)	↔	
Emergency caesarean section rate			11.2%	13.6%	14.3%	16.4%	20.8%	16.5%	13.5%	13.2%	18.0%	15.3%	↑	
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)	92.5%	**71.7%**	91.9%	**70.9%**	93.5%	100%	N/A	**84.6%**	**84.3%**	**84.5%**	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	92.2%	94.4%	97.4%	93.4%	100%	94.4%	**83.3%**	94.4%	95.5%	93.6%	↓	
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)	91.3%	**86.2%**	**87.5%**	**77.5%**	**80.8%**	91.7%	N/A	**77.6%**	**82.2%**	**80.1%**	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** -	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**78.0%**	**75.0%**	**85.3%**	**85.7%**	**87.9%**	100%	100%	**79.6%**	**89.4%**	**86.5%**	↔	
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**	**1**	**1**	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 expected deaths)**	Contractual (Local Quality Requirement)	**1.19**	**1.16**	**1.18**	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)	**113.4**	**112.7**	**113.0**	**114.4**	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)	**105.4**	**102.7**	**109.8**	**111.3**	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**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	**62.8%**	**64.3%**	**47.0%**	**38.7%**	**28.4%**	**43.9%**	**23.8%**	**57.9%**	**36.9%**	**43.7%**	↓	
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%	100.0%	↔	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are	**90%**	Contractual (Local Quality Requirement)	**86.4%**	**62.9%**	**62.5%**	**73.3%**	**40.0%**	91.3%	**81.3%**	**68.5%**	**79.1%**	**73.0%**	↓	
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	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	30	29	24	26	40	24	34	83	90	173	↓	
Complaints - Percentage response timescale met (1 month in arrears)	**Dec '18 = 95%**	Local Trajectory	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	N/A	N/A	N/A	N/A	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	98.4%	98.5%	98.7%	97.8%	**95.2%**	97.6%	98.5%	97.9%	97.0%	97.7%	↑	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	**82.3%**	84.5%	**83.0%**	**82.8%**	**80.4%**	**83.7%**	**83.7%**	**82.9%**	**82.2%**	**82.8%**	↑	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**91.7%**	94.5%	**93.9%**	94.4%	94.1%	**93.4%**	**93.5%**	**93.7%**	94.0%	**93.7%**	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**22**	**18**	**14**	**17**	**10**	**22**	**8**	**54**	**49**	**111**	↓	

Metric	Threshold/ Standard	Type of Standard	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-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)	**75.1%**	**76.6%**	**76.0%**	**76.3%**	**73.3%**	**71.5%**	**70.2%**	**76.0%**	**71.5%**	**70.2%**	↓	
RTT Incomplete Pathway Waiting List size	**11,991**		**15,179**	**15,189**	**15,135**	**15,797**	**16,291**	**16,248**	**16,442**	**15,135**	**16,291**	**16,442**	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**68.8%**	**61.8%**	**75.5%**	**65.0%**	**58.8%**	**69.3%**	**75.7%**	**68.2%**	**64.3%**	**67.6%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**3.6%**	**4.5%**	**37.5%**	**0.0%**	-	100.0%	100.0%	**8.6%**	**66.7%**	**14.3%**	↔	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	100.0%	100.0%	**96.0%**	**94.7%**	97.7%	98.0%	99.0%	98.7%	96.7%	97.9%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**81.8%**	**63.6%**	**83.3%**	100.0%	100.0%	**75.0%**	**88.9%**	↑	
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%	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%	100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**84.0%**	**81.6%**	**81.7%**	**70.8%**	**72.9%**	**73.5%**	**79.2%**	**82.4%**	**72.3%**	**82.4%**	↑	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	94.1%	92.9%	**72.7%**	**69.6%**	**68.8%**	**76.9%**	**81.8%**	**88.1%**	**71.2%**	**88.1%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**88.2%**	**89.0%**	**90.3%**	**89.2%**	**85.5%**	**90.7%**	**93.3%**	**89.2%**	**88.5%**	**89.4%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**78.3%**	**90.4%**	**85.9%**	**82.1%**	**77.2%**	**79.9%**	**79.5%**	**84.8%**	**79.8%**	**81.8%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from	**95%**	Contractual (National Operational Standard)	**89.5%**	95.5%	**93.3%**	**91.6%**	**89.5%**	**90.4%**	**90.2%**	**92.8%**	**90.5%**	**91.4%**	↓	
Well Led														
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		36.21%	46.55%	43.97%	46.55%	43.97%	41.38%	N/A	N/A	N/A	N/A		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	3.2%	3.0%	3.1%	3.55%	3.40%	3.66%	N/A	3.10%	3.54%	3.30%	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	88%	88%	88%	87%	86%	86%	87%	88%	86%	87%	↑	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.8%	8.8%	8.9%	9.3%	9.7%	9.6%	9.7%	8.8%	9.5%	9.2%	↓	
Total Workforce Capacity	**2,650.8**	Internal Standard reported to FPC	2,392.9	2,423.1	2,430.4	2,455.0	2,442.9	2,484.6	2,465.7	2,415.5	2,460.8	2,442.1	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	7.9%	8.0%	7.6%	6.3%	7.0%	8.7%	8.8%	N/A	N/A	N/A	↓	
Total Pay Cost	**10,442.1**	Internal Standard reported to FPC	9,583.1	9,287.4	9,181.3	9,391.5	9,717.9	9,737.7	9,558.1	9,350.6	9,615.7	9,493.9	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	2	0	0	0	2	2	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	87%	87%	87%	87%	87%	87%	88%	87%	87%	87%	↑	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,328**	**2,379**	**2,349**	**2,405**	**2,074**	**2,335**	**2,512**	**7,056**	**6,814**	**16,382**	↑	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£2,220,872**	**£2,333,890**	**£2,427,558**	**£2,431,863**	**£2,105,601**	**£2,194,701**	**£2,514,683**	**£6,982,320**	**£6,732,165**	**£16,229,168**	↑	
Surplus/(deficit) (year to date)	**2019/20 = Breakeven YTD M7 = (3,716)**	Local Plan	(879)	(1,536)	(1,972)	(2,418)	(3,064)	(3,528)	(3,402)	(1,972)	(3,528)	(3,402)	**N/A**	**N/A**
Cash Balance	**2019/20 - 1303 M7 = 5,665**		7,738	8,348	7,700	10,988	12,714	10,302	10,125	7,700	10,302	10,125	↓	
CIP - year to date (aggressive cost reduction plans)	**2019/20 = 7,130 YTD M7 = 2,613**	Local Plan	379	**692**	**971**	**1,353**	1,852	2,227	3,005	**971**	2,227	3,005	**N/A**	**N/A**
Agency spend YTD	**2019/20 = 2,929 YTD M7 = 1,471**		**482**	**970**	**1,502**	**2,043**	**2,619**	**3,130**	**3,793**	**1,502**	**3,130**	**3,793**	**N/A**	**N/A**
Agency % of pay expenditure	**2019/20 = 2.3%**		**4.5%**	**4.7%**	**4.8%**	**4.9%**	**4.9%**	**4.9%**	**5.0%**	**4.8%**	**4.9%**	**5.0%**	↓	

Movement Key

Favourable Movement ↑
Adverse Movement ↓
No Movement ↔

Achieving Standard
Not Achieving Standard

Title of Meeting	**Trust Board**
Date of Meeting	**27th November 2019**
Report Title	**Integrated Care System (ICS) Summary**
Author	Nick Johnson
Responsible Executive	Nick Johnson – Director of Strategy, Transformation and Partnerships

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

1. Summary

Appendices A, B, and C provide a summary of the Dorset Integrated Care System key quality, performance, financial and transformation activity as presented to the System Leadership Team (SLT).

Additionally, Appendix D provides a summary of the emerging Dorset Long Term Plan.

2. Quality (Appendix A)

- Ambulance demand and call stack risk are identified as high risk;
- DCH improvement in SHMI is noted
- DCH performance on VTE assessment, prophylaxis prescribing and nutrition screening is flagged as below peers in Dorset.

3. Performance Report (Appendix A) – Sept 19 Data for Nov SLT

- DCH ED demand up against contract plan at 9%, RBH 7.6%, Poole at 1.1% (all 0% plan)
- Non-elective admissions down 2.1% at DCH, Poole down 11.4%, RBH up 6.4%
- DCH DTOCs higher (5.5%) than Poole (3% and RBH (3.5%) (August figures)
- Long Length of stay down 22% at DCH, 33% RBH, 12% Poole.
- Integrated Urgent Care service failing number of KPIs. CCG seeking assurance on 111 insource
- DCH lowest performance on RTT, GP referrals have increased 1.5% DCH, 2.6% for RBH, -4.7% for PH.
- Criteria Based Access Protocols reduced 27% in first five months.

4. Financial Report (Appendix B)

- M6 forecast ICS forecast on plan with significant pressures
- £110.4m savings for system. £5.7m unidentified and 35.2m are non-recurrent
- Agency spend continues to increase

5. Sustainability and Transformation Plan Report (Appendix C)

One Acute Network

- The contract and pan-Dorset collaboration agreement supporting the Pathology IT replacement project (LIMS) sign off is complete. The start of the more detailed work toward system replacement confirmed as the 9th October.
- Submission of the Dorset LEP bid to support the hub build was supported by the Trusts.
- The regional Directors of Finance group meeting gave approval to OJEU tender for the replacement of all equipment in Pathology. Radiology (& Medical Physics):
- Agreement at Merger Steering Group 1 October 2019 for a merger date of 1 July 2020. Timelines have been revised to reflect this decision. All the key merger products will now be submitted to the NHSI at the beginning of March 2020.
- NHSI have completed the recommendation reports for the Regional Directors approval in

October, this will then be reviewed by Investment and Resources Group (IRG) in October and Delivery, Performance, Quality, Committee (DPQC) in November. DH/HMT Treasury is anticipated for February 2020 this however is not confirmed, therefore we continue to show target April 2020.

Integrated Community & Primary Care Services

- Data Analysis preparation for supporting children's health needs in the community is ongoing and supporting understanding of need and access points of services in paediatrics. Now working alongside Emily Merrell on population health data systems within PCNs with a focus on paediatric health needs and service provision.
- eConsult is now live in 42 practices and there are plans for a further 40 practices to have eConsult live and in active use by March 2020.
- Support required to negotiate further space in primary care or in community settings.

Prevention at Scale

- Pan-Dorset Project Lead for Smoking in Pregnancy (Poole based) now working well with DCH and RBCH maternity teams. RBCH are going to run a pilot with the Sunshine Team for Specialist Smoking Cessation Assistant.
- Living Well Scale: Year to date (April – August) there has been 3,002 individuals' access LiveWell Dorset support. This is a 21% increase on the same period the previous year and is almost on track with the 10,000 targets for the full year.

Digitally Transformed Dorset

- There are difficulties with the installation of the secondary HSCN circuit into DCH owing to a blocked duct which will require re-digging. This may add significantly to the delay. Discussions are on-going about whether it will be acceptable to run both circuits down the same duct as a temporary workaround.
- GovRoam: Specification agreed. Procurement begins week commencing 14th October for 4 weeks. Award of contract planned for December. Funding arrangements not yet agreed.

Leading and Working Differently

- Representatives from the DWAB attended OFRG and presented the strategic workforce investment plans for support new supply routes. The plans were well received and it was agreed that a more detailed business case would be developed.
- Following a bid to the SW Leadership Academy, Dorset ICS has been allocated £50k to support system wide leadership and talent management activities, this will include the expansion of the Walking in the Same Direction programme and master classes on inclusion and compassionate leadership.

Integrated Travel Programme

- DC Adult Services have agreed that clients receiving Personal Social Care Budgets is inclusive of the persons transport needs. DC have yet to agree if this will be extended to clients who use other Adult Services transport, e.g. those who use LA transport into day care centres.

Paper Previously Reviewed By
Appendices reviewed by System Leadership Team

Strategic Impact
DCH has developed a strategy focused on integration and collaboration and is therefore currently committed to the development of the ICS.

Risk Evaluation
ICS activity and involvement is currently delivering variable benefit to DCH and DCH must balance system focus and transformation with organisational focus and transformation.

Impact on Care Quality Commission Registration and/or Clinical Quality
DCH retains all CQC and quality obligations as an organisation

Governance Implications (legal, clinical, equality and diversity or other): As the ICS governance matures there will be an increasing expectation for 'decisions' to be made at ICS level and endorsed at the statutory/organisational level.	
Financial Implications DCH retains an individual control total, within a wider system control total.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	It is recommended that Trust Board: a) note and comment on the report b) identify any issues to be raised with the ICS System Leadership Team

CONFIDENTIAL **09.**

SYSTEM LEADERSHIP TEAM (SLT) MEETING

SUSTAINABILITY AND TRANSFORMATION PROGRAMME (STP) TRANSFORMATION REPORT

Date of the meeting	21/11/2019
Author	M Gorman, Head of PMO
Purpose of Report	To provide an update on the transformation programme
Recommendation	The SLT is asked to discuss and agree the risks, issues and decisions in the report.

1. Introduction

1.1. The report highlights the major decisions required and key areas for discussion to progress the delivery of the Sustainability and Transformation Plan (STP).

1.2. Further Information, including the major risks and progress updates of the portfolios, can be found in the STP Highlight Report (Appendix 1), the STP Risk Report (Appendix 2) and the STP Milestone Report (Appendix 3).

2. Risk Report Summary

2.1. Currently the Portfolio's within the STP have identified and are managing 28 risks that are significant or major, of these risks, 9 (32.2%) have been identified as major risks (risk score of 15 and above).

2.2. Further to the Major risks identified, 19 (67.8%) have been categorised as significant (Risk score of 8 – 14) Details of all the identified risks can be found in Appendix 2: STP Risk report.

2.3. Since August, 0 new risks have been added to the register. Since the August report no risks have been escalated.

3. Portfolio Highlights & Escalations

3.1. The information below has been produced from the STP Highlight Report (Appendix 1) and identifies some of the highlights and escalations for SLT.

One Acute Network

3.2. The contract and pan-Dorset collaboration agreement supporting the Pathology IT replacement project (LIMS) sign off is complete. The start of the more detailed work toward system replacement confirmed as the 9th October.

3.3. Submission of the Dorset LEP bid to support the hub build was supported by the Trusts.

3.4. The regional Directors of Finance group meeting gave approval to OJEU tender for the replacement of all equipment in Pathology. Radiology (& Medical Physics):

3.5. Agreement at Merger Steering Group 1 October 2019 for a merger date of 1 July 2020. Timelines have been revised to reflect this decision. All the key merger products will now be submitted to the NHSI at the beginning of March 2020.

3.6. NHSI have completed the recommendation reports for the Regional Directors approval in October, this will then be reviewed by Investment and Resources Group (IRG) in October and Delivery, Performance, Quality, Committee (DPQC) in November. DH/HMT Treasury is anticipated for February 2020 this however is not confirmed, therefore we continue to show target April 2020.

Integrated Community & Primary Care Services

3.7. Data Analysis preparation for supporting children's health needs in the community is ongoing and supporting understanding of need and access points of services in paediatrics. Now working alongside Emily Merrell on population health data systems within PCNs with a focus on paediatric health needs and service provision.

3.8. eConsult is now live in 42 practices and there are plans for a further 40 practices to have eConsult live and in active use by March 2020.

3.9. Support required to negotiate further space in primary care or in community settings.

Prevention at Scale

3.10. Pan-Dorset Project Lead for Smoking in Pregnancy (Poole based) now working well with DCH and RBCH maternity teams. RBCH are going to run a pilot with the Sunshine Team for Specialist Smoking Cessation Assistant.

3.11. Living Well Scale: Year to date (April – August) there has been 3,002 individuals' access LiveWell Dorset support. This is a 21% increase on the same period the previous year and is almost on track with the 10,000 targets for the full year.

Digitally Transformed Dorset

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Leading and Working Differently

3.14. Representatives from the DWAB attended OFRG and presented the strategic workforce investment plans for support new supply routes. The plans were well received and it was agreed that a more detailed business case would be developed.

3.15. Following a bid to the SW Leadership Academy, Dorset ICS has been allocated £50k to support system wide leadership and talent management activities, this will include the expansion of the Walking in the Same Direction programme and master classes on inclusion and compassionate leadership.

Integrated Travel Programme

3.16. DC Adult Services have agreed that clients receiving Personal Social Care Budgets is inclusive of the persons transport needs. DC have yet to agree if this will be extended to clients who use other Adult Services transport, e.g. those who use LA transport into day care centres.

Table of Abbreviations

STP	Sustainability and Transformation Plan
LIMS	Laboratory Information Management System
LEP	Local Enterprise Partnership
OJEU	Official Journal of the European Union

NHSI	NHS Improvement
IRG	Investment and Resources Group
DPQC	Delivery, Performance, Quality, Committee
DCH	Dorset County Hospital
RBCH	Royal Bournemouth & Christchurch Hospital
PCN	Primary Care Networks
DWAB	Dorset Workforce Action Board
OFRG	Operations and Finance Reference Group

Author's name and Title: M Gorman, Head of PMO
Date: 24/10/2019
Telephone Number: 07989171249

APPENDICES		
Appendix	**Document**	**Link**
Appendix 1	STP Highlight Report	Link
Appendix 2	STP Risk Report	Link
Appendix 3	STP Milestone Report	Link

SYSTEM LEADERSHIP TEAM MEETING

FINANCE REPORT

Date of the meeting	21/11/2019
Author	M Gravelle, Assistant Director of Finance, Dorset CCG
Purpose of Report	The purpose of the report is to provide an update to members on the position of the collaborative organisations as at September 2019 in respect of the financial position as well as the overall financial position for the health and care system.
Recommendation	The System Leadership Team is asked to **note** the report.
Stakeholder Engagement	This paper has been approved by members of the OFRG.

Dorset ICS – Finance Report (September 2019 data)

Our Dorset
Local NHS and Councils Working Together

November 2019

Contents

1. Executive Summary ICS (1)

Dorset Integrated Care System
As at Month 6 (September) the system (NHS & LAs) is forecast to be over plan for 2019/20 due to a Dorset Council forecast in year over spend. In achieving this position a number of financial risks are being mitigated.

System Control Total / Dorset Health System – In September, Dorset ICS (NHS) is forecast to be on plan at year end, although significant pressures exist within this assumption, including **£5.7m of unidentified savings** of which **£2.17m remains unmitigated (See slide 6)**.
This position was achieved with **£35.2m non-recurrent** savings in 2019/20, which presents a risk for future years.

Dorset ICS (NHS) has opted for the full PSF System control total in 2019/20. Therefore, £14.3m of PSF will be contingent upon delivery of the system financial control total. Central FRF & MRET funding of £21.5m will relate to organisational performance and not relate to system control total achievement. **South Western Ambulance FT** would not count towards the calculation of the system PSF.

Dorset Local Authorities - Bournemouth, Christchurch and Poole Council are currently reported as on plan. Dorset County Council is currently **forecast to be £7m over plan**. Joint work is continuing on Better Care Fund (BCF) projects and prioritising the 2019/20 uplift.

Primary Care Commissioning
Within the reported Dorset CCG position (included above) there is a delegated commissioning budget for primary care GP services of **£109.1m.** This is forecast to be on plan for 2019-20.

Specialised Commissioning
Specialised commissioning spend is not incorporated into the Dorset health system control total. Combined expenditure within Dorset Acute Trust budgets is **£103m**, for the month 6 forecast this is reported as on-plan.

1. Executive Summary (2)

Dorset system savings (£110.4m target)
The level of **savings** required by the NHS system is **£99.6m**. There is currently **no identified solution** for **£16m** of these.
The total level of **savings** required by **BCP Council is £10.8m**.
Dorset Council Adult Social Care savings plans are **£TBC**, a total figure will be provided for month 6.

Dorset system risks
Slide 5 quantifies some of the known financial risks. In more general terms the system is facing the following risks:

- Non-delivery of individual or system control totals leading to the non-achievement of Provider Sustainability Funds (PSF)
- Non-delivery of demand management compared to previous year levels in non-electives
- Non-delivery of current Savings (CIP and QIPP) schemes and failure to tackle unidentified savings.
- Agency spend control is key to delivery of the 2019/20 financial plans.
- Dorset County Hospital are rated 4 RED risk on liquidity.
- Poole Hospital are rated 4 RED risk on Agency Rating, so are expected to exceed the agency cap.

Workforce (slide 7)
Monthly agency spend continues to increase across the system, whilst the number of substantive employees is also increasing (currently c800 WTE above levels in April 2017) and the vacancy rate is reducing.

NHS Capital
There is a national requirement for all NHS provider capital plans to be resubmitted with a 20% reduction in the system total spend in 2019/20, this was delivered by the Dorset System.

2. Key Financial Duties – plan for 2019/20

This table summarises the ICS key duties and targets on a risk rated basis (Red/Amber/Green). Our financial plan as approved by the SLT allows for all key financial duties and targets to be met for 2019/20 if the plan is delivered.

