Ref: MA/TH
Date: 22nd July 2020

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **29th July 2020 at 9am to 11.15am** in the THQ Boardroom/CEO's Office and via Lifesize. This meeting will be recorded and made available to the public via the Trust website.

The agenda is as set out below.
Yours sincerely

Mark Addison
Committee Chair

AGENDA

1.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	9.00-9.05
	a) Apologies For Absence: Victoria Hodges, Ian Metcalfe	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 24th June 2020.	ENC	Mark Addison	Approval	
	d) Matters Arising: Action Log	ENC	Mark Addison	Approval	
2.	**Patient Story – Natasha's Story**	Presentation	Nicky Lucey / Sonia Gamblen / Rachel Cookson / Alison Male	Note	9.05-9.25
3.	**Chief Executive's Overview**	ENC	Patricia Miller	Note	9.25-9.35
4.	**Integrated Performance Report including Committee Chair Input and Escalation Items** • **Quality** • **Performance** • **Finance** • **Workforce**	ENC	N Lucey/J Gillow I Robotham/S Tilton P Goddard/S Tilton M Warner/V Hodges	Note	9.35-9.55
5.	**COVID-19 Update** • **Overview Response Report**	ENC	Inese Robotham	Note	9.55-10.05

	Break 10.05-10.15				
6.	**Learning from Deaths: Mortality Q1 Report**	ENC	Alastair Hutchison	Note	10.15-10.25
7.	**Equality, Diversity and Inclusion Annual Report**	ENC	Mark Warner	Note	10.25-10.50
8.	**Board Assurance Framework and Corporate Risk Register**	ENC	Nick Johnson/ Nicky Lucey	Approve	10.50-11.00
9.	**IPC Annual Report**	ENC	Nicky Lucey / Emma Hoyle	Note Discuss	11.00-11.10
	CONSENT SECTION				11.10-11.15
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
10.	**Responsible Officer/Revalidation Annual Report**	ENC	Alastair Hutchison	Note	
11.	**Combined Safeguarding Annual Report**	ENC	Nicky Lucey	Note	
12.	**Communications Update**	ENC	Nick Johnson	Note	
13.	**Dorset HealthWatch Annual Impact Report**	ENC	Nicky Lucey	Note	
14.	**Any Other Business**				
	None Notified				
15.	**Date and Time of Next Meeting**				
	The next Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **10.30am** on the **26 August 2020** via Lifesize.				

Minutes of a Meeting of the Board of Directors of Dorset County NHS Foundation Trust Held at 10.30am on 24th June 2020 at the Children's Centre, Dorset County Hospital and via Lifesize.

Present:		
Mark Addison	MA	Non-Executive Director *(Chair)*
Sue Atkinson	SA	Non-Executive Director
Paul Goddard	PG	Director of Finance and Resources
Judy Gillow	JG	Non-Executive Director
Victoria Hodges	VH	Non-Executive Director
Alastair Hutchison	AH	Medical Director
Nick Johnson	NJ	Director of Strategy, Transformation and Partnerships
Nicky Lucey	NL	Director of Nursing and Quality
Ian Metcalfe	IM	Non-Executive Director
Inese Robotham	IR	Chief Operating Officer
Stephen Slough	SS	Chief Information Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
Mark Warner	MW	Director of Organisational Development (OD) and Workforce
In Attendance:		
Simon Bishop	SB	Governor
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
James Metcalfe	JM	Divisional Director

BoD20/086	**FORMALITIES**	**Action**
	The Chair declared the meeting open and quorate. Apologies for absence were received from Patricia Miller (PM). MA reported that PM, Chief Executive, had returned to work following her recent ill health and extended thanks to NJ for his calm leadership as Acting Chief Executive over the previous three months during the pandemic crisis on behalf of the Board and system partners. He also welcomed ST, Non-Executive Director to his first meeting of the Board of Directors.	
BoD20/087	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the Agenda.	
BoD20/088	**Minutes of the Meeting held on the 27th May 2020**	
	There were no questions or points of accuracy raised in respect to the Minutes of the meeting held on 27th May 2020.	
	Resolved: that the Minutes of the meeting held on the 27th May 2020 be approved as an accurate record.	
BoD20/089	**Matters Arising: Action Log**	

	No matters arising were raised in connection with the Action Log and the Committee agreed to close items completed. All items were identified within the agenda or paused due to the pandemic. A brief discussion ensued regarding the revised Board committee work plans that would be presented to respective committees and the Board for approval in July. IM noted the additional interaction with Internal and External Auditors and the Counter Fraud service in respect of the Risk and Audit Committee and proposed that an interim work plan would be presented.	**Committee Chairs**
	Resolved: that the Action Log be received and approval be given for the removal of completed actions.	
BoD20/090	**Chief Executive's Overview**	
	NJ highlighted key points from the report and thanked the Executive team for their outstanding response to the COVID crisis in delivering the changing guidance and for their support over the preceding months. Following a change to the social distancing guidance announced the previous day, NJ advised that the trust would undertake a further review of arrangements pending further specific health service guidance on implementation. DCH had experienced low numbers of COVID positive patients during June with no confirmed cases on a number of days. However, the trust was not COVID free and significant demand continued to be placed on services resulting from national guidance changes and the Restart programme. NJ noted the reduced capacity impact and the need to retain service resilience. NJ commented on the Black Lives Matter campaign and the recent publication of the Public Health England (PHE) report outlining inequalities and disparities within the public sector and re-iterated the trust's commitment to addressing these complex issues. DU questioned whether the issue of national announcements without consultation should be further escalated. MA advised that there had been a significant response from healthcare provider organisations and that their representative body, NHS Providers, had responded strongly on matter. SA enquired whether the Early Warning system in place at the hospital was specific to DCH and questioned proactive action being undertaken to ensure risk assessments were completed to protect BAME staff. She noted that inequality and structural racism impacted morbidity for this group of staff and reflected that the need to undertake risk assessment for BAME staff had been	