Individual Provider Risk Ratings	Dorset County Hospital NHS Foundation Trust	Dorset Healthcare University NHS Foundation Trust	Poole Hospital NHS Foundation Trust	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Summary Of Risk Ratings Within Individual Planning Templates	RBD 2019/20 YTD	RDY 2019/20 YTD	RD3 2019/20 YTD	RDZ 2019/20 YTD
Capital Service Rating	4	2	4	2
Liquidity Rating	4	1	3	1
I&E Margin Rating	4	3	4	2
Variance From Control Total Rating	1	1	1	1
Agency Rating	4	1	4	1
Overall Rating (rounded)	3	2	4	1

3. Dorset Integrated Care System Finance Position Overview – September 2019

Month 6 - Forecast	Surplus / (deficit) (exc. PSF, FRF, MRET)	Variance To Control Total (exc. PSF, FRF, MRET)	System PSF (Core PSF)	PSF, FRF, MRET Total	Surplus / (deficit) (inc. PSF/FRF/MRET)	Variance (inc. PSF/FRF/MRET)	Q1 Forecast
	2019/20 Forecast £000	2019/20 Variance £000	2019/20 Forecast £000	2019/20 Forecast £000	2019/20 Forecast £000	2019/20 Variance £000	2019/20 Q2 Forecast (Internal) £000
NHS Dorset CCG	2,000	0	0	0	2,000	0	2,000
Dorset County Hospital NHS Foundation Trust	-9,023	0	3,046	9,023	0	0	0
Dorset Healthcare University NHS Foundation Trust	-166	0	2,202	2,202	2,036	0	2,036
Poole Hospital NHS Foundation Trust	-17,742	0	4,820	17,742	0	0	0
Royal Bournemouth & Christchurch Hospitals NHS FT	-6,884	0	4,260	6,884	0	0	0
Sub-Total - Dorset Provider CT (For PSF)	**-31,815**	**0**	**14,328**	**35,851**	**4,036**	**0**	4,036
South Western Ambulance Service NHS Foundation Trust	0	0	1,924	1,924	1,924	0	1,924
Sub-Total - Dorset NHS Position - Surplus/ (Defici	**-31,815**	**0**	**16,252**	**37,775**	**5,960**	**0**	5,960
Bournemouth, Christchurch Poole Council	0	0	0	0	0	0	0
Dorset Council	-7,104	-7,104	0	0	-7,104	-7,104	0
Total - Dorset ICS Position - Surplus/ (Deficit)	**-38,919**	**-7,104**	**0**	**0**	**-1,144**	**-7,104**	5,960
Note- other NHS organisations -							
Specialised Commissioning (South West) - Dorset Provide	0	0	0	0	0	0	0

	Key narrative
NHS Dorset CCG	Forecast on plan - risks on PHC/CHC placement costs & activity
Dorset County Hospital NHS Foundation Trust	Current underlying Run rate pressures, unidentified CIP and activity relating to 52 week patients
Dorset Healthcare University NHS Foundation Trust	Forecast breakeven
Poole Hospital NHS Foundation Trust	Forecast breakeven
Royal Bournemouth & Christchurch Hospitals NHS FT	Forecast on plan
South Western Ambulance Service NHS Foundation Trust	YTD £70k ahead of plan - SWASFT Not included in calculation Dorset system PSF delivery
Bournemouth, Christchurch Poole Council	BPC - Forecast to be on budget
Dorset Council	DC - Overspend pimarily due to Looked after Children and Adult Social Care pressures
Specialised Commissioning (South West) - Dorset Provide	Dorset NHS Acute providers only (excl DHFT). High level summary at this stage, still to play through IR changes if required

4. Dorset Integrated Care System – Summary I&E Position – September 2019

Dorset ICS - 2019-20 Forecast Expenditure

	DCH	DHC	PHT	RBCH	SWASFT	GP Services - Dorset Primary Care Delegated	Dorset CCG - Other commissioned	Total
	All '£000s							
Dorset CCG Contract value (Dorset Patients)	129,681	226,905	173,322	197,424	27,920	109,129	375,073	**1,239,454**
Total Operating Income (All patients seen at Organisation)	196,294	279,650	279,764	318,210	249,817	109,129	375,073	**1,807,937**
Total Employee Expenditure	(125,972)	(204,071)	(186,612)	(203,551)	(180,475)			**(900,681)**
Total Operating Expenditure Excluding Employee Expenditure	(67,613)	(73,311)	(91,288)	(109,023)	(65,029)	(109,129)	(373,073)	**(888,466)**
Net Finance Costs	(2,709)	(232)	(1,864)	(5,636)	(2,319)			**(12,760)**
								-
Surplus/ (deficit) - adjusted for control total	-	**2,036**	-	-	**1,994**	-	**2,000**	**6,030**
								-
Staff numbers - WTE	2,671	5,282	3,891	4,267	4,145			**20,256**

Ambition for month 6 to include:

- Dorset Council and BCP Council figures.
- Specialised contract values and GP and CCG workforce figures

5. Cost Improvement Forecast – as at July 2019

Month 6 - Forecast Savings	Total Savings Plan		Of which Unidentified	Non-Recurrent	Total Savings Actual			Key narrative
Organisation Name	2019/20 Plan £000	2019/20 Plan %	2019/20 Forecast £000	2019/20 Forecast £000	2019/20 Forecast £000	2019/20 Forecast Variance £000	2019/20 Achievement %	
NHS Dorset CCG	53,026	4.28%	425	14,942	53,026	0	100%	Unidentified QIPP due to increase in CHC placement costs and activity, less 0.5% contingency
Dorset County Hospital NHS Foundation Trust	7,130	3.76%	1,576	2,851	7,130	0	100%	Of the schemes identified £0.5 million relates to high risk schemes.
Dorset Healthcare University NHS Foundation Trust	10,431	3.61%	1,500	6,182	10,431	0	100%	Unidentified CIP gap stands at £1.5m as at month 6, with plans in development to identify and deliver required savings in year
Poole Hospital NHS Foundation Trust	9,031	3.37%	931	5,527	9,031	0	100%	YTD savings on plan. Risk relates to system wide scheme.
Royal Bournemouth & Christchurch Hospitals NHS FT	10,452	3.60%	1,255	5,719	10,452	0	100%	In PFR reported as undelivered by unidentified value £324k
Sub-Total - Dorset Provider	90,070		5,687	35,221	90,070	0	0%	
South Western Ambulance Service NHS Foundation Trust	9,506	3.78%	0	2,700	9,506	0	100%	A risk has been flagged regarding £500k of non-delivery schemes, the Trust is working to mitigate this.
Sub-Total - Dorset NHS Position - Surplus/ (Deficit)	99,576		5,687	37,921	99,576	0	0%	
Bournemouth, Christchurch Poole Council	10,798	9.82%	0	0	10,798	0	100%	BPC - Total savings for the Council overall. There are no savings identified at serious risk of delivery
Dorset Council (Savings TBC subject to approval)	0	0.00%	0	0	0	0	100%	DC - The savings plans are still being discussed within the new council and no final figure has been reached yet
Total - Dorset ICS Position - Surplus/ (Deficit)	110,374		5,687	37,921	110,374	0	0%	
Note- other NHS organisations -								
Specialised Commissioning (South West) - Dorset Providers	3,541	0.00%	0	0	3,541	0	100%	Dorset NHS Acute providers only (excl DHFT). High level summary at this stage, at this point, set to QIPP per contract values not plan values. Unidentified value TBC M6

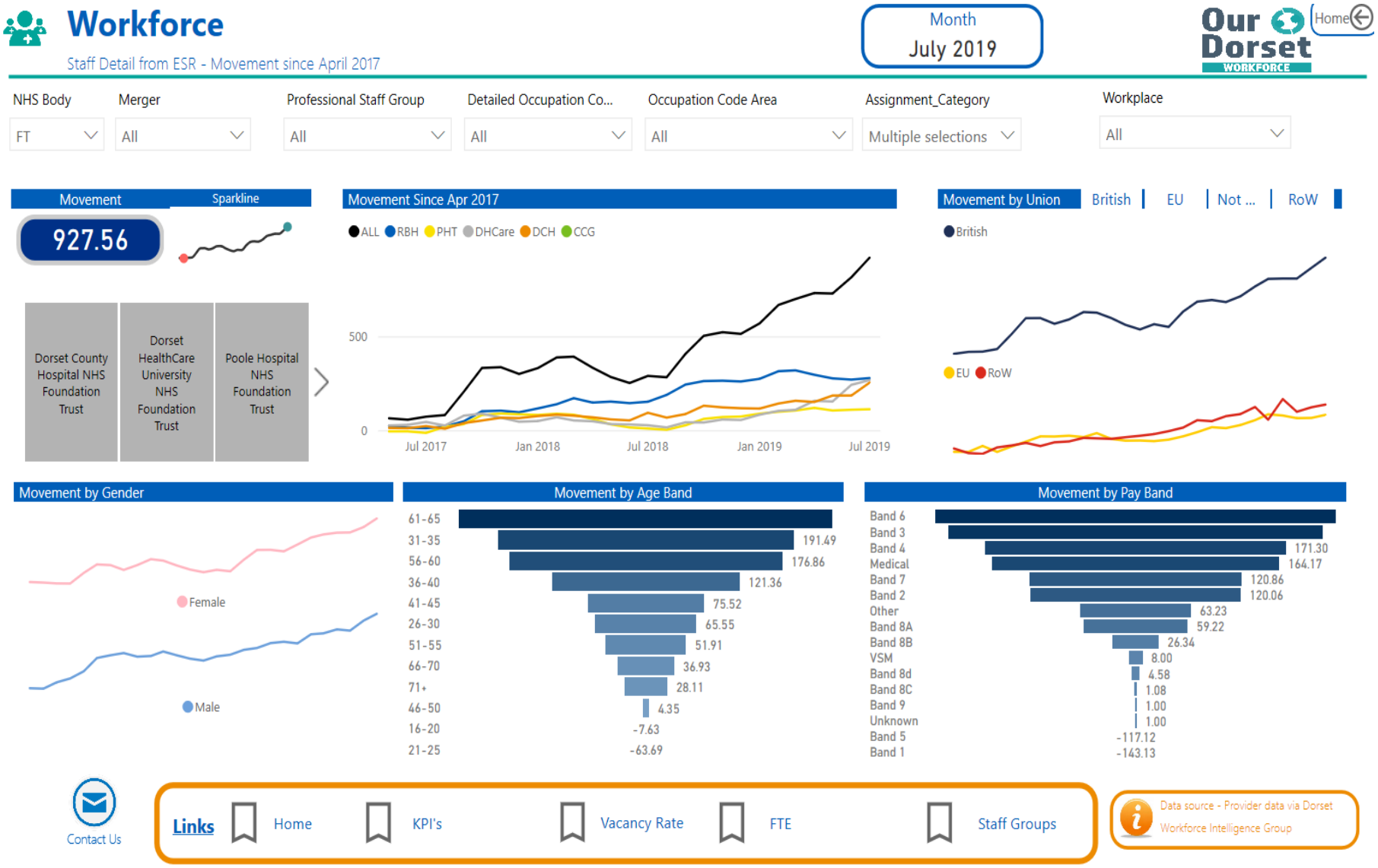
- Total savings requirement for the system is £110.4m - Savings are reported as forecast on plan for month 6.
- £5.7m is unidentified and £35.2m are non-recurrent, **SLT requests OFRG provide an update on plans for organisations to close the unidentified CIP gap.**
- Note - Dorset Council savings plans are still to be approved. BCP are included but for Adult Social Care Services only.

6. Underlying position with mitigations

- Savings are reported as forecast on plan for month 6.
- £5.7m is unidentified and £35.2m are non-recurrent, **SLT requested OFRG provide an update on plans for organisations to close the unidentified CIP gap: Currently £2.2m remains unmitigated.**

		Dorset County Hospital NHS FT £m	Poole Hospital NHS FT £m	Dorset Healthcare University NHS FT £m	Royal Bournemouth & Christchurch Hospitals NHS FT £m	Dorset Clinical Commissioning Group £m	Total £m	Notes
Planned Surplus/(deficit) / Control Total				**2.036**		**2.000**	**4.036**	
RISKS/COMMITMENTS								
Loss of Commercial Income		- 0.931	- 0.931	- 0.931	- 0.931		- 3.724	Assumed in initial plans
Investment in 52 week waits 19/20 plan		- 0.488	- 0.142		- 0.438	- 1.068	- 2.136	Per OFRG Sept 19 (validation not complete)
Agency		- 0.500	- 2.000				- 2.500	Run rate forecast higher than plan
Personal Health Commissioning (PHC)						- 1.932	- 1.932	Umitigated portion of over-spend
Accounting Treatment for RICS							-	Not identified in initial plans
Medical payaward shortfall		- 0.400	- 0.328		- 0.474		- 1.202	Not identified in initial plans
Unidentified CIP		- 0.181		- 3.169	- 2.900		- 6.250	
Other					- 0.300		- 0.300	
							-	
Unmitigated risk Surplus/(deficit)		**- 2.500**	**- 3.401**	**- 2.064**	**- 5.043**	**- 1.000**	**- 13.708**	
Distance from Control Total		*- 2.500*	*- 3.401*	*- 4.100*	*- 5.043*	*- 3.000*	*- 17.744*	
MITIGATIONS	**Rating**							
International Recruitment	M		1.000				1.000	Recruitment starts in Q3/4 so split M&H
International Recruitment	H		1.000				1.000	Recruitment starts in Q3/4 so split M&H
Improving Productivity	M			0.650			0.650	
Targeting Agency	M	0.500		0.650			1.150	
Commercial Income technical adjustment	H	0.931	0.931	0.931	0.931		3.724	Not known if alternative is possible yet
Increase Commercial Income Opportunties	M				3.200		3.200	
Gains on disposals	H			0.600			0.600	If available will need to agree with NHSE/I
PHC Transformation Plan	M					1.000	1.000	Too early to predict turnaround split M&H
PHC Transformation Plan	H					1.000	1.000	Too early to predict turnaround split M&H
Accounting Treatment for RICS	H	0.900					0.900	
Other	M		0.350	1.000			1.350	
Surplus/(deficit) after risks and mitigations		**- 0.169**	**- 0.120**	**1.767**	**- 0.912**	**1.000**	**1.866**	
Distance from Control Total		*- 0.169*	*- 0.120*	*- 0.269*	*- 0.912*	*- 1.000*	*- 2.170*	
Distance from Control Total (excluding High Rated risk mitigations)		*- 2.000*	*- 2.051*	*- 1.800*	*- 1.843*	*- 2.000*	*- 9.394*	

7.1 Workforce – DWAB development report



System Quality and Performance Report

For the period: September 2019

Section A: Quality

Section B: Performance

Section A: Quality

This report provides an overall exception report of the quality of health and some care services across Dorset.

Areas requiring improvement are:

- Completion of Initial Health Assessments (IHA) within statutory timeframes.
- Impact on quality due to operational pressures on performance
- SWASFT call stacking
- Ambulance handover delays
- Quality Scorecards are included for information at appendix 2.

Emergency Departments/ Urgent Care / SWAST

Ambulance handover times remain challenged at PHFT, DCH and RBCH. This is being monitored through the Contract review meetings and remedial action being led by the UEC Board.

A final single item QSG led by NHSE/I took place this month regarding the call stack risk. Mitigating actions to reduce ambulance demand will be progressed through the new regional ambulance delegated committee. Performance of the Out of Hours service is being monitored through the contract meetings.

Mortality

There is a continued improved of SHMI value of 1.16 (previously 1.20 then 1.18) reported for DCH for the latest available period June 2018 – May 2019. Progress on action is being monitored at the Pan Dorset Mortality Group. A further update will be reported in March 2020.

Surgical checklist

QA visits to theatres at each acute Trust over the summer gave good assurance regarding the compliance with WHO surgical safety requirements. At each site there is a qualitative audit of the process that underpins the assessment and addresses poor performance of individuals.

VTE

A task and finish group has been instated in DCH to look at areas of poor performance in quality indicators including VTE assessment and prescribing of prophylaxis. The Trust position is below the national average in England and when compared with peers in Dorset. At the time of writing this report the actions are not fully defined but will be provided in a future quality report.

Nutrition

Lower performance has been recognised by DCH in relation to MUST risk assessments. Further analysis of data has been requested. Poole Hospital also continue to focus on improvements to the screening and referrals process.

Staffing, mandatory training including safeguarding

Trust reporting of appraisal rates varies as some reset at the beginning of each year to zero and do not use rolling month averages. All Trusts are amber for compliance with staff mandatory training and this is consistent across safeguarding training. Operational pressures are cited as the main reason for this. More detail regarding safeguarding and PREVENT training is provided in the 6 monthly update report to Governing Body.

Early Warning scores

Compliance with this area has not been reported by DCH in the year to date. The parameter has changed following the introduction of NEWS 2 nationally. All trusts electronic patient observation systems are now complaint with the Patient Safety Alert requirements.

Mixed Sex Accommodation breaches

The reporting requirements have recently been refreshed with new criteria for justification of breaches, which will provide great clarity on reporting breaches in Critical care areas where the most significant changes will be made.

Complaints

RBCH are reviewing their policy and aligning investigation and response times standards with other Trusts in Dorset. The number of complaints meeting the revised timescales will be monitored over the next quarter.

Infection control

We have had notification of a case of MRSA bacteraemia in September for Dorset CCG, current investigation underway. To date we have had 5 cases this year in Dorset, with one case attributed to a trust outside of the county, one to an acute Trust within Dorset and three community onset cases.

Looked After Children update

Pan Dorset IHA performance remains variable due to challenges in Children's health and social care due to factors related to workforce capacity and system wide reorganisation. Since May 26 IHA appointments have not been available due to workforce capacity. Current completion of IHAs within 20 working days is 39.2 % for Q1. An additional 35.5 % were completed between 20 and 30 days. Data also shows that we have 3 LAC in Dorset who have waited greater than 31 days due to multifaceted reasons. Assurance can be given that for all LAC in Dorset entering care who have not had their IHA within the statutory 20 days health oversight is maintained and actioned by the nursing team as a priority.

Primary Care

CQC ratings ; Currently there are 5 practices rated as Outstanding in Dorset, and 3 as Requires Improvement. The remainder are rated as Good.

Dorset Quality Surveillance Group Items for note - September Meeting

- Single item QSG call stack for SWASFT
- Ambulance Handover delays
- The Never Events at Dorset Healthcare and RBCH
- The impact of pension tax on workforce
- Dental health in children and links to possible neglect -safeguarding
- Monitoring the changes to safeguarding at Dorset Council.
- Improvement notice on IRMER and links to Medical Physics
- Workforce as single biggest risk
- Sustained demand on urgent care services
- Deep dives at today's meetings were:
  - Maternity Services
  - Mental Health (Adult)
  - Klebsiella outbreak summary report and learning
  - Specialist Commissioning – Dental, Pharmacy and Optometry

Urgent and Emergency Care

Emergency Department Performance - ED attendances exceed the contract plan by 5.6% with the greatest variances being at DCH (9%) & RBH (7.6%). System ED performance is at 86% against the 95% target. NEL admissions are down across the system by 3% with the main decrease being seen at PHFT due to the new ED standards pilot. The new ED Delivery Group has met and is finalising its action plan for the November meeting. Donna Parker is chair. A further CEO meeting has been held to progress actions to reduce UEC demand, interfacing with the system winter plan (to be submitted to NHSE/I by 8 November).

Long Length of Stay (LLOS) - Current performance, as at 14 October against the 40% reduction target is as follows: National reduction – 20%, Dorset ICS – 16%, RBCH – 33%, DCH - 22%, PGH – 12% (above the baseline). The LLOS Delivery Group have met and a planning workshop has been arranged for the 7th November when the group will be focussing on system level actions to support sustainable change.

Ambulance - Dorset ICS is the highest contributing area in the SW to 60-minute handover delays. Year to date Dorset had 282 patients waiting > 60 minutes. Poole is the highest contributing trust in the SW with Bournemouth being 3rd highest. In same period Dorset has had 8714 patients waiting > 15 minutes for ambulance handover. Cat. 1 target continues to be met and there are trajectories for improvement on Cat 2, 3 & 4. Dorset is 3.82% above plan for the year till end of September which has resulted in two "break glass payments. New Delivery Group has met with SWASFT County Commander as chair. Demand management plan in line with contract SDIP being developed for November meeting.

IUCS Failing KPIs for : Call handling ;clinical assessment; & face to face. CCG assurance letter week commencing 28/10th to DHC re assurance process for their intention to in-house 111 and CAS requires significant improvement in current performance as part of this process. Also required is resilience partner for winter.

Elective

Referrals & Waiting Lists: All referrals (from all referrer types to all ICS providers) are 0.2% less over the last 12 months, than the previous 12 months. However within this- GP referrals have increased by 1%. Referrals for gynaecology, and trauma have seen significant referral increases. Waiting List growth is still significant with the number of patients waiting longer than 40 weeks for first definitive treatment remaining a concern. Trusts continue to report their potential 52 week breaches during 19/20 with daily internal monitoring at patient level. Actual against predicted breaches are shown below. CEO concern on the progress of elective care raised in call with COOs. Agreed to look at what feasible action could be taken to address all waiting > 40 weeks- and to calculate cost- ahead of discussions with CCG.

52 Week Breaches September

	Predicted	Actual
PGH	3	1
DCH	14	4
RBH	16	7
	33	**12**

Endoscopy Actions

- Joint letter to GPs explaining pressure
- Slow invitation to be screened for Dorset Bowel Cancer Scope
- Work with PCNs to review CCLIPs where these plan increases
- Shared room booking
- Passporting
- Support PHT business case
- Formalise Endoscopy network
- Continue insourcing

Diagnostics: Overall there has been a reduction in diagnostic (6 week) performance across the ICS; 90.4% in August compared to 93.8% in July 2019. When comparing August 2019 with July 2019 performance, there is an additional 426 patients waiting over 6 weeks and an additional 135 patients waiting over 13 weeks. Endoscopy position fragile even despite outsourcing. Workshop identified 20 options to consider-with 8 above being actively pursued.

Cancer:

Dorset remains under significant pressure in terms of increasing demand in fast track referrals and delivery of 62 days and 2ww. At DCH, head and neck (H&N) has reduced capacity due to lack of consultant availability for breaking bad news clinics. All H&N patients breaching as they transfer to PHT due to patient choice/patient initiated delays. At RBH the colorectal 2ww pathway has staffing issues - also down by one breast consultant due to sickness. H&N patients go to PHT for diagnostics which creates a delay in their pathway. Brachytherapy waiting times at PHT have improved significantly following increased clinic lists which has subsequently alleviated the system pressure in this pathway. Clinical working session on breast made recommendations for new ways of system working to improve 2ww breast performance.

Dermatology:
Dermatology workstream being brought under the Dorset Clinical Networks Programme – part of Dorset STP's One Acute Network Portfolio). Work will continue to be delivered via the Dermatology Steering Group and working groups. Away day planned for December to develop system model. Currently identifying a clinical lead to support leadership of the new model development. 2WW pressures reduced slightly at RBH but demand still outstripping current clinic capacity. Only one consultant in post with 1.6 vacancy.

CBAP audits reveal significant level of benign skin lesion procedures at RBCH and PHT. For example at RBH 75 were carried out during the audit period (June) with only 14 within criteria. Trust help being sought in identifying rationale for this activity. Poole audit data has not been received.

Ophthalmology:
External system-wide review of ophthalmology underway (Moorfields Hospital supported by PA Consulting). 6-week review to be completed by end of Nov/early December. Meeting being arranged with lead COO to discuss structure and governance of ophthalmology working groups post review.
Particular pressures at DCH for both corneal and oculoplastic services with longstanding consultant vacancies and long waits/potential 52 week breaches. System-wide support is sought to identify solutions.

Outpatient Transformation:
Confirmation received from NHS E that Dorset ICS is able to progress as part of the national pilot of Attend Anywhere – 20 waiting rooms allocated. Expressions of interest received from specialties as below.

RBCH	Poole	DCH	DCNs
Diabetes	Diabetes	Diabetes & Endocrinology	Urology
Gastroenterology	Gastroenterology	Renal	Rheumatology
Cardiology	Cardiology	Paediatrics	Haematology
Dermatology	Respiratory		
	Gynaecology		

Planning to "go live" with Rheumatology MDT meeting 13th November to test technology with clinicians. I.G. issues being resolved to enable patient correspondence via e-mail. Targeting first patient contacts early December. Comms plan being developed. NHS England funding supporting webcams and microphones where not already in place. Transformation bids submitted for: (a) tool to deliver online groups sessions/webinars and (b) Developing and implementing Robotic Process Automation/intelligent automations

Maternity:
LMS continues to focus on smoking cessation currently 10.9% smoke at time of delivery compared to 6% target. Poole maternity unit is the first in the country to pilot taking a 'whole family approach' towards smoking cessation targeting the partner and family who are smokers. LMS has identified 2 midwives to lead across East and West Dorset on improving continuity of carer to increase rates from current baseline of 10%. Dorset LMS reduced stillbirth rates by half in 2018 compared to 2016. However work continues to implement saving babies live care bundle version 2 to reduce stillbirths and neonatal deaths to meet the national ambition.

Criteria Based Access Protocols:
NHS England Evidence Based Interventions policy recommended maximum levels of 17 procedures which should not be routinely commissioned. For Dorset a reduction to the recommended levels from 17/18 levels would release cost/ or capacity of around £4m. Changed criteria where relevant were formalised in a number of CBAPS and an audit process established.

Section B: Performance

A review of activity April- August shows a reduction of >27% in the volume of relevant procedures. If sustained for a full year it equates to £2.8m less cost/proxy cost than in 17/18. However there is further scope to improve with activity currently still at 157% of recommended levels). Current reporting year to August shows activity as below.

	April- August 19/20 Activity				
	RBH	**PHT**	**DCH**	**DHFT**	**All Other**
EBI	**Spells**	**Spells**	**Spells**	**Spells**	
A Intervention for snoring (not OSA)	-	2	1	-	-
B D&C for heavy menstrual bleeding	-	-	-	-	-
C Knee arthroscopy with osteoarthritis	2	-	2	-	3
D Inj for low back pain w/o sciatica	-	-	-	-	3
E Breast reduction	1	1	2	-	5
F Removal of benign skin lesions	324	393	72	42	133
G Grommets	-	16	4	-	5
H Tonsillectomy	-	55	23	-	16
I Haemorrhoid surgery	11	5	11	1	4
J Hysterectomy for heavy bleeding	30	64	34	-	17
K Chalazia removal	34	-	4	-	1
L Shoulder decompression	15	-	25	-	21
M Carpal tunnel syndrome release	166	2	67	39	124
N Dupuytren's contracture release	53	-	10	12	15
O Ganglion excision	17	3	3	2	3
P Trigger finger release	33	-	9	4	10
Q Varicose vein surgery	70	-	22	-	17
Grand Total	**756**	**541**	**289**	**100**	**377**

Areas with a high remaining opportunity are: benign skin lesions, shoulder decompressions, hysterectomy for heavy bleeding, carpel tunnel and Dupuytrens.

A more detailed mid year report will go to CRG in November with a further report recommended in January using December data. Trust support in reinforcing agreed CBAPs and providing audit data is sought.

Primary Care:
We continue to assess local progress against National Service Specifications to be implemented as part of the PCN DES and future Community Services contractual requirements. Enhanced health in care homes DSP toolkit roll-out progressing well to support integrated care delivery. A new toolkit has been developed to support Electronic repeat dispensing and improve our current performance of 4.58% against a national average of 14.43%. System expectations on PCNs remain high and some 'breathing space' and targeted support is required, if we are to enable Networks to provide a strong platform within their local communities.

Mental Health:
SMI health check: Robust plan in place to improve current position. Dedicated posts working across primary/secondary care commencing Oct /Nov. Draft share care protocol developed. IT challenges being resolved. Anticipating improvement through Q3 and Q4.
Eating Disorders: Intensive assessment week has enabled service to improve waiting times. Over 18 aspect now seeing referrals within 4 weeks.
CYP: Clarification re potential reporting inaccuracies being sought. CYP steering group governance and membership refreshed. Business case to support assessment and brief intervention approach being finalised – anticipated this will reduce waiting times and increase accessibility. Mental Health support teams in schools implementation progressing.
Dementia Diagnosis: Continuing challenge from national team regarding compliance. Review of diagnosis rates in care homes nearing completion – will offer improved insight into potential gap in diagnosis rates.

Workforce:
Data now provided monthly directly by trusts. Dorset Workforce Intelligence Group (DWIG) have set the following thresholds:

Mandatory Training	90%
Sickness Absence Rate	5%
Staff Appraisal Rate	85%
Turnover	5%
Vacancy Rate	Up to 5% Green; 5-10% Amber; 10%+ Red

Investigation underway with RBH re anomalous return.

Our Dorset
Local NHS and Councils Working Together

Performance Metrics

For RAG rating explanation see back page

National Targets
Local Targets

Our Dorset

						Provider	System		PHT	DCH	RBH	SWAST
Responsible To	ToR	Area of Concern	BID Link	NHSEI Threshold	System Threshold	Date as at	Value	.	Value	Value	Value	Value
Quality		Infection Control: Clostridium Difficile				Sep19	5		1	2	2	
		Mortality: SHMI				Sep19					0.949	
		Never Events				Sep19	0		0	0	0	
		Safeguarding: Staff trained in Level 3 children				Sep19	%		73.0%	81.0%	85.3%	
		Safeguarding: Staff trained in MCA and DoLs				Sep19	%		78.0%	89.0%	95.4%	
		Safeguarding: Staff trained in PREVENT				Sep19	%		89.0%	81.3%	97.7%	
		Safeguarding: Staff trained level; 2 – Adults				Sep19	%		78.0%	86.0%	94.6%	
		Serious Incidents: Falls				Sep19	2		0	0	2	
		VTE				Sep19	%		97.5%	%	96.1%	
Urgent & Emergency Care Board		Category 1 Ambulance Response Times (mins)			7 mins	Sep19	6.4					6.4
		Category 2 Ambulance Response Times (mins)			18 mins	Sep19	29.1					29.1
		Category 3 Ambulance Response Times (mins)				Sep19	94.8					94.8
		Category 4 Ambulance Response Times (mins)				Sep19	114.1					114.1
		4 hour A&E Wait			95%	Sep19	86.0%			90.4%	81.6%	
		Ambulance Conveyances vs previous financial year (YTD)				Sep19	3.8%		2.6%	3.3%	5.6%	
		ED Demand vs Contract Plans (YTD)				Sep19	5.6%		1.1%	9.0%	7.6%	
		NHS111 vs previous financial year (YTD)				Sep19	3.7%					3.7%
		Non-Elective Admissions** vs Contract Plans (YTD)				Sep19	-3.0%		-11.4%	-2.1%	6.4%	
		Delayed Transfers of Care			3.5%	Aug19	3.9%		3.6%	5.5%	3.5%	
		Stranded Patients - those waiting over 21 days				22/10/19	182		73	44	65	

Business Intelligence Dorset

Our Dorset
Local NHS and Councils Working Together

Performance Metrics

For RAG rating explanation see back page

National Targets
Local Targets

Our Dorset

						Provider	System		PHT	DCH	RBH	DHC
Responsible To	ToR	Area of Concern	BiD Link	NHSEI Threshold	System Threshold	Date as at:	Value	.	Value	Value	Value	Value
Elective Care Board		Consultant-Led RTT Performance: 18 week wait			83.5%	Sep19	78.9%		82.0%	71.5%	81.0%	93.5%
		Consultant-Led RTT Performance: Numbers waiting >26 weeks				Sep19	6114		1514	2247	2344	9
		Consultant-Led RTT Performance: Numbers waiting >52 weeks			0	Sep19	12		3	2	7	0
		Consultant-Led RTT Performance: Waiting List Growth- compared to March 19				Aug19	9.0%		4.5%	12.1%	9.7%	11.9%
		Consultant-Led RTT Performance: Waiting List Total (current)			57460	Sep19	61213		15103	16248	28876	986
		Criteria Based Access activity vs previous financial year (YTD)				Aug19	7.0%		-14.7%	6.0%	11.4%	
		Diagnostics: 6 week wait			>92.8%	Sep19	91.5%		95.6%	90.7%	88.9%	inf%
		Diagnostics: Total List			13388	Sep19	12656		3835	4009	4812	
		Elective Admissions** vs Contract Plans (YTD)				Sep19	-3.9%		1.2%	-9.0%	-3.7%	
		GP Referrals (all specialties) vs previous financial year (YTD)				Sep19	0.1%		-4.7%	1.5%	2.6%	
		OP 1st Attendances vs Contract Plans (YTD)				Sep19	-7.0%		-14.7%	-4.4%	-1.9%	
		OP FUp Attendances vs Contract Plans (YTD)				Sep19	-4.2%		3.4%	-4.7%	-9.8%	
Dorset Cancer Partnership		Cancer: 2 week wait - GP Urgent Referral to First Consultant Appointment			93%	Aug19	82.4%		97.9%	58.8%	86.7%	
		Cancer: 31 day wait for First Treatment			96%	Aug19	98.3%		97.9%	97.7%	98.9%	
		Cancer: 62 day GP Urgent Referral to First Treatment			85%	Aug19	83.1%		85.2%	74.8%	86.1%	

Business Intelligence Dorset

Performance Metrics

						Provider	System		DHC
Responsible To	ToR	Area of Concern	BiD Link	NHSEI Threshold	System Threshold	Date	Value	.	Value
Primary & Community Care		Community Health Contacts vs previous financial year (YTD)				Sep19	0.7%		0.7%
		Electronic Repeat Dispensing				May19	5.0%		
		GP online consultation (% practices)				May19	54.0%		
		ICPCS recruitment against target				Aug19	104.1		
		Improving Access to GP Services: utilisation				Jun19	75.0%		
		Occupied Beds				Aug19	90.0%		90.0%
		Over 65s Admissions (Elective, Emergency and Non-Elective Non Emergency) Rolling 12 months				Aug19	47357		
		Re-Admissions within 30 days (all Emergency Admissions)				Aug19	15.7%		
		Workforce GP numbers against target			512	Apr19	521		
Mental Health Board		CYP - Access Rate			34%	Q1	32.0%		32.0%
		CYP Eating Disorder Waiting time - Routine 4 weeks			74.3%	Aug19	100.0%		100.0%
		CYP Eating Disorder Waiting Time - Urgent 1 week			100%	Aug19	100.0%		%
		Dementia Diagnosis Rate			61.1%	Sep19	61.9%		61.9%
		EIP standard and services - NICE concordance			60%	Aug19	100.0%		100.0%
		IAPT - Access Rate			4.8%	Aug19	4.8%		4.8%
		IAPT - Moving to Recovery			50%	Aug19	51.6%		51.6%
		IAPT - Treated within 18 weeks			95%	Aug19	100.0%		100.0%
		IAPT - Treated within 6 weeks			75%	Aug19	92.0%		92.0%
		Out of Area Placement bed days				Q1	280		280
		SMI Phyiscal health checks in the preceding 12 months			20%	Jun19	18.4%		18.4%

Business Intelligence Dorset

Performance Metrics

						Provider	PHT	DCH	RBH	DHC
Responsible To	ToR	Area of Concern	BiD Link	NHSEI Threshold	System Threshold	Date	Value	Value	Value	Value
Workforce		Mandatory Training				Aug19	86.0%	87.0%	94.8%	96.7%
		Sickness Absence Rate				Aug19	3.6%	3.6%	4.1%	4.7%
		Staff Appraisal Rate				Aug19	86.0%	87.0%	55.9%	91.7%
		Turnover				Aug19	1.4%	2.2%	7.7%	0.9%
		Vacancy Rate				Aug19	4.0%	7.9%	5.6%	6.6%

Title of Meeting	**Board of Directors**
Date of Meeting	**27 November 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. This version reflects a further update but the changes made are minimal and the review does not consider that there are any changes required to the risk scores.

5. The following section outlines the changes made to the BAF:

Strategic Objective 5 - Sustainable: Productive, effective and efficient.

- Changed the risk rating from Amber to Red on the strength of the control in relation to the financial Sustainability Strategy (Control reference C1). This reflects the in year financial pressures facing the Dorset Health system and the current draft position of both the Trust and the ICS within the draft Long term Plan and the consequential impact on the Trust's long term financial outlook.
- Changed the risk rating from Amber to Red on the assurance of delivery in relation to the Dorset Collaborative agreement (control reference C7) ensuring that the Dorset system delivers its financial objectives. The current status of the Dorset system delivering the system wide control total is considered to be at risk.

Paper Previously Reviewed By
Executive Management Team
Risk and Audit Committee, 19th November 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 of Directors is requested to: • review the Board Assurance Framework; and • note the high risk areas

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: November 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 still marginally better than plan, delivery of the year end control total is at risk given current run rates and the CIP gap of c£1.4m. The strength of assurance for this objective continues to be Red particularly in light of the latest draft system wide Long Term plan.

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 continue to experience increasing dependancy on the use of temporary clinical staff and the failure to maintain spend within the regulator ceiling for agency staff.

There is a moderate risk in the strength of controls on ensuring we have **INTEGRATED** and joined up services. Demand for secondary care services continues to out strip supply. Stranded patient numbers are increasing and the pace of integrated demand management with primary and community services is not progressing at the required pace.

Objective	Range of Risk Scores	Strength of Controls	Strength of assurance
1. Outstanding: Delivering outstanding services every day. We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	**6-20**	**A**	**G**
2. Integrated: Joining up our Services. We will drive forward more joined up patient pathways, particularly working more closely with and supporting GP's.	**2-20**	**A**	**G**
3. Collaborative: Working with our patients and partners. We will work with all of our partners across Dorset to co-design and deliver efficient and sustainable patient-centred, outcome focussed services.	**6-12**	**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 quartile of key quality and clinical outcome indices for safety and quality can lead to reduced confidence in the organisation from the public and other bodies.	NL	3	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 of Delivery**
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits). ICS quality surveillance Group monitors and scrutinises safety and quality with the system and the regulator. (R1)	G	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 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 of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Reframed Urgent and Emergency care Boards and ICPCS Boards objectives linked to the Boards delivery plan. (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 of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Patient and Public engagement as part of transformation framework, with Trust Transformation lead and team trained in service improvement; plus Patient Experience lead in place; Communications team link with CCG for public consultations and engagement events where relevant (R1)	A	Senior Management Team (SMT), Executive Management Team (EMT), Patient Experience Group (PEG) - via CCG , Health Oversight and Scrutiny Committee, Healthwatch, special interest groups	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 of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	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 of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	The Board approved a financial sustainability strategy in Sept 17. The Director of Finance and Resources is leading on the implementation of the strategy. The Transformation Team is supporting the delivering of key work streams in the strategy. (R1)	R	The Better Value Better Care Group oversee the implementation of the financial savings. The Senior Management Team receive regular updates on the Transformation Programme. Regular reports received by the Finance and Performance Committee and the Board.	R
C2	Model hospital metrics accessible to service areas. Regular reports and opportunities identified by the Better Value Better Care Group (R2)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	G
C4	Commercial Board reviews income against metrics, overseen by Better Value Better Care Group (R3)	G	Financial reporting mechanisms at commercial board and the Better Value Better Care Group	A
C3	Model hospital will provide information on the efficient use of our estate. (R4)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	A
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	A	The Authorising Engineers which the Trust appoint, are independent and ensure that safe systems of work and inspection regimes are in place and carried out in accordance with the legislative requirements	G
C6	Six facet survey 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 Colloborative Agreement to ensure that funds and control totals are amended across the system (R5)	A	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	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 >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or 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 Inadequate/performance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

The average of the five domain scores is calculated to identify the overall consequence score

(C1 + C2 + C3 + C4 + C5) / 5 = C

Title of Meeting	**Board of Directors**
Date of Meeting	**27 November 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 within the agreed timescales with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.

It should be noted that all open and active risks for all care groups are now on Datix. However, now we are able to review online and search it has identified that there are some corporate and support functions that are not, and have never been on the Trust wide risk registers. There are risk registers in place but these have been held locally, for example I.T.

It was also identified that some of the services in the Executive's portfolios are not on the risk register, for example, Director of Strategy, Transformation & Partnerships. The Head of Risk Management is in the process of ensuring any missing services and functions are contacted and that the relevant risks are added to the appropriate level of risk register.

The Risk Register was reviewed by the Executive team 03.10.19 and the following comments were made:

- Colours not always matching the risk matrix, eg things scored as 15 being red when should be amber. COMPLETED. This had been set up incorrectly in the background of Datix.
- EDS - need to change executive sponsor as Alastair - COMPLETED
- **Deep dive on Fire doors requested for RAC – to be reviewed at RAC**

Actions outstanding:

Mortality indicator – Medical Director to meet with Head of Risk Management (HoRM) and update Mortality learning from deaths and the narrative description and mitigation updated so coding sits outside of this risk. MEETING BOOKED FOR 18.11.19.

Follow-up waiting list backlog risk considered to be higher at 5x5 - to review with Chief Operating officer – meeting arranged w/c 18.11.19

RISK RATING:

Financial Sustainability – NO CHANGE (This risk was reviewed again at the end of QTR 2).

Update: November 2019.

- *At 30 September 2019 - £0.3 million we are ahead of plan (£3.5 million deficit vs £3.8 million deficit planned)*
- *Includes £0.233 million of 'extra' PSF for 2018-19*
- *Qualifies for Month 6 PSF/FRF of £0.6 million*
- *Plan is for breakeven position including Provider Sustainability*
- *Funding and Financial Recovery Funding of £8.692 million*
- *Assumes CIP of £7.13 million*
- *Of the CIP target schemes totalling £5.554 million have been identified*
- *Balance of unidentified CIP is £1.576 million*

Recruitment and retention of Medical staff across specialities - NO CHANGE (This risk is not due to be reviewed until 31.12.19)
Update from Executive Lead: 12.11. 2019 nothing further to add at this point. Actions continue.
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 31.12.19)
Update from Executive Lead: 12.11. 2019 nothing further to add at this point. Actions continue.
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:

Fraud:
Director of Finance and Head of Risk met with TiAA on 08 November 2019 in regards to adding Fraud risks to the Corporate Risk Register to meet the NHS Counter Fraud Authority Standards for NHS Providers 2019-20, Fraud, bribery and corruption. (Jan 19).

These standards include:
Key Principle 1: Strategic Governance
Key Principle 2: Inform and Involve
Key Principle 3: Prevent and Deter
Key Principle 4: Hold to account

TiAA was able to provide information and assurance that the risks that the Trust carries in relation to these standards are relatively 'LOW' and are being well managed and mitigated by the procurement team and the vigilance of the finance team.

These risks and workstreams will be added to the Corporate risk register in conjunction with TiAA, in order that the assurance and their findings can be added simultaneously shortly. *However, as the risks will in the main be 'LOW', they are unlikely to feature on the ARC papers, but the*

Committee and the Board will need to be aware of the risks and mitigations in place.

Strategic Estates:
We are in the process of adding on to the Risk Register those risks that will impact on the Trust in terms of the strategic estate plans in place, for example: plans for new builds, consultations regarding redesign, planning permissions, expansion of existing ward areas. This will be completed before the end of December 2019.

These have not previously been captured on any of the Trust risk registers. There will be some moderate and above risks that will be showing on the next RAC report against the Corporate Risk Register. For example, failing to obtain planning permission would be scored as High or Extreme depending on the impact on the Trust, its services and the reliance on achieving this for the rest of the development plans. It will also impact on the ability for the Trust to deliver safe services, deal with the capacity, the potential for claims and adverse publicity.

DIVISIONAL LEVEL EMERGING RISKS
Urgent and Integrated Care Division

- **ED Estate (Currently rated as 20 (EXTREME – Consequence: Major (4), Likelihood: Certain – event is expected to occur on many occasions/daily (5)) on the Divisional risk register and unlikely to be managed at Divisional Level).**

  Rationale for score: Not meeting strategic objectives in relation to:
  - Outstanding: Not achieving an outstanding rating from CQC by 2020
    Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality
    Not achieving national and constitutional performance and access standards
  - Integrated: Emergency department admissions continuing to increase per 100,000 population
  - Sustainable: Failing to be efficient as outlined in the Model Hospital
    Not using our estate effectively and flexibly to deliver safe services.

In terms of evidencing Consequence Score: (Major) Impact on safety of patients, staff and public (physical and psychological harm included), non-compliance with national standards, multiple complaints, potential for low performance rating, loss of key staff, low staff morale, multiple breaches in statutory duty, national media coverage, key objectives and targets not met, financial incentives not being received, claims worth between £100k and £1m.

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.

MITIGATION:
Escalation protocol linked to seasonal and surge planning
Start Date: 25.07.19 Due date: 13.09.19 - COMPLETED
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: 31.12.19
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.

- **Virtual Board in the ED Department. (Currently rated as 20 (EXTREME – Consequence: Major (4), Likelihood: Certain – event is expected to occur on many occasions/daily (5))**

Details of Risk
The reliability of the Virtual Board in ED is variable and prone to failure, recording of activity and timelines against the national 4 hour standard to be able to document the patient's journey.

MITIGATING ACTIONS:
New Service Manager to meet with IT to see how the system can better be supported.
Back-up hand written system in place

Issues:
When the system is not fully working this impacts on flow through the department and through the hospital. This system is used by the Site Team to allocate beds to patients in the Emergency Department, and details capacity, and queues in Majors and Minors.

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 12.11.19.

Paper Previously Reviewed By Audit and Risk Committee, 19 November 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 of Directors is 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	High (16)	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.	07/11/2019	Matt Chivers 07/11/2019	Finance	Estates Department	**Strategic Objective 5**: **Sustainable** Not using our estate efficiently and flexibly to deliver safe services **MITIGATION:** The electrical installation enabling works have been awarded. Works to commence beginning 2020. Tender documentation for the COTAG system is prepared and expected to be released in NOV.
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 14/11/2019	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 their training was completed 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 we can maximise legitimate income to assist with the financial sustainability.

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
											From Dr Foster October 2019 data: The main findings of the report are: - The Standardised Mortality Ratio (SMR), whilst still statistically significantly higher than expected, has decreased by 1.7 vs. the previous rolling 12 month period, this is due to a combination of a reducing crude rate and stabilisation of the expected rate - Compared to peers, the Trust is one of three with a statistically significantly higher than expected SMR - Emergency admissions continue to have a statistically significantly higher than expected relative risk although the trend is decreasing in line with the overall SMR The mortality dashboard shows the following new alerts: - CUSUM alert for other excision of gall bladder, this relates to one death in April 2019 - The In-hospital Deaths nationally (HSMR), whilst still statistically significantly higher than expected, has decreased by 1.2 vs. the previous rolling 12 month period and is very close to becoming within the expected range - Emergency weekday HSMR continues to be statistically significantly higher than expected

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
											whilst emergency weekend HSMR is within the expected range - Both emergency weekday and weekend HSMR have decreased vs. the previous rolling 12 month period (0.4 and 3.2 respectively) **The Summary Hospital-Level Mortality Indicator (SHMI) for June 2018 to May 2019, whilst still statistically significantly higher than expected, has decreased by 2.27 vs. the previous rolling 12 month period**
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.

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 are reviewing skill mixes to reduce pressure on medical workforce. We also subscribe to LocumsNest to provide medical bank staff.
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	**To meet with COO w/c 18.11.19**	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 	High (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.	31/12/2019	Mandy Ford 14/11/2019 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:** Update: November 2019. - At 30 September 2019 - £0.3 million we are ahead of plan (£3.5 million deficit vs £3.8 million deficit planned) - Includes £0.233 million of 'extra' PSF for 2018-19 - Qualifies for Month 6 PSF/FRF of £0.6 million - Plan is for breakeven position including Provider Sustainability - Funding and Financial Recovery Funding of £8.692 million - Assumes CIP of £7.13 million - Of the CIP target schemes totalling £5.554 million have been identified - Balance of unidentified CIP is £1.576 million

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	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.	31/10/2019	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 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	31/12/2019	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.

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
											reviewed employer branding. We have invested in a workforce planning capability to consider longer term actions to mitigate staff shortages, actions.
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.	30/11/2018	Matt Chivers 07/11/2019	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. Current status is that 80% of the doors assessed as being RED have been replaced, 26% of doors that were assess as AMBER have been actioned, and 28% of those categorised as GREEN have been reviewed.
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:** From Dr Foster October 2019 data: The main findings of the report are: - The Standardised Mortality Ratio (SMR), whilst still statistically significantly higher than expected, has decreased by 1.7 vs. the previous rolling 12 month period, this is due to a combination of a reducing crude rate and stabilisation of the expected rate

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
											- Compared to peers, the Trust is one of three with a statistically significantly higher than expected SMR - Emergency admissions continue to have a statistically significantly higher than expected relative risk although the trend is decreasing in line with the overall SMR The mortality dashboard shows the following new alerts: - CUSUM alert for other excision of gall bladder, this relates to one death in April 2019 -The In-hospital Deaths nationally (HSMR), whilst still statistically significantly higher than expected, has decreased by 1.2 vs. the previous rolling 12 month period and is very close to becoming within the expected range -Emergency weekday HSMR continues to be statistically significantly higher than expected whilst emergency weekend HSMR is within the expected range - Both emergency weekday and weekend HSMR have decreased vs. the previous rolling 12 month period (0.4 and 3.2 respectively) **The Summary Hospital-Level Mortality Indicator (SHMI) for June 2018 to May 2019, whilst still statistically significantly higher than expected, has decreased by 2.27 vs. the previous rolling 12 month period**

Safe Staff Return September

	Day				Night				Day		Night					
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		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
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								
Abbotsbury Short Stay Surgical Unit	1607	1401.15	1011	1314.5	616	895	616	629	87.2%	130.0%	145.3%	102.1%	722	3.2	2.7	5.9
Barnes	1171.5	1035.25	1459	1218	616	616	792	902	88.4%	83.5%	100.0%	113.9%	689	2.4	3.1	5.5
Critical Care Unit	1998.5	1965.25	322	299.5	1932	1861	0	57.5	98.3%	93.0%	96.3%	-	173	22.1	2.1	24.2
Day Lewis	1338.5	1198.17	1032	1185.4	616	605	616	627	89.5%	114.9%	98.2%	101.8%	678	2.7	2.7	5.3
Fortuneswell	883.5	1026.5	708	866	660	671	330	462	116.2%	122.3%	101.7%	140.0%	441	3.8	3.0	6.9
Ilchester Intergrated Assessment Unit	1733.25	2054	1484	1675.25	1380	1713	1380	1736.5	118.5%	112.9%	124.1%	125.8%	951	4.0	3.6	7.5
Kingfisher	1441	1208	589	492.5	1035	907.5	345	322	83.8%	83.6%	87.7%	93.3%	198	10.7	4.1	14.8
Lulworth	1814.25	1696	1458.5	1391	990	1007	990	1036.5	93.5%	95.4%	101.7%	104.7%	863	3.1	2.8	5.9
Maternity	2842	2395.25	1506.95	997.25	2016	1919	660	572.42	84.3%	66.2%	95.2%	86.7%	401	10.8	3.9	14.7
Maud Alex	1183	1176	766	734.25	1035	1023.5	345	345	99.4%	95.9%	98.9%	100.0%	424	5.2	2.5	7.7
Moreton	1194.75	1142	1481	1465	660	661	990	1056	95.6%	98.9%	100.2%	106.7%	678	2.7	3.7	6.4
Prince of Wales	1401.25	1265.25	731.5	705.25	660	660	330	319	90.3%	96.4%	100.0%	96.7%	392	4.9	2.6	7.5
Purbeck	1622.5	1550.8	1485	1387.75	657.25	668.25	990	954	95.6%	93.5%	101.7%	96.4%	760	2.9	3.1	6.0
Ridgeway	1267	1198.5	1087.5	1388.25	660	682	660	638	94.6%	127.7%	103.3%	96.7%	642	2.9	3.2	6.1
SCBU	720	813	354.5	198.5	660	693	330	297	112.9%	56.0%	105.0%	90.0%	165	9.1	3.0	12.1
Stroke Unit	1442	1365.7	1076	1198	660	660	660	831	94.7%	111.3%	100.0%	125.9%	586	3.5	3.5	6.9

Exception report: Day shifts were supported by supervisory ward sisters to assist other staff with night coverage. There were 4 shifts with only 1 RN on duty during this reporting period (Elderly Care, Renal,); these were supported by adjacent ward areas with night sister presence on all occasions.

Note- Many areas are showing as greater than 100% (particularly in support staff) due to additional staff required for extra capacity beds due to demand and activity, particularly on night shifts Staffing for this extra capacity continues to rely on temporary staffing.

Title of Meeting	**Board of Directors**
Date of Meeting	**27 November 2019**
Report Title	**Guardian of Safe Working Annual Report**
Author	**Mr Kyle Mitchell, Guardian of Safe Working**
Responsible Executive	**Alastair Hutchison, Medical Director**

Purpose of Report (e.g. for decision, information) For information	
Summary The Guardian is required to report to the Board on a quarterly basis and this report adheres to the nationally agreed Board report template and that of the Lead Employer template. This report is the quarterly report covering the period March 2019 and April 2019 – June 2019; the additional month will allow future reports to be aligned to the financial year.	
Paper Previously Reviewed By SMT – 16 October 2019	
Strategic Impact Junior Doctors are central to the Trust being able to achieve its key strategic objectives. Their service provision enables DCHFT to deliver its core functions. The 2016 contract is essential to help maintain their training requirements and the safety of their working environment	
Risk Evaluation Analysis of the data summarised within this report will assist in identifying key areas of concern and potential risk.	
Impact on Care Quality Commission Registration and/or Clinical Quality The Guardian of Safe Working role is one of the mechanisms within the 2016 contract introduced to provide assurance of safety and clinical quality.	
Governance Implications (legal, clinical, equality and diversity or other): No specific implications relating to the contents of the paper.	
Financial Implications Potential risk associated with payment due to excess hours worked. The divisions need to implement a robust system for administering time back in lieu to prevent the risk of fines.	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	a) Continue Board level support for Exception Reporting process. b) Support recruitment to improve resilience in medical rotas. c) Support the development of posts to enable the recruitment of Physicians Associates and Clinical Assistants. c) Provide support for engagement with the BMA Fatigue & Facilities Charter.

Title of Meeting	**Trust Board**
Date of Meeting	**30 October 2019**
Report Title	**Quarterly Guardian Report on Safe Working Hours: Doctors in Training (July 2019 – September 2019)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working**

1 Introduction

This production of report is requirement of the contract and is the route through which the guardian will provide the required assurance to junior doctors, the Trust Board, HEE and the GMC.

This report is the quarterly report covering the period July 2019 – September 2019.

2 Overview

- Number of training post (total): 159 training posts in total
- Number of doctors sat in training post (total): 149.1 in total (the 9.9 posts equivalent of vacancies and LTFT trainees sat in a WTE post)
- Number of doctors in training on the new 2016 contract (total): 149.1 (All DiT in post at DCH have now transitioned to the 2016 T&C).
- Admin support provided to the guardian: Support from the Workforce department but set amount not stipulated.
- Amount of job-planned time for educational supervisors: 0.125 PA per week

3 Exception reports (with regard to working hours)

During the period covered by this report 62 exception reports were submitted. On closer scrutiny these exception reports are related to additional hours worked 85%, service support available (8%), and pattern of work undertaken (6%). Of the additional hours worked equal numbers were returned as time in lieu and as overtime payment. Of the 62 exception reports, 45 have been addressed and closed.

Further detail is contained within Appendix 1 – Exception Reports by department, grade, rota and response time.

4 Work schedule reviews

Three work schedule reviews have been conducted between trainees and their educational supervisors. These were triggered in relation to exception reports and occurred for doctors working in acute medicine FY1, Trauma & Orthopedics FY1 and Trauma & Orthopedics FY2

5 Locum bookings

Appendix 3 provides data on the total locum agency bookings in this quarter and bank spend. The majority of agency locum shifts were booked to cover gaps in the rota due to ongoing vacancies.

7 Vacancies

During this period there was an average of 9.02 training grade vacancies. This is an improvement compared to the previous two quarters (15 and 11.28). Details are found within Appendix 4.

8 Fines

No Fines have been levied since the start of the new contract at DCH.
Appendix 5 of this report will indicate the total amount of money levied in fines. The HR department will continue to monitor the return of TOIL due to doctors who have worked over the contracted hours. If this TOIL is not returned within 4 weeks of the Exception Report being agreed then this will be converted to hours worked outside of the contract and will induce a GoSW fine. Fines are calculated at 4x the hourly rate.

9 Key issues arising during this quarter

The key issues relating to the Junior Doctor Contract during the last quarter are:

A) Commencement of transitional arrangements leading to the implementation of the negotiated changes to the Contract for Doctors in Training 2016
As previously reported, a number of changes to the original contract have been agreed between the BMA and NHSE. Transitional arrangements for implementation run Aug 2019 – Aug 2020. The Head of Operational Human Resources has provided an update for the rota coordinators and service managers.

B) Fatigue and Facilities Charter – Monetary Award to DCH
As previously reported, £30,000 of new funding was made available to the trust to improve working conditions for junior doctors. A subcommittee of the Junior Doctors Forum has been formed to oversee spending of this.

C) New Guardian of Safe Working
Kyle Mitchell, the newly appointed Guardian of Safe Working, has expressed his appreciation of being offered the opportunity to take on the role and is his grateful to Dr Jon Chambers for the excellent job he has done in establishing the role in DCH.

10 Immediate safety concerns:

Four Exception Reports submitted during this period were indicated to represent Immediate Safety Concerns and were immediately reported to divisional directors and managers. One can be attributed to an unexpected combination of factors that lead to exceptional understaffing on that occasion. The other two originated from a

role that has also been highlighted by GMC surveys and previous feedback as being associated with an unrealistic workload. In response to these concerns, and after the divisional director and manager met with clinical leads, changes have already been made to the medical staffing levels and the situation remains under review.

11 Junior Doctor Contract:

Following a period of negotiation between NHS Employers, the British Medical Association (BMA) and Department of Health and Social Care (DHSC) there was a subsequent consultation undertaken by the BMA JDC in June. 80 per cent of the relevant British Medical Association (BMA) members voted in favour of the deal proposed. There are multiple changes which started to be implemented from as early as August 2019 in a staged approach.

Of the multiple changes there are three key elements that we know from the outset will impact some DCH rotas and for which rota adjustments will be required. These are:

- Rest after nights shifts *(46hr rest after any number of rostered night shifts)*
- Breaks for night shifts *(30 min paid break)*
- Breaks for night shifts (30 min paid break)

The Workforce team have delivered information sessions to the clinical divisions; theses were attended by service managers, business managers and rota coordinators. The sessions were also supported by an F2 Junior Doctor Representative.

12 Other Information:

The GoSW has presented the role, and encouraged Exception Reporting, at the FY1 induction and at Junior Doctor Forum. The rate of submission of Exception Reports has been discussed at September's Trust Board and there is likely to be an element of underreporting. The Guardian will continue to promote the importance of Exception Reporting. More than twice as many Exception Reports were generated than in the same period last year.

13 Summary

All junior doctors working at DCHFT are provided with rotas that comply with the 2016 contract. All junior doctors have access to Exception Report any significant or regular variation between work schedule and hours worked.

Rota gaps continue to contribute to the challenge of complying with safeguarding aspects the 2016 contract. Further recruitment is still required to develop the resilience needed to avoid our current doctors in training working outside of their agreed contracts.

All exception reports raised are being dealt with in line with the T&Cs of the junior doctor contract. With the ongoing support of the SMT, Trust Board and working alongside the DME and BMA reps, the aim of the GoSW is to continue to work to improve the working lives of, and training environment experienced by, doctors in training at DCH.

APPENDICES - TRUST BOARD PAPER OCTOBER 2019

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

Appendix 1 – Exception Reports by department, grade and rota

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Paediatrics	0	0	0	0
Obstetrics & Gynaecology	0	0	0	0
ENT	0	3	3	0
Urology	0	7	0	7
Colorectal/Breast	0	1	0	1
Colorectal/Upper GI/Vascular	0	2	2	0
Orthopaedics	2	21	21	0
Anaesthetics	0	0	0	0
Anaesthetics ICU	0	0	0	0
Haematology	0	1	0	1
Histopathology	0	0	0	0
A&E	0	0	0	0
Acute Medicine	1	7	7	0
Elderly Care	0	7	2	5
Stroke	0	0	0	0
Clinical Oncology	0	0	0	0
Cardiology	0	5	0	5
Respiratory	0	4	4	0
Renal	0	0	0	0
Gastroenterology	0	2	0	2
Diabetes & Endocrinology	0	0	0	0
Adult Psychiatry	0	0	0	0
General Psychiatry	0	0	0	0
General Practice	0	2	0	2
Total	**3**	**62**	**39**	**23**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	3	44	29	15
F2	0	13	10	3
CT1-2/ST1-2	0	5	0	5
ST3-8	0	0	0	0
Total	**3**	**62**	**39**	**23**

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Paediatrics ST3-8	0	0	0	0
Paediatrics FY2/GPVTS	0	0	0	0
Obstetrics & Gynaecology FY2/ST1-2	0	0	0	0
Obstetrics & Gynaecology ST3-8	0	0	0	0
General Surgery FY2/CT1/2/GPVTS	0	10	10	0
General Surgery ST3-8	0	0	0	0
Orthopaedics ST3-8	0	0	0	0
Anaesthetics CT1-2	0	0	0	0
Anaesthetics ICU CT1-2	0	0	0	0
Anaesthetics ICM FY2	0	0	0	0
Anaesthetics ST3-8	0	0	0	0
Haematology ST3-8	0	0	0	0
Histopathology ST1-2	0	0	0	0
A&E FY2/GPVTS	0	0	0	0
General Medicine FY2/CT1/2/GPVTS	0	6	0	6
CMT/GPVTS Cardiology	0	0	0	0
CMT – FW Clinical Oncology	0	0	0	0
General Medicine ST3-8	0	0	0	0
ST3+ Cardiology	0	0	0	0
GPVTS Palliative Care	0	0	0	0
GPVTS – GP	0	0	0	0
FY2 General Practice (AHAH – Med On Call)	0	0	0	0
FY2 AHAH	0	0	0	0
FY2 GP – Med On Call	0	2	0	2
FY2/CT Gastro	0	0	0	0
FY1 CAMHS	0	0	0	0

(Gen Adult)				
FY1 Geriatric/Stroke	0	2	2	0
FY1 Respiratory	0	4	4	0
FY1 Renal	0	0	0	0
FY1 Acute Internal Medicine	1	7	7	0
FY1 Cardiology	0	5	0	5
FY1 Gastroenterology	0	2	0	2
FY1 Colorectal/UGI	0	2	2	0
FY1Urology	0	7	0	7
FY1 ENT	0	0	0	0
FY1 Breast/Vascular	0	1	0	1
FY1Orthopaedic	2	14	14	0
Paediatric FY1	0	0	0	0
FY1 Adult Psychiatry (Surgical on call)	0	0	0	0
FY1 Child & Adolescent Psychiatry (Orthopaedic On call)	0	0	0	0
Total	**3**	**62**	**39**	**23**

Standard Exception Reports - response time			
	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	25	19	15
F2	6	7	3
CT1-2 / ST1-2	0	5	5
ST3-8	0	0	0
Total	**31**	**31**	**23**

Exception reports - Immediate safety Concern - response time				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	2	1	1
F2	0	2	0	0
CT1-2 / ST1-2	0	0	0	0
ST3-8	0	0	0	0
Total	**0**	**4**	**1**	**1**

N.B One extra ISC was generated in error; therefore the system would report 5.

Appendix 2 – Work schedule reviews by grade and department

Work schedule reviews by grade	
F1	3
F2	0
CT1-2 / ST1-2	0
ST3+	0

Work schedule reviews by department	
Paediatrics	0
Obstetrics & Gynaecology	0
ENT	0
Urology	1
Vascular	0
Breast	0
Upper GI	0
Colorectal	0
Orthopaedics	1
Anaesthetics	0
Anaesthetics ICU	0
Orthodontics	0
Ophthalmology	0
Haematology	0
Histopathology	0
A&E	0
Acute Medicine	1
Elderly Care	0
Stoke	0
Clinical Oncology	0
Cardiology	0
Respiratory	0
Renal	0
Gastroenterology	0
Diabetes & Endocrinology	0
Adult Psychiatry	0
General Psychiatry	0
General Practice	2
Total	**3**

N.B Two extra were generated in error; therefore the system would report 5.

Appendix 3 - Locum agency bookings and bank usage

Please see separate spreadsheets entitled:

1. **Locum bank booking data**
2. **Medical agency spend and full rate**

Bank usage - Bank hours worked by medical staff are not recorded centrally as there is currently no rostering system in place for medical staff. The following table sets out spend for each department and grade; this is indicative of the amount of bank activity in each area.

	July	August	September
DIVISION A	**£155,220.93**	**£130,064.34**	**£91,767.58**
CONSULTANT BANK	**£8,856.75**	**£19,091.41**	**£29,581.60**
HISTOPATHOLOGY	-£99.09	£4,931.73	£21,918.37
MEDICAL MICROBIOLOGY	£0.00	£8,585.34	£0.00
LOCUM GERIATRIC MEDICINE	£8,955.84	£5,574.34	£7,663.23
STAFF GRADE BANK	**£5,000.00**	**-£5,000.00**	**£0.00**
EMERGENCY MEDICINE	£5,000.00	-£5,000.00	£0.00
SPECIALTY DOCTOR BANK	**£6,351.22**	**£2,988.52**	**£1,892.30**
EMERGENCY MEDICINE	£4,922.01	£2,749.13	£1,892.30
PALLIATIVE MEDICINE	£1,429.21	£239.39	£0.00
GENERAL PRACTITIONERS BANK	**£116,553.79**	**£94,724.96**	**£44,186.02**
GP DOCTORS IN TRAINING	£102,240.72	£81,754.75	£33,280.71
GENERAL MEDICAL PRACTITIONER	£14,313.07	£12,970.21	£10,905.31
SPECIALTY TRAINEE BANK	**£8,090.47**	**£9,986.82**	**£7,464.06**
GENERAL (INTERNAL) MEDICINE	£6,573.77	£7,822.47	£5,233.81
GENERAL SURGERY	£0.00	£0.00	£0.38
EMERGENCY MEDICINE	£1,516.70	£2,164.35	£2,229.87
FOUNDATION YEAR 2 BANK	**£10,368.70**	**£8,272.63**	**£8,643.60**
GENERAL (INTERNAL) MEDICINE	£350.00	£8,272.63	£8,642.17
EMERGENCY MEDICINE	£5,598.96	£0.00	£0.00
TRAUMA AND ORTHOPAEDIC SURGERY	£0.00	£0.00	£1.43
RESPIRATORY MEDICINE	£4,419.74	£0.00	£0.00
DIVISION B	**£50,984.66**	**£86,244.60**	**£88,214.52**
CONSULTANT BANK	**-£5,203.82**	**£28,939.07**	**£18,727.25**
LOCUM GENERAL SURGERY	-£910.40	£0.00	£0.00
TRAUMA AND ORTHOPAEDIC SURGERY	£0.00	£0.00	£864.88
LOCUM TRAUMA AND ORTHOPAEDIC	£8,639.89	£0.00	£0.00
			-
PAEDIATRICS	£6,500.00	£6,500.00	£32,500.00
DERMATOLOGY	£1,452.07	£0.00	£695.76
CLINICAL NEUROPHYSIOLOGY	£2,688.62	£8,078.21	£9,104.00
LOCUM CLINICAL RADIOLOGY	£8,497.00	£11,047.86	£11,236.05
YEOVIL DISTRICT HOSP NHS FT	-£4,077.00	£3,313.00	£3,311.00
LOCUM PAEDIATRICS	£0.00	£0.00	£23,967.56
LOCUM OTOLARYNGOLOGY	-£27,994.00	£0.00	£2,048.00

STAFF GRADE BANK	**£2,570.67**	**£2,570.66**	**£2,570.67**
YEOVIL DISTRICT HOSP NHS FT	£2,570.67	£2,570.66	£2,570.67
SPECIALTY DOCTOR BANK	**£37,656.26**	**£26,298.97**	**£14,022.11**
ANAESTHETICS	£0.00	£0.00	£8,267.37
GENERAL SURGERY	£0.00	£10,450.03	£0.00
OTOLARYNGOLOGY	£15,586.26	£16,921.94	£10,242.74
POOLE HOSPITAL NHS FT	£3,073.00	£3,927.00	-£4,488.00
LOCUM OTOLARYNGOLOGY	£18,997.00	-£5,000.00	£0.00
SPECIALTY TRAINEE BANK	**£12,929.45**	**£27,291.94**	**£48,306.46**
ANAESTHETICS	£0.00	£0.00	£2,234.91
GENERAL SURGERY	£0.00	£9,972.49	£16,591.65
UROLOGY	£0.00	£751.27	£4,898.50
TRAUMA AND ORTHOPAEDIC SURGERY	£6,461.98	£8,337.99	£19,178.49
PAEDIATRICS	£2,925.45	£3,869.44	£5,402.91
OBSTETRICS AND GYNAECOLOGY	£3,542.02	£4,360.75	£0.00
FOUNDATION YEAR 2 BANK	**£3,032.10**	**£1,143.96**	**£4,588.03**
TRAUMA AND ORTHOPAEDIC SURGERY	£3,032.10	£1,143.96	£4,588.03

Appendix 4 – Medical training grade vacancies

Department	Grade	Rotation Dates	July	August	September	Average Q2
Paediatrics	ST1	Sept 18 to Sept 19	1	1	0	0.6
Paediatrics	ST3+	Sept 18 to Sept 19	0.4	0.4	0.4	0.4
O&G	ST1	Oct 18 to Oct 19	0	0	0	0
O&G	ST3+	Oct 18 to Oct 19	1	1	1	1
Surgery	CT1	Aug 18 to Aug 19	0	0	0	0
Surgery	CT2	Aug 18 to Aug 19	0	0	0	0
Surgery	ST3+	Oct 18 to Oct 19	0	0	0	0
Orthopaedics	ST3+	Sept 18 to Sept 19	0	0	1	0.3
Anaesthetics	CT1/2	Aug 18 to Aug 19	0.4	0	0	0.13
Anaesthetics	ST3+	Aug 18 to Aug 19/Feb19 to Feb 20	0.2	0.2	0.2	0.2
Medicine	CT1/2	Aug 18 to Aug 19	0	0	0	0
Medicine COE	ST3+	Mar 19 to Mar 20	1	0	0	0.3
Medicine Diab/Endo	ST3+	Aug 18 to Aug 19	1	0	0	0.3
Medicine Gastro	ST3+	Sept 18 to Sept 19	0	0	0	0
Medicine Resp	ST3+	Aug 18 to Aug 19	0	0	0	0
Medicine Cardio	ST3+	Feb 19 to Feb 20	0	0	0	0
Medicine Renal	ST3+	Aug 18 to Aug 19	2	0	0	0.6
Heamatology	ST3+	Sept 18 to Sept 19	0	0	0.4	0.13
Med/Surg	FY1	Aug 18 to Aug 19	0	0	0	0
Med/Surg	FY2	Aug 18 to Aug 19	0	0	0	0
GPVTS	ST1	Aug 18 to Aug 21	2.4	2.4	2.4	2
GPVTS	ST2	Aug 17 to Aug 20	0.4	1.4	1.4	1.06
GPVTS	ST3	Aug 18 to Aug 19	3	1.5	1.5	2
			12.8	7.9	8.3	9.02

Appendix 5 – Fines levied by Department and Cumulative Total

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

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

BUSINESS PLANNING GUIDANCE 2020/21

1. INTRODUCTION

1.1 The business planning process brings together operational, quality, financial and workforce plans to ensure our services can be delivered in an affordable manner whilst maintaining a safe level of service.

1.2 The Trust has planned for a breakeven position in 2019/20, but has a substantial underlying recurrent deficit. Therefore in order to ensure the quality of services does not fall the Trust will need to improve productivity and remove inefficiencies.

1.3 The business planning process will identify business plans for each division and corporate area which detail the operational plans for 2020/21 together with the budget for this period.

1.4 The purpose of this paper is to set out the business planning framework for 2020/21 and to clarify the process and timescales. The business planning process brings together operational, quality, financial and workforce plans to ensure our services can be delivered in an affordable manner whilst maintaining a safe level of service.

2. STRATEGIC CONTEXT TO THE PLANNING PROCESS

2.1 The Trust Strategy is founded on its desire to provide outstanding care for people in ways which matter to them. This will be achieved through our strategic objectives:

- Outstanding: Delivering outstanding services every day;
- Integrated: Joining up our services;
- Collaborative: Working with our patients and partners;
- Enabling: Empowering our staff; and
- Sustainable: Productive, effective and efficient.

It is the strategy that drives the business plan and budgets for 2020/21. The Business Planning Framework will ensure the Trust's strategic objectives are met.

2.2 New ways of working will potentially require new workforce models. There are a number of areas where recruitment is difficult due to the national shortage of certain professions together with the rural location of DCH. The business planning process will identify workforce risks and plans to ensure we have the correct workforce in place to deliver the plans.

2.3 The NHS Long Term Plan requires all trusts to achieve financial balance by 2023/24 without the requirement for Financial Recovery Funding. This will require significant efficiency savings to be delivered. The approach at DCH to

delivering efficiencies will be through our approach for continuous improvement and will be overseen through our Better Value, Better Care Programme.

2.4 Service transformation, service and quality improvement are all enablers of improving or maintain quality whilst optimising efficiency and productivity and will be fundamental to our approach. DCHFT is part of the Dorset STP and is working towards a Dorset Integrated Care System model. It is expected that a new financial collaborative agreement will be in place for 2020/21 and income levels will increase by approximately 1.3%. This is yet to be confirmed by Commissioners and subject to the outcome of contract negotiations.

2.5 DCHFT was set a financial control total for 2019/20 of a breakeven position. The control total for 2020/21 will be determined as part of the finalisation of the Dorset ICS Long Term Plan and will need to be agreed with NHS Improvement.

3. DEMAND AND CAPACITY PLANNING

3.1 In order to understand the demand on our services for 2020/21, it is essential to forecast the likely levels of activity as accurately as possible

3.2 Service leads will be expected to produce capacity plans that identify there is sufficient outpatient, day theatres, main theatre and bed capacity to deliver the expected levels of demand. Any shortfalls in expected capacity must be highlighted and raised at the business planning meetings together with proposed solutions to deliver this work within current funding levels. This may require innovative solutions and include partnership working with other organisations.

3.3 Specialty teams will be expected to understand demand and capacity and to demonstrate the links between demand, capacity and activity using the IMAS system. The national Get It Right First Time (GIRFT) Programme should also be factored into operational plans. Speciality teams will be expected to have a good understanding of phasing, scheduling and annual leave planning to optimise the use of capacity and resources.

4. WORKFORCE PLANNING

4.1 Each specialty is expected to develop a workforce plan that demonstrates the proposed level of demand can be safely delivered. Areas of concern which may require innovative recruitment solutions or workforce remodelling must be outlined within care group business plans.

4.2 Where additional workforce is required to deliver activity, new workforce models must first be considered to ensure the service can be delivered within current resources before consideration is given to requesting additional funding.

4.3 The workforce implications of all planned service developments should be considered and captured.

4.4 Anticipated difficulties in recruitment must be identified during the business planning process to enable mitigating plans to be agreed with the Human Resources Department.

5. CLINICAL QUALITY AND SERVICE IMPROVEMENT

5.1 Service and clinical leads will be expected to review the current level of clinical quality (patient experience, clinical outcomes, safety and harm events, and ability to meet national standards appropriate to their specialty) and identify areas for improvement.

5.2 Specialties should have plans to participate in nationally mandated clinical audits as well as having a locally defined audit programme.

5.3 Innovation in clinical pathways and models to deliver quality care within an affordable framework need to be included in the service improvement plans, with expected outcomes and cost implications identified and included in the business plan.

6. RISK MANAGEMENT

6.1 Specialty leads are expected to identify any anticipated risks in the delivery of a safe service in 2020/21 within available resources. Mitigating action plans are to be produced by the Speciality for agreement during the business planning process.

6.2 Mitigating actions for risks on the Trust risk register are expected to be identified through the business planning process.

7. FINANCIAL PLANNING PRINCIPLES

7.1 The setting of the Trust's overall budget is integral to the business planning process. The financial allocation will be agreed for each service and will be based on available resources and calculated as follows:

- Full year effect recurring budget;
- Plus pay inflation and incremental increases;
- Plus non pay inflation where appropriate
- Less efficiency requirements;

7.2 All budgets are required to be agreed and signed by budget holders at a service manager/department head level and to allow ongoing financial management, budget holders will receive budget monitoring and forecasting reports to enable active budget management;

7.3 The recurrent Full Year Effect (FYE) budgets will be rolled over from 2019/20 as the starting point for every budget and any variations to this will be discussed and agreed as part of the business planning process

7.4 Income budgets will be set as follows:

- Income budgets relating to contracts and specialised services will be set at the value agreed with the Commissioner;
- Other patient care income budgets e.g. NCA's, non-contracted activity, RTA's etc will be set at a level that reflects the actual amounts earned in 2020/21 adjusted for non-recurring elements;
- Income budgets associated with trading activities (car parks, catering receipts etc.) should be set at a level consistent with anticipated 2020/21 deliverable income levels based on actual income levels in 2019/20; and
- Any reductions in non-clinical income levels will be matched with a reduction in expenditure budgets.
- Each department providing private health care will be set an income target, agreed during the business planning process with the divisional managers. The income target will be based on the predicted level of private work, calculated from the work undertaken in 2019/20 adjusted for known developments.

7.5 Pay budgets will be set as follows:

- The baseline pay budget will be based on the full year effect recurring budget;
- Increments will be identified for each filled pay post and will be included in the pay budgets;
- Pay increases for those staff on Agenda for Change contracts will be included based on the published scales for 2020/21;
- Medical staffing baseline budgets will be calculated on the existing funded establishment based on the current staff in post. This will ensure that the budget reflects the most up to date position on the consultant contract and the "bandings" for the Junior Doctors;
- Employers NI and pension contributions will reflect the rates payable from April 2020 and will reflect the pension status of the employee;
- Any further allowance for pay inflation will be held within a central budget and applied to posts as pay awards take effect.

7.6 Non-pay budgets will be set as follows:

- Non pay budgets will be based on the recurrent full year effect budget;
- Inflation will be added where this can be clearly evidenced and linked to the inflation funding passed to the Trust by Commissioners.

- Any predicted risks to staying within current funding levels will be highlighted and service efficiencies must be identified to mitigate this risk.
- Budgets for anticipated increases in depreciation from capital schemes will be set based on the estimated value; and
- Drug increases will be in line with inflation.

8. COST IMPROVEMENT PROGRAMME

8.1 It is anticipated that the Trust will be required to deliver significant efficiency savings during 2020/21. In order to achieve these levels of savings whilst continuing to deliver high quality services, a service improvement approach is required which will improve both the efficiency and quality of services. The delivery of the CIP will be overseen by the Better Value, Better Care Board.

8.2 A realistic savings programme will be developed following the business planning process which will be aligned to the Trust's Financial Sustainability Strategy and the Dorset STP/ ICS Long Term Plan requirements.

8.3 It is essential that all opportunities for improving efficiencies are identified and delivered in a manner that allows sustainable change;

8.4 The delivery of efficiency savings will be the responsibility of specialty, divisional and departmental leads. They will be expected to undertake a quality impact assessment for approval by the Medical Director and Director of Nursing & Quality. It is expected that each specialty/department will present during the business planning process how they can deliver efficiency savings through using the following sources:

- Transformation Board;
- Better Value, Better Care Board
- Divisional and specialty projects;
- Identification of new service models;
- Service line reporting information;
- Review of opportunities with departments and divisions;
- Model Hospital benchmarking and productivity information; and
- Health economy wide efficiencies.

9. CAPITAL BUDGETS

9.1 The business planning process aims to deliver a detailed annual capital plan for 2020/21.

9.2 The objectives of the capital planning process are as follows:

- The affordability of the capital plan will be based on the liquidity plan for the Trust;
- A capital plan will be set on a risk based approach so that risks to service delivery are prioritised above further developments to the estate and services;
- The capital plan will be aligned to the Trust's Strategy, the Estate Strategy and the HI Strategy;
- The quality, productivity and efficiency of resources will be maximised; and
- There will be an improved experience for patients, their families and carers.

9.3 The Trust's Capital Programme is allocated over four separate elements: Estates Schemes, Health Informatics Schemes, Operational Schemes and Medical Equipment Schemes. There is a committee structure in place to cover each of these elements. The committees will be responsible for advising on the required level of capital expenditure for their area of responsibility together with managing the delivery of the programme.

9.4 As in previous years a risk based approach will be taken in 2020/21 and the divisions are required to ensure that all risks are identified and adequately addressed as part of the planning process. Solutions to risks must not be omitted on the basis of affordability as this assessment will take place once the overall position is understood.

9.5 Investment in Health Informatics (predominantly Information Communication and Technology (ICT)), can undoubtedly improve working practices and the quality of care provided. The HI strategy will identify the required investment in ICT. The Dorset Informatics Programme Board will be responsible for advising on the required level of capital investment for ICT development in line with the HI Strategy.

9.6 A maintenance programme will be led by the Head of Estates and Facilities, and this will be the basis of capital investment required to ensure the estate is fit for purpose.

9.7 Any developments to the estate will be based on affordability and be aligned to the Estate Strategy. The Head of Estates and Facilities is responsible for developing and delivering the Trust's Estate Strategy.

9.8 A medical equipment replacement programme has been developed based on an assessment of risk. The Medical Devices Group is responsible for recommending the level of funding required for the medical equipment replacement programme and they will be responsible for the delivery of it.

9.9 Each of the above areas i.e. HI, Estates and Medical Devices Committee will present their plans to the Capital Planning Group to ensure all proposed investments are in line with the relevant strategy. The agreed plans will then go to the Senior Management Team for approval.

9.10 The Capital Programme will not be fully committed each year in order to provide a contingency for changes in funding sources and for urgent risks to be addressed.

9.11 The Trust is likely to have to borrow cash in 2020/21 and this could have an adverse impact on the amount of funding available for the capital programme. However, it is essential that services are provided safely and therefore the capital investment required will be reviewed in the overall context of cash required in 2020/21.

9.12 The proposed capital programme will be reviewed by the Capital Planning Group, Senior Management Team and approved by the Board of Directors.

10. PROCESS

10.1 Each Specialty and Corporate Service is expected to develop a proposed list of development priorities taking into account the outcomes of demand and capacity planning and addressing patient safety concerns. This should be accompanied by a fully developed cost improvement programme. The prioritisation process must first be undertaken within each specialty and signed off by the relevant clinical director, matron and service manager. A further prioritisation exercise should then be undertaken by the divisional management team.

10.2 The final divisional plan must be signed off by the divisional management team and each care group management team.

10.3 Each specialty and corporate service should summarise the outcomes of the process in a business plan and a template for this is included as Appendix 1. The Business Plan should include actions for risk and issues that need a specific action to address. The Business Plan should not include actions that are considered business as usual for running a safe and efficient service.

10.4 A number of key events will occur in order to ensure the business planning process is effective. These will be as follows:

- Business planning meetings will be held with all budget holders to discuss and agree all areas outlined in the framework. The meetings will include the Director of Finance & Resources, the relevant budget holders and a representative from the Finance team.
- An SMT meeting will have dedicated time to discuss risks, priorities and mitigations from the business planning process.
- Guidance setting out how the trust will undertake final prioritisation of developments is being developed and will be issued in due course.

10.5 All budgets will be signed off by budget holders.

10.6 The table below highlights the timescale for implementing the business planning framework for 2020/21 and is indicative at this stage and could be subject to change based on National guidance.

Action	Due Date
Business Planning Guidance to be agreed by SMT	18/09/2019
Divisional Strategy Days / Workshops	30/09/2019
Demand & Capacity Models completed	18/10/2019
Business Planning Guidance presented to FPC	22/10/2019
Initial Budget Setting Meetings including Demand & Capacity Review	WC - 11/11/2019
Business Planning Guidance presented to Board of Directors	27/11/2019
Divisional Plan agreed with Care Group Management Teams and signed off by Divisional Management team	30/11/2019
Prioritisation of Service Developments – Joint meeting of the leadership teams of the two clinical divisions to agree development priorities.	TBC
Initial Headline submission to NHSi	**TBC**
Draft Business Plans presented to SMT	15/01/2020
Draft Business Plans presented to FPC	21/01/2020
Draft Business Plans presented to Board	29/01/2020
Draft Business Plan submission to NHSi	**TBC**
Re-Prioritisation of Service Developments & Review CIP (SMT)	19/02/2020
Final Business Plans presented to SMT	17/03/2020
Final Business Plans presented to FPC	18/03/2020
Final Business Plans presented to Board	25/03/2020
Final Business Plan submission to NHSi	**TBC**

11. ACTION REQUIRED

Budget holders are requested to read the updated business planning guidance for 2020/21 and ensure plans are in place to enable its implementation.

Paul Goddard
Director of Finance and Resources

September 2019

2020/21 Business Planning

Specialty Name

2020-21

97+% Friends and Family	Rated Outstanding & meeting performance standards	Reduced ED admissions and hospital bed days per 100,000 population	Top quartile staff engagement	1% Operating surplus

Outstanding care for people in ways which matter to them

Contents

1. Instructions

- Please complete this template following the detailed work completed as part of the Divisional and Care Group business planning process.
- Please complete these templates for each Care Group and then summarise into the Divisional position.
- Corporate services should also complete the templates where applicable
- It is not expected that all actions relating to business as usual are included in the business plan. Please focus on the exceptions where a particular action is required to mitigate a risk that would prevent the delivery of your objectives. Expected exceptions to achieving quality and performance standards in 2020-21 and/or changes required to service delivery and workforce models should be summarised in this template.
- Please complete the Sign-Off Sheet.

2. Quality and performance

Please identify any expected exceptions to the achievement of required quality and performance standards for your Division and Care Groups in 2020/21. Please summarise the exception, its outcome of the root cause analysis, along with the action plan for recovery, including key milestones and the improvement trajectory. Please also identify the quality, performance and/or financial impact

Reference	Exception	Root Cause analysis	Actions for recovery, including key milestones and trajectory	Quality Impact	Performance Impact	Financial Impact £000's
1						
2						
3						

3. Demand & Capacity

Please set-out your Division's planned activity levels for the year, also detailing the current capacity of the services. These figures should ensure the Trust is maintaining key targets such as RTT, Cancer Wait Times, Diagnostic times and A&E standards. In the second table please highlight key issues which may put these targets at risk and the planned mitigating actions.

LIAISE WITH MARK STOCKMAN & ADAM SAVIN

SERVICE MANAGERS / SPECIALTY TO WORK ON THIS THROUGHOUT SEPTEMBER – TBC WITH DM

- **Observations:**

- **Concerns – impacting capacity 2020/21:**

- **Solutions**

4. Workforce

Please identify any significant changes to the Division and Care Group's workforce model. Please identify the change, the reason for the change, the key milestones to delivering the new workforce model and when that new model will be in place. Please also identify the impact once the new model is in place

WTE Change	Source of Request	Rationale	Recruitment Difficulty Level (L/M/H)	Key milestones and when new workforce model in place	Other Department / Support Service Impacted	Quality Impact	Performance Impact	Net Financial Impact £000's

5. Finance

Please set-out your Division's planned financial budget for the year. These figures should ensure the Trust is maintaining key targets without compromising quality or safety standards. In the second table please highlight any unavoidable cost pressures which may put these targets at risk and how these will be mitigated.

Division/Care Group	Pay £'000	Non Pay £'000	Income £'000	Total £'000
2019-20 Budget				
Non Recurring / FYE items				
Pay Inflation				
Non Pay Inflation				
2020/21 Baseline Budget				

5. Finance continued

Division/Care Group	Pay £'000	Non Pay £'000	Income £'000	Total £'000
2020/21 Baseline Budget				
Agreed Developments 2020/21				
New Cost Pressures 2020/21				
Revenue Impact of Capital 2020/21				
2020/21 Gross Budget				
Less Cost Improvement Programme 2020/21				
TOTAL PROPOSED BUDGET 2020/21				

6. CIP / Transformation

Scheme Description	Division	Specialty / Team	Project Lead	Pay Non-Pay Income	Recurring Non-Recurring	CIP Value £'000	Will CIP be delivered within existing resources?	Is Additional support required (if so, where from?)

7. Key operational risks for the Division

Please set-out your Division's Top 5/6 key strategic risks. Please set out the key risk, with a description and a summary of the actions being taken to mitigate or eliminate this risk. Please identify who the individual owner is for this risk and cross-reference it to the Corporate Risk Register or Board Assurance Framework if applicable.

Key Risk	Description	Actions for mitigation/elimination	Owner	X-Ref to RR

8. Sign-off - VERSION

Specialty	
Slides Completed by	
Service Manager approval	
Clinical Director approval	
Matron approval	
Divisional Manager approval	
Divisional Director approval	
Head of Nursing approval	
Confirmed engagement of HR	
Confirmed engagement of Transformation Office	
Confirmed engagement of Finance	
Confirmed engagement of Risk	
Confirmed engagement of Strategy	
Confirmed engagement of Private Patient service	

Title of Meeting	**Board of Directors**
Date of Meeting	**27 November 2019**
Report Title	**Mortality Report: Learning from deaths Qtr 2 2019/20**
Author	Prof. Alastair Hutchison, Medical Director
Responsible Executive	Prof. Alastair Hutchison, Medical Director

Purpose of Report (e.g. for decision, information) To inform the Board of the learning that has occurred as a result of deaths being reported, investigated and disseminated throughout the Trust.	
Summary The Trust's SHMI and HSMR figures remain elevated in the 'higher than expected' category. This report provides assurance that there are no other indicators to suggest standards of in-patient care are contributing to this elevation. Structured Judgement Reviews are being used to review the care of an appropriate sample of people who died whilst in-patients, and to learn from any lapses identified. This process has been strengthened by the introduction of Medical Examiners during Q2, who undertake a rapid review of the notes of every in-patient who dies whilst under the care of DCH staff.	
Paper Previously Reviewed By Quality Committee, 22 October 2019	
Strategic Impact Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that a higher than expected SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI/HSMR can have a negative impact on the Trust's reputation both locally and nationally.	
Risk Evaluation • Clinical coding data quality is adversely affecting the Trust's ability to assess quality of care • Reputational risk due higher than expected SHMI/HSMR • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor	
Impact on Care Quality Commission Registration and/or Clinical Quality The higher than expected SHMI continues to raise concerns with NHS Improvement and the CQC. NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019.	
Governance Implications (legal, clinical, equality and diversity or other): Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016).	
Financial Implications Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	The Board is asked to note the content of the report

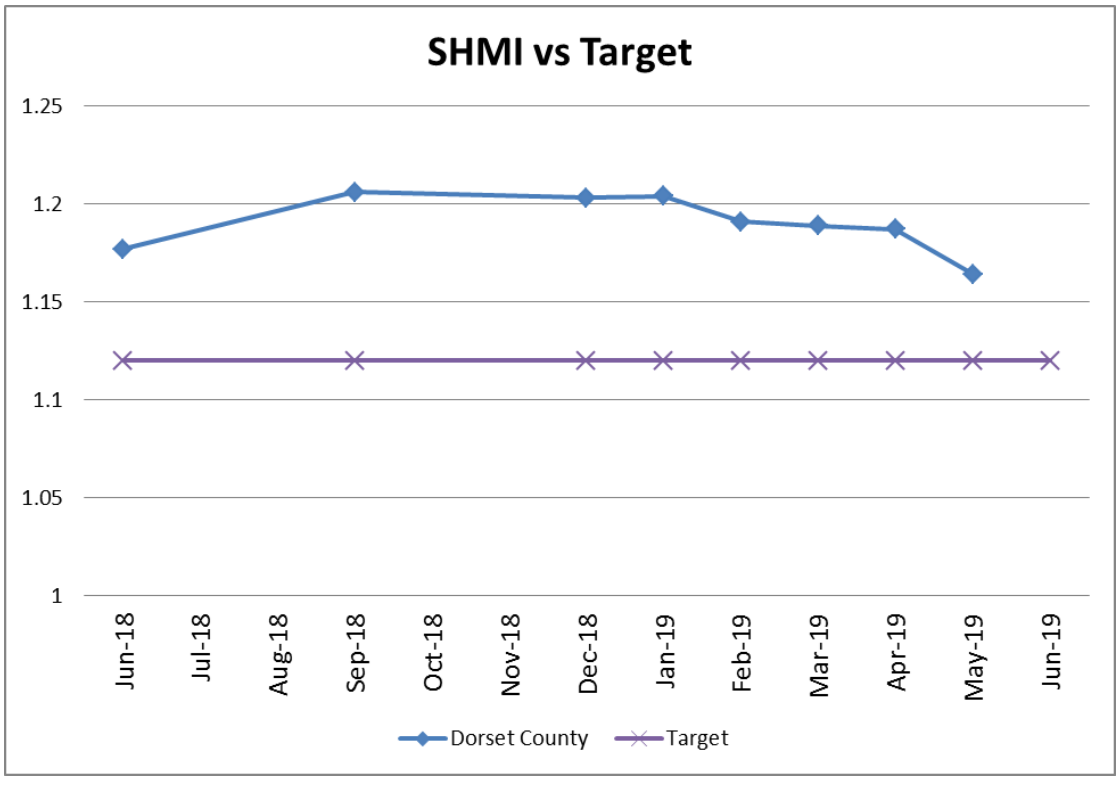
MORTALITY DATA AND STATISTICS

1.1 Data Summary

These indicators are provided by DrFoster for a rolling 12 month period, and usually 4 months in arrears. In summary:

- The SMR, whilst still statistically significantly higher than expected, has decreased by 1.7 vs. the previous rolling 12 month period, this is due to a combination of a reducing crude rate and stabilisation of the expected rate
- Compared to peers, the Trust is one of three with a statistically significantly higher than expected SMR
- Emergency admissions continue to have a statistically significantly higher than expected relative risk although the trend is decreasing in line with the overall SMR
- The HSMR, whilst still statistically significantly higher than expected, has decreased by 1.2 vs. the previous rolling 12 month period and is very close to becoming within the expected range
- Both emergency weekday and weekend HSMR have decreased vs. the previous rolling 12 month period (0.4 and 3.2 respectively)
- The SHMI for May 2018 to April 2019, whilst still statistically significantly higher than expected, has decreased for three consecutive months, and by 0.23 vs. the previous rolling 12 month period

1.2 Summary Hospital-level Mortality Indicator (SHMI)



DCH's SHMI has improved for 4 consecutive months, but will only be within the 'expected range' when it reaches 1.12 (although this 'target' varies depending on performance across the whole country).

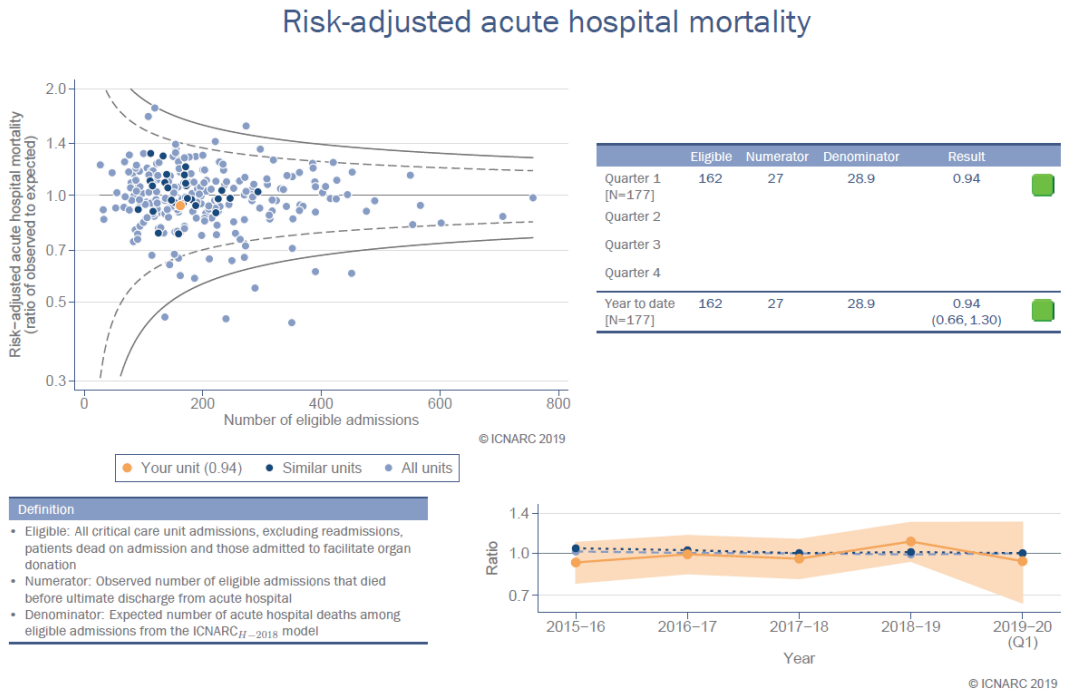
2.0 OTHER INDICATORS OF CARE

With SHMI and HSMR both higher than expected, the DCH Hospital Mortality Group regularly examines other data which might relate to standards of care. The following sections report data available from various national bodies who report on individual Trusts' performance. For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, VTE, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing.

2.1 NCAA Cardiac Arrest data

No new data this quarter

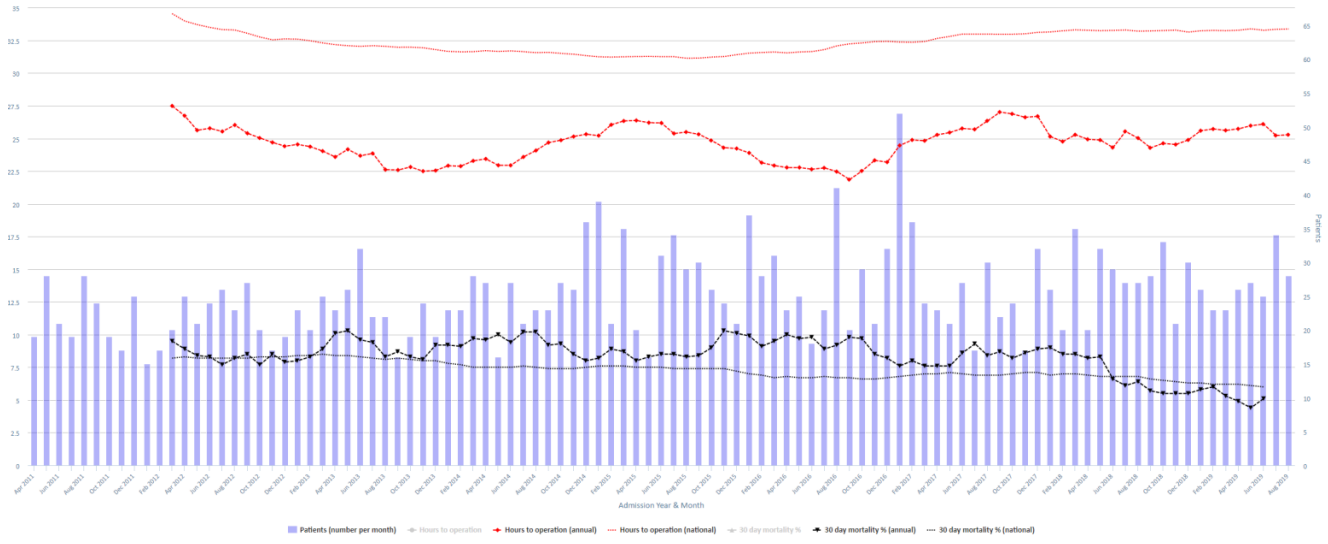
2.2 ICNARC Intensive Care survival data published 8/10/2019



2.4 Pneumonia mortality data

Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

2.5 National Hip Fracture database



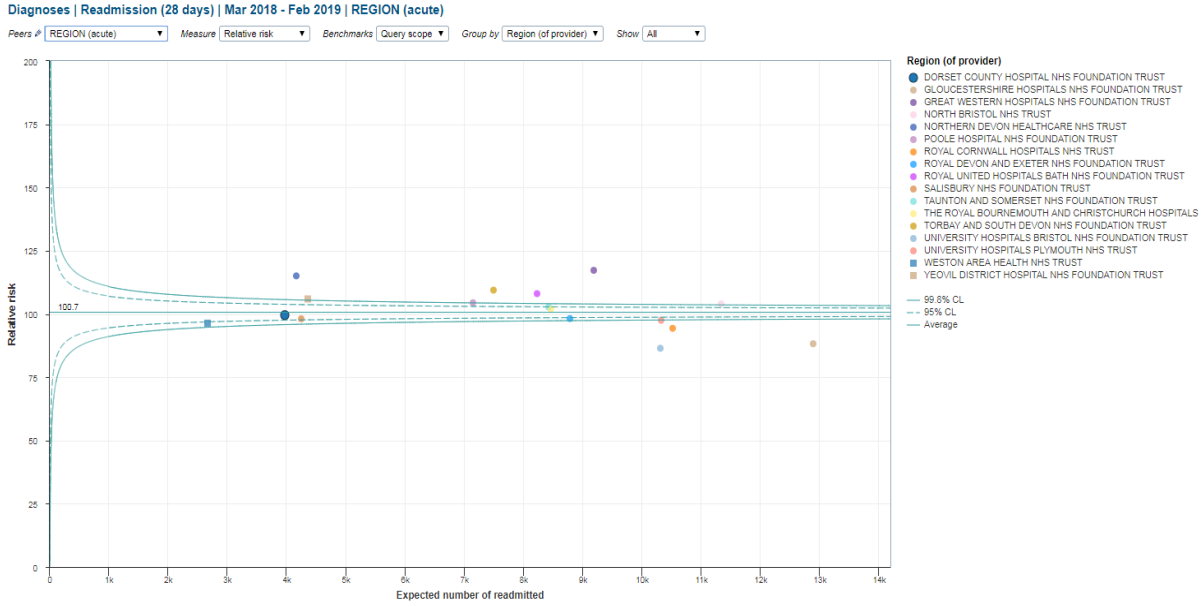
2.6 Colorectal Surgery Annual audit

No new data this year

2.8 Getting it Right First-Time reviews

GIRFT reviews undertaken at DCH during this quarter are as follows;
Endocrinology 9th September 2019
Full reports from GIRFT visits will be available, but feedback from each review has been very positive. Action plans have been developed and are being worked through at present.

2.7 Readmission to hospital within 30 days



2.8 Dr Foster Safety Dashboard

Indicator	Observed	Relative risk
Accidental puncture or laceration	55	87.7
Deaths after surgery	13	84.4
Deaths in low-risk diagnosis groups	12	112.9
Decubitus ulcer	161	67.3
Infections associated with central line	0	0.0
Obstetric trauma - caesarean delivery	0	0.0
Obstetric trauma - vaginal delivery with instrument	7	72.6
Obstetric trauma - vaginal delivery without instrument	25	104.2
Postoperative haemorrhage or haematoma	5	82.4
Postoperative hip fracture	1	74.9
Postoperative physiologic and metabolic derangement	4	218.8
Postoperative pulmonary embolism or deep vein thrombosis	30	86.7
Postoperative respiratory failure	4	39.7
Postoperative sepsis	3	70.6
Postoperative wound dehiscence	0	0.0

3.0 LEARNING FROM DEATHS

3.1 Structured Judgement Reviews

SJRs are undertaken in accordance with the Trust's Learning from Deaths Policy, which is currently being rewritten. Each Division is responsible for monitoring its SJR processes and reporting to the Hospital mortality Group on a quarterly basis. Processes within the Family Services and Surgical Division are more robust and mature than those within the Urgent and Integrated Care Division.

DIVISION A – verbal update to be provided at the meeting

During quarter 2: DIVISION B

Total number of in-patient deaths	48	
Number of SJRs requested	48	(% of all deaths)
Number of SJRs completed	22	(% of requested)
Number resulting in score ≤2	0	(% of all deaths)

3.2 Lessons learned from completed SJRs –
Q1 and Q2: 1. Admission clerking poor – specifically surgical : PMH and drug history, cardiac and respiratory examination
2. Sepsis 6 screening and delay in antibiotics
3. Outreach/ H@N informed of patient but no referral to ICU from parent speciality.
4. Lack of elderly care input on orthopaedic ward
5. DNAR/ DNE not addressed in timely manner.
6. Delay/ absent escalation of sick patients to seniors.
7. Notes – poor filing, poor handwriting and times not documented
8. Not recognising/ acting on severe lab or VBG/ABG derangements
9. ICU consultant presence at weekends after midday

Areas of good practice
Consultant delivered care
Documentation of mistakes and apologies – Duty of candour
Early out of hours OGD

3.3 Actions taken All SJRs are forwarded to the individual Speciality Governance Leads and to Anaesthetics Clinical Lead if patient died on ICU and/or had a recent procedure in Theatres, for discussion at local M&M meetings, with individual action plans for highlighted issues.

1. All SJR's with an overall assessment score of 1 or 2, or an avoidability score of 1-3 will be presented at HMG and agree if an RCA is required.

2. All SJR's with a score of 1 or 2 in any phase, excluding overall assessment, to be forwarded to Divisional Director & Divisional Governance Lead to review if require second review, RCA and/or escalation to HMG.

3. Key learning to be fed back through Divisional Governance Meeting, Departmental Governance Meetings and the Complaints, Incidents & Action Plan Group (CIA).

4. Common themes to be included in the Divisional Newsletter.

3.4 Learning Disability Deaths

There were no Learning Disability deaths notified within Q2. The third annual report of the English Learning Disabilities Mortality Review (LeDeR) programme was published in May 2019. It presents information about the deaths of people with learning disabilities aged 4 years and over notified to the programme from 1 July 2016 – 31 December 2018. Key findings include:

- The proportion of people with learning disabilities dying in hospital is higher (62%) than in the general population (46%).
- Almost a half (48%) of deaths reviewed in 2018 received care that the reviewer felt met or exceeded good practice, slightly more than the 44% in the 2017 report.
- The proportion of deaths notified from people from Black, Asian and Minority Ethnic (BAME) groups was lower (10%), than that from the population in England as a whole (14%). However, children and young people from BAME groups were overrepresented in deaths of people with learning disabilities.

3.5 Neonatal and Maternal Deaths

There were no maternal deaths reported in Q2. The Clinical Negligence Scheme for Trusts requires that cases and actions are reviewed using the Perinatal Mortality Review Tool (PMRT) and reported to the Trust Board quarterly. The PMRT enables a comprehensive and standardised review of all perinatal deaths from 22+0 gestations (excluding terminations) to 28 days after birth; as well as babies who die after 28 days following neonatal care.

3.6 Working with Families

The End of Life team have co-designed improved information leaflets to bereaved families. All bereaved relatives now have the opportunity to discuss their relative's death with a Medical Examiner.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

Quality improvement projects linked to learning from SJRs include the following initiatives:

1. Patient Flow programme
2. Sepsis strategy
3. End of Life strategy

No new QI projects have yet been initiated as a direct result of learning from SJRs, and this will be addressed following the appointment of a QI Lead (October 2019).

5.0 MORBIDITY and MORTALITY MEETINGS

All departmental Clinical Leads have been asked to ensure that M&M meetings are taking place on a regular basis (depending on the number deaths within each department), We are moving towards using the Royal College of Surgeons M&M meeting Best Practice document as the template. Work in progress

6.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 3 new Coroner's inquests being opened in the period 01.07.19 – 30.09.19. During Quarter 2, the Trust had 14 inquests listed from previous quarters to be heard.

Of these 14, 8 were heard as documentary inquests, with staff having to attend to give evidence in the remaining 6. None has resulted in adverse criticism of standards of care and the Trust has not received any Regulation 28 letters.

7.0 PAN-DORSET MORTALITY GROUP AND LeDeR REPORT

The Pan-Dorset Mortality Group is led by the CCG with representation from all four provider Trusts. The July Quarterly Pan-Dorset Mortality review Meeting was rescheduled and took place on 23rd September 2019, attended by Richard Jee. Minutes are available.

The LeDeR Programme Quarterly Report for Q2 2019-20 is not yet available from Dorset CCG.

8.0 SUMMARY

SHMI and HSMR remain higher than expected, although during Quarters 1 and 2 2019/20 there is evidence of a clear trend towards improvement, which most likely results from changes within the Coding Department. No other metrics of in-patient care suggest that excess mortality is occurring at DCH.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion of SJRs and Learning from Deaths are being improved and this will be facilitated by the appointment of a new Divisional Director and a QI Lead.

The Trust is undertaking a full review of its Quality Improvement processes, led by the Executive team.

Title of Meeting	**Trust Board**
Date of Meeting	**27 November 2019**
Report Title	**Communications Activity Report – Q2 July-Sept 2019**
Authors	Susie Palmer, Communications Manager Meghan Hindley, Communications Officer
Responsible Executive	Nick Johnson, Director of Strategy, Transformation and Partnerships

Purpose of Report (e.g. for decision, information) For information	
Summary This quarterly report gives an overview of communications activity for the Trust. Included in the report is information about key campaigns, initiatives and events, and analytics for our social media channels and public website. There is also a summary of news releases issued over the quarter and media coverage.	
Paper Previously Reviewed By	
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?	Yes

Recommendations	a) To receive for information

Communications Activity Report

Quarter 2: July – September 2019

1. Introduction

This quarterly report gives an overview of communications activity for the Trust. It is not an exhaustive round-up of what the communications team has been involved with over the quarter but gives a flavour of key areas of our work and a summary of activity.

2. Key Campaigns, Initiatives and Events

Recruitment

The communications and recruitment teams are continuing to work together to further develop the new dedicated recruitment microsite https://joindchft.nhs.uk/ and the use of social media channels to promote vacancies and the benefits of working at DCH. The microsite launched in August and feedback has been very positive.

The Communications Officer is also supporting the recruitment team through the use of social media to promote key vacancies and recruitment events. We now publish a 'Job of the Week' and general jobs post each week through Facebook, Twitter and LinkedIn. The posts are proving successful and the recruitment team receive regular reports on engagement rates. Dedicated artwork has been produced for use in posts and a photo session was held with staff to expand the library of photos available for use in recruitment advertising.

Site Development Engagement

Engagement events were held in early July to explain the plans for the multi-storey car park and wider site development to staff, stakeholders and the public. This was supported by information on our public website https://www.dchft.nhs.uk/about/site-development/Pages/default.aspx, a news release, leaflet drops to residents and meetings with key stakeholders.

The events were well attended and valuable feedback was received. The views, ideas and concerns gathered have been fed into the final planning application.

The Communications Manager will continue to liaise closely with the Programme Manager and the Prime Communications Executive to ensure all engagement/publicity activities are coordinated and managed appropriately.

Summer Spectacular

The Trust's first Summer Spectacular was held on 6 July and went extremely well with hundreds of visitors attending and enjoying an afternoon of stalls, displays and performances. Over £2,500 was raised for the Chemotherapy Appeal and other good causes. We hope to stage another Summer Spectacular next year, and will look at alternative venues if the school field is no longer available due to site development. The small organising committee worked incredibly hard over and above their day jobs to put together the event and received well-deserved Hospital Hero awards.

Divisional Comms Support
The Communications Manager is supporting divisions to review and improve communication both within their teams and more widely internally and externally. Care group listening events have been set up which the Communications Manager will attend to open discussions with staff. The Communications Manager is also involved with the Theatre Culture Sub-group looking at improving communications and staff morale within the theatres team. Divisions now present a slide at Team Brief meetings to highlight positive achievements.

Staff App Update
We have continued to push the staff app and, at the time of writing this report, over 900 staff members had downloaded the app. We have worked with the developers to improve the functionality in response to feedback and push notifications now take users directly to the section where the update sits. The DCH Staff App was praised at a system workforce event and other local organisations are keen to replicate it.

Design Work
The Communications Officer has been developing her design skills which has meant we can continue to bring more design jobs in house. Recent well-received design jobs have included thank you cards for the Director of Nursing to issue to staff, thank you cards for maternity to send to donors and fundraisers, a 'strategy on a page' for the patient engagement strategy and the latest issue of our staff and public membership newsletter The DCH Way.

Video Work
Our plan to increase the use of video has been going well. The Communications Officer is regularly producing videos to enhance our social media channels. She has also supported the patient experience team to produce patient experience videos for showing at Trust Board meetings and for use in staff training.

Flu Vaccination Campaign
We have kick-started this year's campaign with an appeal for staff peer vaccinators and will be pushing messages internally and externally from October – the next Communications Activity Report will provide a round-up.

Winter Pressures Comms
We are continuing to work closely with the CCG and our other partners on developing and coordinating public messaging around using local services appropriately and staying well through the winter months. Another focus is super stranded patients and encouraging people to prepare for leaving hospital in a timely way following planned surgery.

A CCG-funded campaign will be running from mid-November to March targeting people aged 18 to 34 as figures show they are one of the top groups visiting A&Es inappropriately. Adverts will be running on social media and at bus stops/on the backs of buses throughout Dorset referencing television programmes popular with that age group to make it more striking and engaging than the usual 'Stay Well' messaging.

EU Exit Comms
The Communications Manager is a member of the EU Exit Team which is meeting regularly to coordinate preparations. A dedicated intranet page provides links to useful information and updates have been circulated via the Staff Bulletin and Team Brief as preparations have progressed. Regional NHS England/Improvement comms teams are leading on the

public/media comms around the EU Exit and we are liaising closely with the South West team over messages.

ICS Communications Network
We continue to take an active role in the Our Dorset Communications Network. We are working closely with comms colleagues from partners to develop awareness of Dorset's Integrated Care System and the work going on between organisations.

We supported the promotion of a survey for NHS staff and the public to feed into the development of the updated Dorset STP: www.ourdorset.nhs.uk/lookingforward
Over 800 responses to the online survey were received and face-to-face events attracted more than 300 attendees. There was good representation from community and voluntary groups as well as minority groups. The survey has now concluded and the feedback received is shaping the updated version of the STP. The main priority areas/themes for Dorset are now Wellbeing, Prevention at Scale, Quality Care, Workforce and Digital Innovation.

3. Social Media

Social media engagement continues to grow. The statistics below demonstrate how many people we are reaching each month through each channel. Also included is a small selection of the most popular posts in the quarter.

Facebook Analytics – www.facebook.com/DCHFT

	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
Engaged users	102,546	115,118	92,238	93,646
Number of posts	222	173	164	132
Number of followers	4,020	4,850	4,929	5,256

Facebook Highlights for July

We are hoping to expand our Emergency Department (ED) and Intensive Care Unit (ICU) as well as establish an Integrated Care Hub as part of a long-term project to deliver the recommendations of Dorset's Clinical Services Review.

To free up space on the hospital site for the development of clinical facilities, we are proposing to build a multi-storey car park to improve parking for patients, visitors and staff. We are also working in partnership to develop the land we own on the site of the former Damers School and the current Trust Headquarters to raise income to contribute to the cost of the clinical facilities building work.

Members of the public are invited to come and find out more about the plans on Wednesday 17 July from 3pm to 7pm in the West Annex building on the old Damers School site on Damers Road.

For more information, visit https://bit.ly/2G94aS0

Any queries and feedback about the plans can be sent to masterplan@dchft.nhs.uk

12,468 People Reached | 2,765 Engagements | Boost Post

125 | 22 Comments 46 Shares

It was an honour to welcome Dr Richard Purvis back to DCH to mark the launch of his new book. Dr Purvis worked at the Trust as a Consultant Paediatrician for 40 years, starting in 1973.

Full of fantastic photos and anecdotes, A History of Dorchester Paediatrics, records the dramatic development of the children's medical services at DCH and across West Dorset over the past half-century.

Dr Purvis will be in Damers Restaurant all day tomorrow for anyone who wishes to buy a copy. From then, his book will be available to buy from our Children's Centre Reception on Damers Road.

9,005 People Reached | 1,983 Engagements | Boost Post

191 | 51 Comments 17 Shares

Dorset County Hospital is still under a lot of pressure following a very busy few days. Please help us cope with the high demand and continue to spread the word - our Emergency Department should only be used for serious or life-threatening conditions.

There are local alternatives to A&E available so please visit the Staywell Dorset website for advice about accessing GP, pharmacy, minor injury and urgent care services: https://staywelldorset.nhs.uk/
If you're not sure which service to use you can also call 111.

You can find details of your local Minor Injuries Unit or Urgent Care Centre at: https://www.dorsethealthcare.nhs.uk/patients-and.../miu-and-ae

Thank you for your help #StayWellDorset #HelpUsToHelpYou

6,067 People Reached | 547 Engagements | Boost Unavailable

20 | 47 Shares

Facebook Highlights for August

We have launched a new parking app to give patients and visitors, and staff who pay daily, an alternative to using cash in the parking machines at Dorset County Hospital.

The app is called 'PayByPhone' and you can download it on your phone from the Apple App Store or Google Play.

You can also pay online at https://paybyphone.co.uk or call 0330 060 4255
You can find out more on our website:
https://www.dchft.nhs.uk/patients/Pages/Getting-Here.aspx

Please note that the app charges 10p for the convenience of using it each time. It also charges for SMS messages but you can turn off that notification function.

If you have any queries or problems using the app please contact our transport team on 01305 255688 or transport@dchft.nhs.uk

PayByPhoneUK

6,991	748	Boost Post
People Reached	Engagements	

You and 48 others — 38 Comments 23 Shares

Dorset County Hospital NHS Foundation Trust
Published by Meghan Hindley [?] · August 14 ·

A lovely afternoon celebrating all our Hospital Heroes!! Our Director of Nursing Nicky Lucey read some really inspiring and emotional testimonials from both staff and patients - followed by tea and cake of course!! 👏👏👏
#TeamDCH

7,510	2,198	Boost Post
People Reached	Engagements	

196 — 1 Comment 7 Shares

THERAPY SERVICE OPPORTUNITIES
Are you looking to join a dynamic and enthusiastic department? Are you highly motivated and strive for opportunities for improvement? Do you positively impact the experience of patients by providing a high standard of care?

Therapy services at Dorset County Hospital are modernising and expanding.

We have exciting opportunities across various grades and specialties, including:
- Occupational Therapists and Physiotherapists Band 6
- Senior Physiotherapy rotational roles (would consider interest in static roles) - MSK outpatients or inpatient rotation.
- Senior Occupational Therapy roles in Stroke and Neurology (rotational acute & community)
- Band 5 - 6 accelerator post in Hand Therapy (OT or Physio)
- Rotational band 5 roles across inpatient, outpatient and community services (OT + Physio)
- Clinical Academics (OT and Physio) Band 5
- Therapy Practitioner Roles (Orthopeadics, Neuro and Frailty) Band 4
- Physiotherapist - Integrated Team Leade Band 7

For more information, or to apply, please click the links below:
https://bit.ly/2OtT0xZ – Preceptee: Occupational Therapist
https://bit.ly/2K6FBaO – Rotational Physiotherapist – Band 6
https://bit.ly/2SRum8Y – Senior Occupational Therapist
https://bit.ly/2Yg5cXi – Hand Therapist
https://bit.ly/2SR1Zl6 – Rotational Physiotherapist – Band 5
https://bit.ly/2Ows1lj – Therapy Assistant Practitioner
https://bit.ly/2K87csf - Physiotherapist Integrated Team Lead Band 7
#TeamDCH #NHSJobs #NHS

9,882	2,035	Boost Post
People Reached	Engagements	

Facebook Highlights for September

#TeamDCH will be at Kingston Maurward College tomorrow from 1pm until 4pm for the Dorset NHS and Social Care Insight and Recruitment Event.

The #NHS is not just doctors and nurses, there are more than 350 non-clinical roles in the NHS with current roles including project management, estates, facilities, finance, IT, HR, retraining, apprenticeships and many more.

Pop along and explore what transferable skills and potential training and career opportunities are available. Whatever your skills, qualifications or interests, there is a career for you!

To view the current roles available at DCH, visit https://bit.ly/2z24nTb

5,486	850	Boost Post
People Reached	Engagements	

103 6 Comments 20 Shares

JOB OF THE WEEK
Staff Nurse - Renal Dialysis Unit
An exciting opportunity has arisen for a motivated Staff Nurse with excellent communication skills to work as part of the renal speciality nursing team covering the county of Dorset. The area is a diverse, multidisciplinary environment which requires flexible and adaptable skills, an aptitude to learn and a motivation to develop your own clinical skills in line with progressive service delivery.

The successful candidate will start their placement in the Heamodialysis Unit and have an opportunity to rotate to the Prince of Wales Ward. Full training and support will be given.

For more information, or to apply visit #NHSJobs here: https://bit.ly/2MTnAlX
#TeamDCH #NHS

4,010	698	Boost Post
People Reached	Engagements	

77 13 Comments 8 Shares

Today marks the start of #OrganDonationWeek 💞

If you haven't already, make sure your loved ones know your wishes, and sign up with NHS Organ Donation. Its so easy - do it today!
For more information, visit https://www.organdonation.nhs.uk/
#PassItOn #shareyourwishes #organdonation

4,734	227	Boost Post
People Reached	Engagements	

32 1 Comment 33 Shares

Twitter Analytics - @DCHFT www.twitter.com/DCHFT

	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
Tweets	348	334	294	285
Tweet impressions	264,000	212,939	302,300	261,000
Profile visits	10,488	8,174	8,453	5,321
Mentions	798	896	967	1,183
Number of followers	3,414	3,741	3,940	4,141

Twitter Highlights for July

Twitter Highlights for August

Top Tweet earned 1,941 impressions

We love our golden tree of life! It represents such an important message around #OrganDonation!
twitter.com/bsidefest/stat…

3 10

Top mention earned 382 engagements

Dr. Oatibix
@DrOatibix · Aug 7

10yrs ago today I walked onto a ward @DCHFT scared nervous & thinking what have I done becoming a Doc 10yrs on now a Clinical Lead @SalisburyNHS supported by an amazing ED family+a business specialising in pre-hospital care & clincial governance @AcosMedical with my best friend pic.twitter.com/W5IVxn7Pyb

3 1 42

Top media Tweet earned 1,935 impressions

We have launched a new parking app to give patients and visitors, and staff who pay daily, an alternative to using cash in the @DCHFT parking machines. You can download the 'PayByPhone' app from the Apple App Store or Google Play
dchft.nhs.uk/patients/Pages…
@PayByPhone_UK
pic.twitter.com/ouTQFCwEV3

4 8

Twitter Highlights for September

Top Tweet earned 2,193 impressions

Our #flu vaccinations arrived at the Trust today! The message this year is to get your flu jab as early as possible so our Trust Board is leading by example! #jabathon #beatthebugs #flujab @NHSEngland @HealthyDorset @DorsetCCG @DCH_DoN @goddardpaul3
pic.twitter.com/s0IsTJLi1B

2 6 34

Top mention earned 418 engagements

Fraser Witherow
@fwitherow · Sep 16

Excellent day doing coronary sinus occluders in @DCHFT with @nealuren. Thanks to all the excellent staff especially Laura Starr who missed the photo!
pic.twitter.com/Z92hnuclHe

3 5 39

Instagram Analytics - www.instagram.com/dorset_county_hospital/

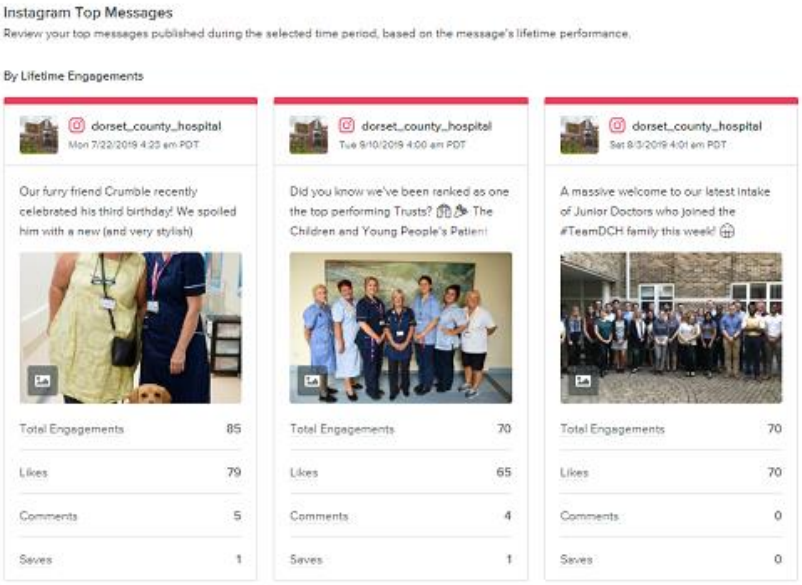
We launched an Instagram page in March in an effort to increase our audience reach. Although women between the ages of 25-34 are currently leading the force among fans, we have increased the number of men interacting with our posts, as well as young people.

In the first month we gained 575 followers, which is increasing daily. We also receive approximately 100 profile visits a day, meaning people are actively searching for the DCH Instagram.

Instagram Impressions

	Q4 2018/19	Q1 2019/20	Q2 2019/20
Total impressions	7,190	22,725	19,970
Average impressions per day	80	250	217
Average daily reach per profile	40	140	108
Number of followers	575	887	1,057

Instagram Highlights



LinkedIn Analytics - www.linkedin.com/company/dorset-county-hospital-foundation-trust

	Q4 2018/19	Q1 2019/20	Q2 2019/20
Total impressions	16,300	10,300	16,700
Total engagements	864	702	855
Organic followers gained	205	90	121
Number of followers	1,339	1,430	1,600

4. Public Website

We will be refreshing our public website, working with our web designers to make it more user-friendly and streamlined, as well as reviewing and updating content. The analytics below show general usage of the website over the quarter and the most visited pages:

Website Analytics – www.dchft.nhs.uk

	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
Page Views*	160,712	174,972	174,937	172,206
Unique Page Views**	118,189	129,020	127,270	126,449
Users	38,107	37,758	42,287	42,549
Average Session Duration	00:01:49	00:01:47	00:01:44	00:01:41

*In Google Analytics, a page view is a single viewing of a web page. This means that any time the page is loaded by the user's browser, the number of page views is incremented. If a user visits the same page multiple times within a single session, each viewing of the page will add to its page view count. Also, if the user refreshes the page in their browser, this counts as a new page view. For this reason, page views are sometimes seen as being of limited significance. For example, if the same user views the same page five times as part of a single session, this is different from five users viewing that page independently.

**Unique page views provide a useful alternative to basic page views. With unique page views, you eliminate the factor of multiple views of the same page within a single session. If a user views the same page more than once in a session, this will only count as a single unique page view. For this reason, unique views can be understood as user sessions per page, with each session potentially representing multiple views of the page but a minimum of one view per session.

Top 10 Most Popular Webpages (July - September 2019)

Page	Page Views	Unique Page Views	Average Time on Page
Site Homepage	19,753	14,825	00:00:41
Staff Section Homepage	6,569	4,519	00:00:51
Visiting Hours	5,507	3,957	00:01:24
Contact Us	5,268	4,372	00:01:39
Departments P-Z Homepage	4,856	3,436	00:00:26
Visitors Section Homepage	4,325	2,932	00:00:21
Patients Section Homepage	4,289	3,060	00:00:26
Wards Section Homepage	4,119	3,049	00:00:28
Departments A-F Homepage	3,950	2,721	00:00:20
Departments G-O Homepage	3,544	2,360	00:00:21

5. StaffNet (Intranet)

We are currently not able to generate analytics about the use of the intranet and are working with our developers and ICT team to make this technically possible.

6. News Releases

A round-up of the news releases issued by the communications team with links to the full releases on our website:

New garage built at Dorset County Hospital to house donated Blood Bikes - 3 July 2019
Funds raised by the Friends of DCH have been used to build a new garage at Dorset County Hospital .

Hospital unveils its plans for future expansion - 3 July 2019
Local residents are being invited to hear more about Dorset County Hospital NHS Foundation Trust's plans to develop the hospital site during a drop-in event.

Dorset County Hospital's first Summer Spectacular raises £2,500 for good causes - 12 July 2019
Hundreds of people flocked to Dorset County Hospital in the weekend's sunshine to enjoy its first Summer Spectacular.

Retired consultant publishes book spanning the development of paediatrics in West Dorset - 23 July 2019
A retired consultant from Dorset County Hospital has published a book recording the development of children's medical services over the past half-century.

Dorset County Hospital launches new recruitment microsite - 5 August 2019
Dorset County Hospital has launched a new recruitment microsite.

Dorset County Hospital holds Endoscopy Open Day - 4 September 2019
Dorset County Hospital will be holding an Endoscopy Open Day this month to showcase the roles and opportunities available in the department.

Dorset County Hospital to host AGM and Annual Members' Meeting - 5 September 2019
Dorset County Hospital is offering people a chance to find out more about how to protect themselves and their families and stay well through the winter ahead.

Dorset County Hospital ranked as one of the top performing Trusts - 6 September 2019
Dorset County Hospital has been ranked as one of the top performing Trusts.

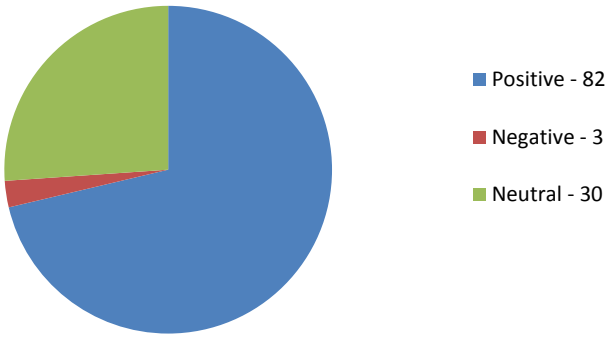
7. Media Coverage

Each of our news releases generated positive local media coverage. Further coverage was prompted by national statistical reports and announcements and public meetings and events. Coverage to note included:

- Hospital urging people only to attend A&E in life-threatening situations
- Fundraisers for DCH Chemotherapy Appeal
- Waiting times for key tests at Dorset County Hospital
- Agency costs
- Hilary Maxwell Volunteer of the Year
- NHS staff wear rainbow badges to show LGBT support
- Patient Safety Day
- ED waiting times
- Thank you letters

There were a total of 115 media stories relating to Dorset County Hospital (newspaper, radio, television, news websites), the vast majority of which were positive and an increase on the last quarter. The chart below shows the balance of positive, negative and neutral stories, and the table shows each quarter.

Media Coverage - 115



	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20
Media stories	81	79	88	115
Positive	55	57	62	82
Negative	15	6	11	3
Neutral	11	16	15	30

Susie Palmer
Communications Manager

Meghan Hindley
Communications Officer

October 2019

Title of Meeting	**Board of Directors**
Date of Meeting	**27 November 2019**
Report Title	**Annual Complaints Report 2018/19**
Author	Alison Male, Public and Patient Engagement Lead Neal Cleaver, Deputy Director of Nursing and Quality

1.0 INTRODUCTION

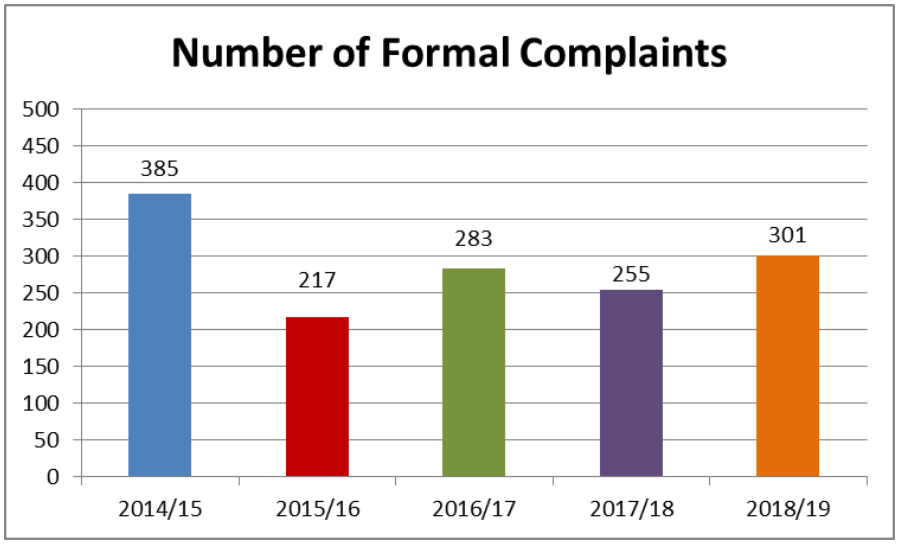
1.1 The annual complaints report complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which requires each NHS Trust to produce regular reports about complaints received, including an annual report.

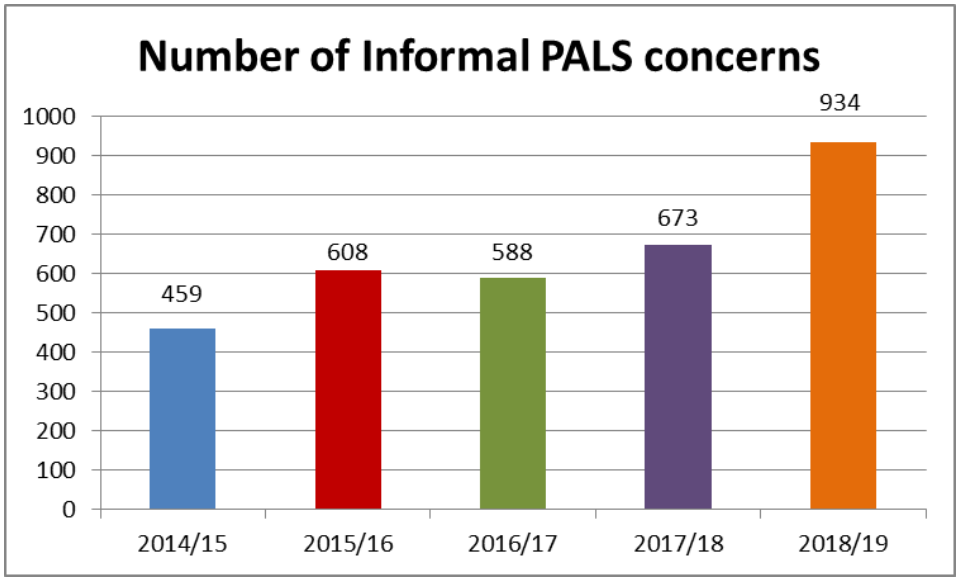
1.2 This annual report includes an overview of the number and nature of complaints received and how complaints are handled.

2.0 NUMBER OF COMPLAINTS RECEIVED

2.1 The total number of formal complaints received by the Trust for this year was 301 which have increased (18%) from the previous year. There were also 934 recorded contacts for PALS informal issues resolved, an increase (39%) on the previous year. Formal complaints account for 0.08% of our patient contacts this year and Informal concerns account for 0.25% of our patient contacts this year.

2.2 The charts below shows a visual comparison of the number of formal complaints and informal PALS concerns over the last five years:





2.3 Each formal complaint is treated as well-founded in order to investigate and a response is provided to the complainant outlining the findings of the investigation.

2.4 During this year 41 complaints (13%) have been reopened. Complaints are normally reopened for the following reasons:

- Complainants contact us to seek further clarification about the complaint raised indicating that the complaint has not been fully addressed
- Additional questions have been asked following receipt of the response
- Complainants take up the offer of a meeting with staff to discuss their complaint in more detail.

The 25 of those reopened were due to additional questions being asked or requesting a meeting.

3.0 PROCESS FOR COMPLAINTS HANDLING

3.1 The Trust informs patients and carers how to raise concerns in the bedside folders, on the website and in the "Comments, Complaints, Concerns & Compliments" leaflet which is found around the hospital.

3.2 All feedback, concerns and complaints are co-ordinated centrally and upon receipt are screened and triaged according to the seriousness of the issues raised. The focus is to consider each complaint from the complainant's perspective and complainants is offered the opportunity to discuss the way in which their complaint is handled.

3.3 In October 2018 the Trust rolled out the use of the Datix web-based system which enables complaints and concerns to be managed in an open, central and accountable manner.

3.4 The responsibility for investigating complaints is devolved to the Divisions and their respective teams, who are required to provide a comprehensive response within an agreed timeframe. This outlines the response to the investigation and recommendations or actions taken for improvement where appropriate, as well as identifying any learning from the complaint. The final response to every formal complaint is agreed and signed by the Chief Executive or a nominated deputy.

3.5 The complaints process allows the Trust flexibility in arranging local resolution meetings with complainants. These meetings usually include the relevant healthcare professionals including the Consultant or Matron in order that questions can be answered by the clinicians delivering care and a personal apology given where appropriate. This has proved to be a very positive and helpful process with the openness of the meetings being well received by all participants.

4.0 TIMELY AND COMPASSIONATE RESPONSE TO COMPLAINTS

4.1 This year again our task was to improve the timeliness of responses to complaints so that complainants are responded to within mutually agreed timescales and to improve the compassion in the response so that it responds to the emotions of the complainant, so giving an improved quality in the response.

4.2 We believe that when our patients or their families have cause to complain, the response they receive should be within an agreed timescale and acknowledge the experience of the patient through their own eyes. We believe that the response should cover all the concerns that are raised and should not cause any further distress.

The following table shows the percentages achieved Trust wide for sending a timely complaint response (from September 2016 the target was 95%).

Trustwide 2018/19	% of complaints responded to within the agreed timescale
April 2018	75%
May 2018	70%
June 2018	79%
July 2018	81%
August 2018	64%
September 2018	64%
October 2018	85%
November 2018	86%

December 2018	**95%**
January 2019	**100%**
February 2019	**100%**
March 2019	**100%**

4.3 A lot of work has been undertaken in the last year to improve the management of complaints and the results show that improvements in timeliness have been successful. During Quarter 4 it is pleasing to report that the Trust achieved the 95% target in the timeliness of complaint responses. This is due to close monitoring of the complaints between the Divisions and the Complaints Officer and where appropriate extensions have been agreed by the Deputy Director of Nursing & Quality. At the time of granting extensions to the timescales, the complainant is contacted by letter or telephone to update them on the progress of their complaint and inform them of the revised response date. The roll out of the Datix web-based system which enables complaints to be managed centrally in an open and accountable manner has also helped to achieve this target.

The quality of the response alongside the timeliness was also focused upon to ensure the complaintive can understand the response, the response responds to the issues raised and the learning from the complaint is identified.

4.4 In order to maintain this achievement we will continue to:

4.4.1 Monitor the number of extensions granted and the reasons for needing the extension.

4.4.2 Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, and complaints in need of urgent response.

4.4.3 Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions and senior management team and Deputy Director of Nursing & Quality.

4.4.4 Where agreed and appropriate make a request for timescale extensions to the Deputy Director of Nursing & Quality.

4.4.5 Review the complaint journey for further development of the Complaints module on Datix.

4.4.6 Review the complaints training offered to staff and promote the complaints management toolkit available on Sharepoint.

4.4.7 Provide adhoc training and support to clinicians and managers around complaint process and responses.

4.4.8 All complaints responses are reviewed by the Director of Nursing & Quality or in her absence the Deputy Director of Nursing & Quality for quality assurance before sent to the Chief Executive to sign.

4.4.9 Participate in a quarterly deep dive review from the Clinical Commissioning Group to quality check processes, responses and action/learning for any improvements to be made.

4.5 Divisions report that complainants receive a personal telephone call or email from the relevant Manager wherever possible.

4.5.1 The purpose of the call is to reassure the patient and try to deal with the matter there and then if possible and to find out whether a written response or meeting is required in the first instance. A timescale for response will also be agreed at this time.

4.5.2 If the patient wants a full and formal response this is provided and is read and signed by the Chief Executive Officer or nominated deputy.

4.5.3 If this response does not meet the needs of the patient, then the patient is offered a meeting with an appropriate person (usually the Divisional Manager). At this meeting every attempt will be made within reason to meet the patient's needs.

5 LEARNING FROM COMPLAINTS

5.1 The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints in order for the organization to learn from what has happened to them. In order for them to be assured that the Trust has taken their complaint seriously and taken the opportunity to learn from their complaint, the learning points are included in the complaint response. These learning points are owned by the Division and form part of the Divisional quality improvement plan.

5.2 Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings, in grand rounds, during junior doctors training, sisters and matrons meetings and porters & housekeeping briefings. The training and support provided by the Patient Experience Team enables them to understand the emotional experience from the complainant and staff perspective and reflect upon improvements in relational aspects of care.

5.3 Patients have assisted in making videos narrating their experience of the care that they received, and also their feelings about the complaints process. These videos are shown to the relevant divisional leads and are available for presentation at Board when required. The creation of patient video stories remains ongoing.

5.4 Feedback from clinicians into the delivery of complaints training and education by the Patient Experience Team is very positive, with clinicians reporting that they have changed their practice to deal with complaints more effectively, understand the emotions in complaints and feel confident when dealing with them.

5.5 Complaints are an integral element of improving the patient's overall experience of health care and help to ensure that safe, high quality care is provided within the hospital. Learning from complaints is included in response letters to provide assurance that complaints are taken seriously and the learning as a consequence of the complaint. Below are some examples of learning identified and included in response letters:

Concern raised:	**Learning/Actions taken:**
Unhappy with discharge arrangements	Ward Sister has shared experiences back to ward staff to ensure that relatives' concerns are directed to the correct staff to ensure answers or appropriate updates are provided. She will reiterate to the ward staff the importance of completing personal belongings checks and the patient property form. The Occupational Therapy Lead will ensure with her team, improved communication with families regarding the discharge arrangements for their loved ones.
Attitude of staff during eye examination	Matron will ensure that feedback is shared anonymously within the team so they can understand the impact of their actions on a patient and that they should be mindful of how vulnerable everyone can feel.
Attitude of doctor and lack of concern over patients comfort during the procedure	Dr was asked to reflect on his actions during your procedure and to ensure that his communication with patients is appropriate. He fully appreciated that for the patient the lack of information and explanations made the procedure all the more unpleasant as the patient was not aware of what to expect. Confident that Dr has learnt from the patient's experience and will ensure it does not happen again. To ensure wider learning, the patient's feedback will be shared anonymously with the team at the next ENT meeting
Lack of confidentiality during consultation due to size of room and other patients present	Head of Physiotherapy will speak to the therapist regarding further appointments to be held in another room, to ensure patient not put in this position again.

Patient fell on wet floor whilst walking to a mammogram appointment with a volunteer whilst the floor cleaning ride on was operating.	Deputy Facilities Manager will ensure all staff have received the most current training for the use of the scrubber/dryer, also arranged for the manufacturer to visit the hospital and provide refresher training.
Patient unaware that they would need time off work following a procedure on her foot	Consultant Dermatologist developed a patient information leaflet providing clear information about recovery and possible time off from work.
Delay in treatment of tumour	For patients seen with suspected keratoacanthoma: Clear documentation of the discussion with the patient in the clinic letter is required, including discussion of the differential diagnosis of squamous cell carcinoma, the mutually agreed management plan, and the opportunity for a patient to telephone the department if there is a significant change in the lesion whilst awaiting surgery.

5.6 The quality improvement or learning outcome following investigation of a complaint is identified and action taken by the respective Division. This is monitored through the Patient Experience Group which continues to meet quarterly. This framework enables the information gained from patient and public feedback to be owned locally whilst providing a strategic overview with a clear focus on improving service quality, ensuring that lessons are learnt and processes are changed to prevent situations recurring.

5.7 To enhance the learning there is triangulation of Risk Management information on incidents alongside complaints and PALS enquiries. Where a complaint raises a clinical concern or falls within the realm of an incident the Risk Management and Patient Experience Team will link and ensure thorough investigation and engagement with the complainant. This is easier now that Complaints are on the same system as incidents and enables proactive analysis of any trends in certain services.

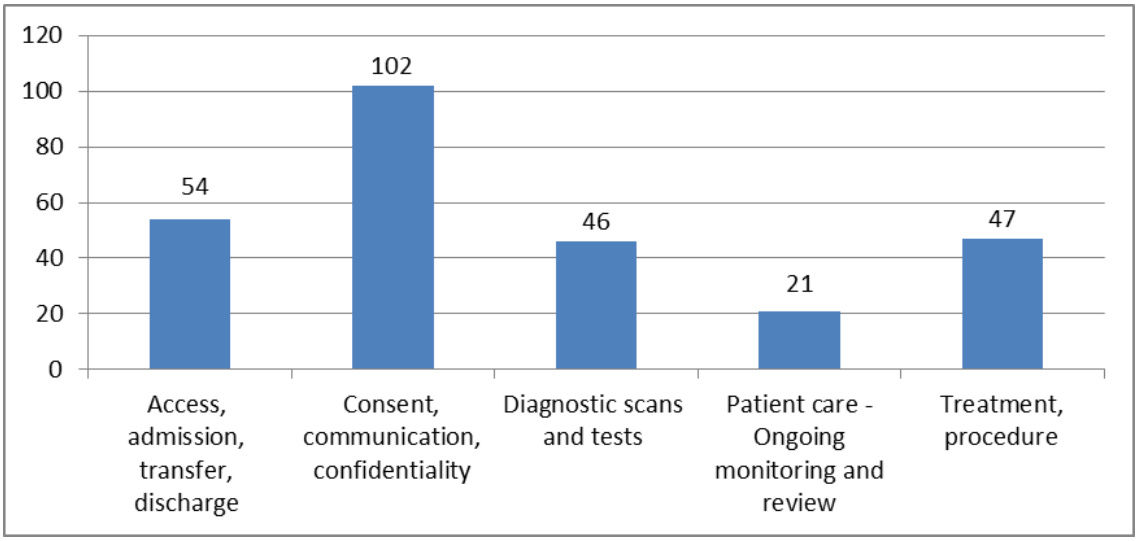
6.0 REPORTING & MONITORING

6.1 The Trust Board receives a monthly summary of the number of complaints received and the issues raised as part of the Integrated Operational Report. A further report which contains a more in depth analysis of the issues raised in complaints is provided quarterly to the Patient Experience Group and exceptions reported to the Quality Committee.

6.2 Complaints are coded on the Datix system under a variety of categories. Although the subject matter may vary, the root causes which result in a complaint being raised can be associated to three main themes: communication, staff attitude and delays.

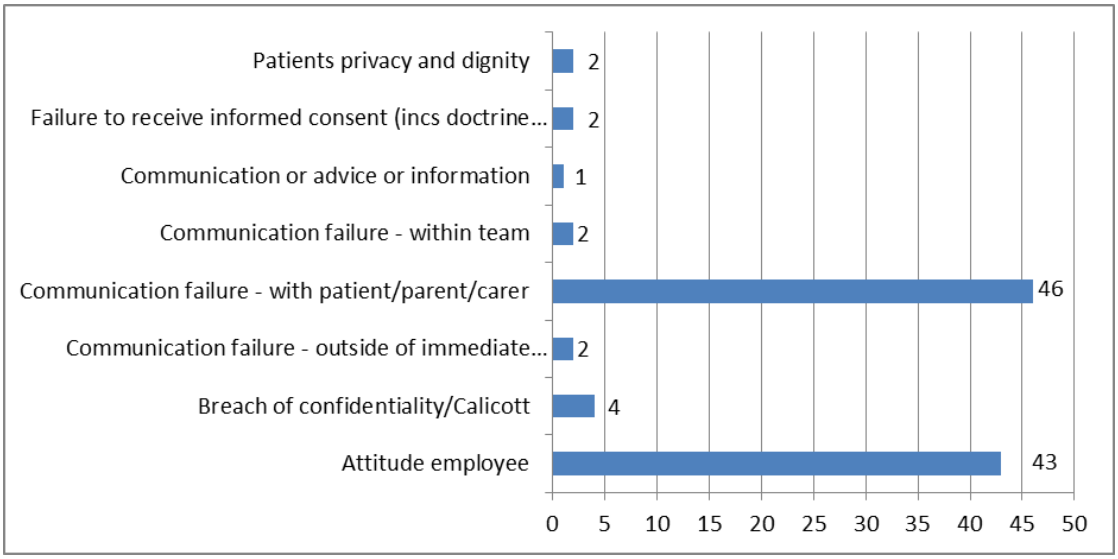
6.3 Complaints related to Consultants are shared with the Medical Director for professional conversations as required.

6.4 The five main themes are shown in the chart below.



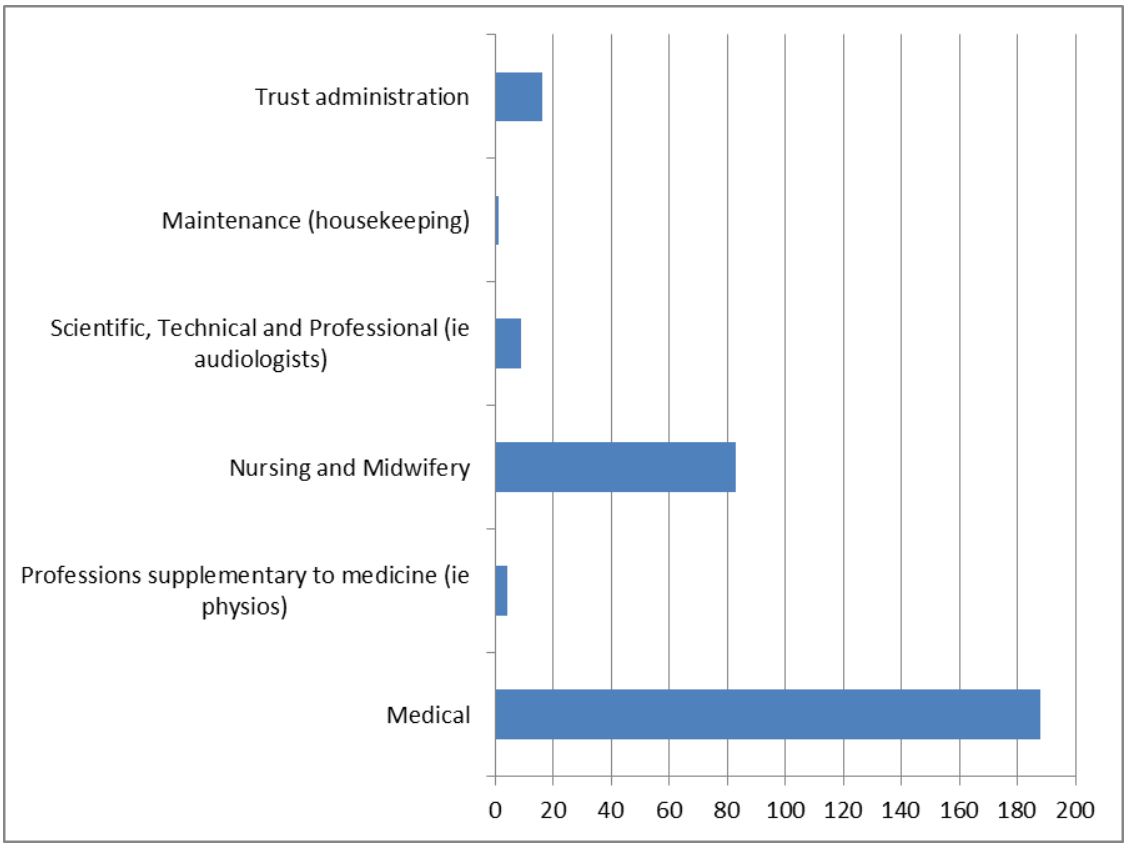
NOTE: SOME COMPLAINTS ARE LOGGED TO MORE THAN ONE SUBJECT

6.5 The chart below shows a breakdown of the largest theme of **consent, communication and confidentiality** in more detail.



NOTE: SOME COMPLAINTS ARE LOGGED TO MORE THAN ONE SUBJECT

7.0 COMPLAINTS BY STAFF GROUPS



8.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

8.1 Contact information for the Parliamentary and Health Service Ombudsman (PHSO) is provided to all complainants should they remain unhappy with the outcome of the Trust's investigation and response. During the last year we have been contacted by the PHSO on three occasions; upon reviewing the relevant complaints the PHSO has closed one, with no further actions and two are currently in process. .

9.0 COMPLAINT PROCESS QUESTIONNAIRE RESULTS

In order to make improvements in the complaints process, as part of the Trust's objective of continuous quality improvement, it is good practice to send a questionnaire to complainants after their complaint has closed. Due to demand on the patient experience team and staff sickness, unfortunately only a small number of surveys were sent to complainants during April 2018 – March 2019. 42 questionnaires were sent out with 21 being returned which has provided us with information about the experience of making a formal complaint at Dorset County Hospital.

Positive feedback from the survey:

- 90% said that the outcome of their complaint was explained in way that they could understand.
- 86% said that all or most of the points raised were addressed in the complaint response.
- 76% said that they felt they were taken seriously when raising their complaint.
- 90% said they found it easy to raise a complaint.
- 58% were aware that they could still ask questions after receiving response letter.
- 76% were aware they could submit their complaint to the Parliamentary and Health Service Ombudsman if unsatisfied.
- 81% said that they would submit a new complaint if they received poor care or had an unsatisfactory experience in the future.
- 62% said they received an explanation of how their complaint would be used to improve services.

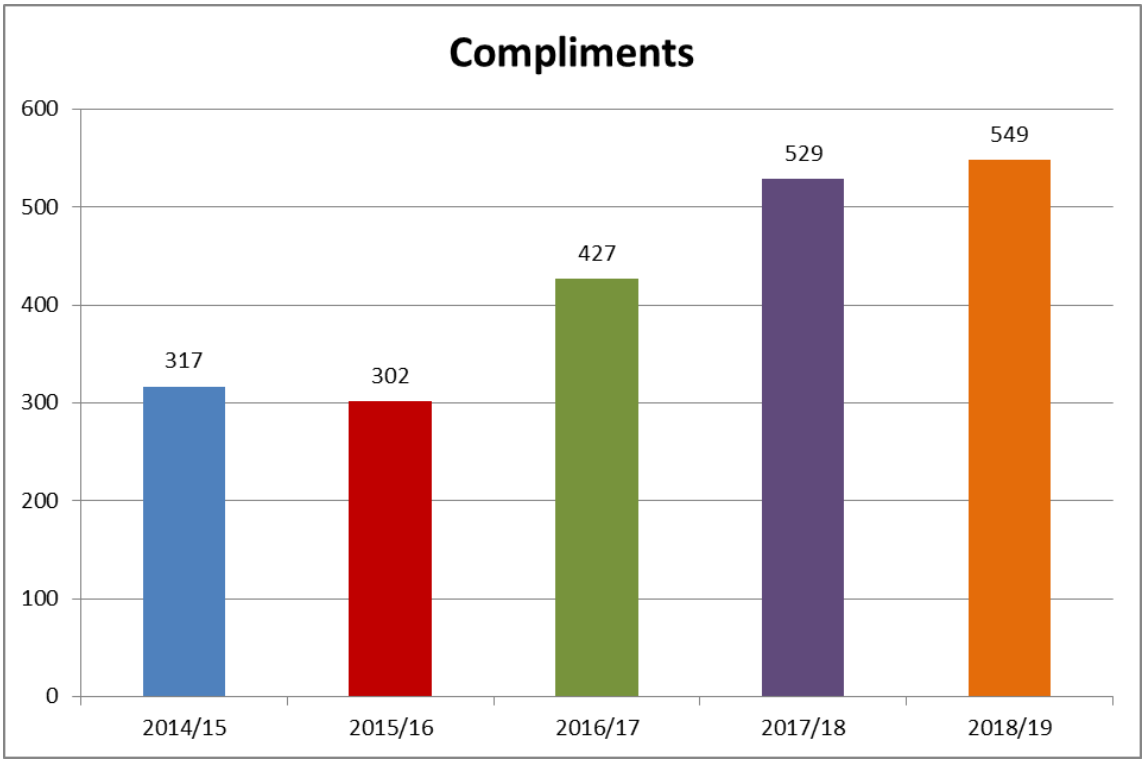
Areas for improvement identified from the survey:

- 38% said that they were not kept updated about the progress of their complaint.
- 48% said that they were not satisfied with the outcome of their complaint.
- 19% said they would have liked to receive an explanation of how their complaint would be used to improve services.

The areas for improvement will be included in the action plan for next year.

10.0 COMPLIMENTS

10.1 The graph below shows the number of compliments collected by the Patient Experience team in recent years, with the number of compliments received this year being 529, up by 24% and a significant increase on the usual numbers received. Compliments account for 0.22% of our patient contacts this year. A monthly ceremony celebrates those staff who have been nominated for a Hospital Hero award where they have gone the extra mile and all compliments are shared with those staff where personal mentions occur. (Note: not all compliments reach the Patient Experience Team – this data below only applies to those sent to the team)



11.0 CONCLUSION

The Trust has made significant improvements in managing complaints and continues to meet the regulatory requirements on managing complaints, identifying learning from complaints and meeting recommendations of the CQC report on complaints taken seriously, identifying learning and responding using clear language with compassion. The focus for next year as part of our continuous quality improvement in managing complaints will be:

- To continue to meet the target of 95% (set in 2016) for the timely and compassionate response to complaints
- The Patient Experience Team with the Divisions will continue to work closely to maintain the target of complaint responses provided within the agreed timescales and improve the process where necessary.

- The action plan implemented last year has been added to and updated, a summary is below:

	ACTION:	Timescale/Update
1	Monitor the number of extensions granted and the reasons for needing the extension.	Process in place - completed
2	Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, complaints in need or urgent response, or any quality issues with responses.	Process in place - completed
3	Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions and senior management team and Deputy Director of Nursing & Quality	Process in place - completed
4	On-going monthly monitoring of response timeliness. A monthly report is provided to reflect progress and numbers received. To be continually monitored to maintain target of 95%.	Process in place - completed
5	Review the complaint journey from receipt of complaints for further development of the Complaints web-based module on Datix	Monthly with Risk Management Team
6	Review the complaints training offered to staff and promote the complaints management toolkit available on Sharepoint.	September 2019
7	Provide adhoc training and support to clinicians and managers around complaint responses.	Process in place
8	Plan quarterly meetings with Patient & Public Engagement Lead and Divisional Managers to review progress and track improvement made.	From Q2 process will be embedded
9	Send out the complaint process survey regularly throughout the next year to gain feedback on the complaint process and monitor the impact of improvements made.	Process in place - completed
10	To spot-check learning from Complaints has occurred as part of continuous quality improvement	Process in place

12.0 RECOMMENDATIONS

12.1 The report was received by the Quality Committee on 20 August 2019. The Board of Directors is requested:

- to receive and note the contents of this report
- receive assurance of improvements in complaints management and learning
- to make any recommendations on future reports on complaints to ensure assurance on the management, monitoring and learning from complaints