	identified by a national report in February. JG sought clarity on the changes recently announced by the CQC regarding the Emergency Support Framework. NL advised that the framework outlined how the CQC would adopt a light touch approach to their interactions with trusts going forward in order to maintain oversight and provide focused support on key issues. ST remarked on the additional pressures on staff arising from the impact of practice changes on their capacity and enquired of the trust's actions to secure additional capacity and in supporting staff. NJ outlined current plans to increase capacity; in the short term converting available space for clinical use to replace lost beds and the acquisition of non-clinical accommodation at Vespasian House and the Atrium in order to release administrative office space within the hospital. Additionally, the trust was preparing a response to regional and national requests to provide their capital and revenue requirements to replace lost beds in order that an assessment of potential funding could be undertaken. Further work was also being undertaken on the longer term Estates Strategy. IR added that the trust continued to utilise the Winterbourne Hospital for elective activity and that the contract with them had been extended until the end of August. It was hoped that a further extension could be secured until March 2021. She noted that the constraining factor to increasing service capacity would be capacity of the workforce as efficiency had reduced as a result of changed practice and guidance; particularly in respect to decontamination and theatre services. MW advised that the trust had required managers to ensure that risk assessments were undertaken for all BAME staff some weeks previously and had contacted individual staff members in order to confirm that this had been done.	
	Resolved: that the Chief Executive's Overview be received and noted.	
BoD20/091	**Integrated Performance Report**	
	Quality NL advised that the trust maintained routine surveillance on the impact of COVID-19 on bed occupancy and that visiting had recently been reintroduced at the hospital and was generally going well. She reminded the committee that the reporting of a number of quality performance metrics within the report had been suspended in line with national guidance and reported that the trust's complaints management process had been fully re-instated. The ability of staff and visitors to complete the Friends and Family Test had been affected by changed operating practices; particularly in Out-patients where more consultations had been undertaken	

	virtually. NL noted that the Risk Register was being reviewed to include the impact of the Restart programme and communications would commence with the public about waiting list issues; offering self-help advice for patients. AH noted the Mortality Report as a consent item on the Agenda and highlighted performance improvement derived from more accurate coding. The latest performance figures were due to be published in July. AH reported that NHSI had advised the exclusion of COVID-19 related deaths in that report and noted performance against other metrics had been maintained throughout the pandemic. It was unclear how the new basis for the mortality measures would affect the metric for DCH. JG advised that the Quality Committee would monitor waiting list safety issues and commended AH and his team on the mortality data improvements. She noted that the trust remained an outlier in terms of performance and that there was further work to be done. AH confirmed that the report provided data to December 2019 and demonstrated performance improvements. SA reported evidence that pre-operative help had a positive impact on outcomes and asked what actions DCH had taken. NL advised on the pre-surgery treatments in place to improve outcomes and the wider public health messaging of 'making every contact count'; maximising opportunities to promote smoking cessation and obesity management in order to improve outcomes. **Performance** IR noted the outstanding performance of the A&E team in achieving the 95% target, despite increases in non-COVID activity and reported that performance had been maintained and was expected to achieve the target in June also; despite an increase in the number of ambulance arrivals. RTT and cancer waiting lists had reduced although the composition of the list had significantly changed. It was anticipated that those patients who were previously shielding would now choose to be seen following the recent change in national guidance for these individuals. Diagnostics performance remained at circa 41% compliance. Endoscopy services were noted to be restarting but MRI capacity was limited. Slow improvements in performance were anticipated. The variable and random nature of patient choice and behaviour had impacted the two week standards and it was reported that the targets had been achieved. **Finance**	

PG reported that trust costs in May had been within £20k of fixed income and that COVID related costs were reducing; reminding the committee of the increasing level of scrutiny being applied to COVID related expenditure at regional and national levels. Agency expenditure had reduced by £200k and the April COVID and 'true up' costs for the trust had been centrally approved. Whilst the finance regime was working well overall, it was expected that 'true up' costs would increase as elective surgery restarted more widely.

ST thanked IR and PG for their reports and commended the A&E achievement. MA extended his thanks on behalf of the Board to the A&E team for achievement of the four hour A&E target. IR noted the contribution of reduced activity in 'minors' to the achievement and commended the excellent dynamics and responsiveness of the team; noting the additional pressure that all patients attending the department had to be swabbed for COVID-19.

VH enquired whether there had been any regional activity or plans to address mental health issues by system partners; particularly as winter approached. NL responded that psychiatric liaison at the hospital was to resume and that there was ongoing discussion regarding the need to increase in-patient capacity. JG added that a briefing paper on mental health issues was anticipated the following week.

Workforce
MW reported that agency expenditure had significantly reduced in month and was at a lower level than the previous year when COVID related expenditure had been removed. He cautioned that bed occupancy levels had also been lower during the reporting period and that international recruits remained unavailable at that time.

Sickness levels had also reduced in April and were 3.5% net COVID related absence.

Reporting on health and wellbeing activity, MW advised that staff were leading and informing the investment of charity funding and that hand creams and water bottles had been provided for staff. In the medium term, a marquee was to be erected on the Damers field to provide a rest area for staff and legacy items were being considered in the longer term.

MW reported on the outcomes of a recent employee survey which had returned a reasonable response rate and mixed responses. Staff reported that they felt supported by colleagues and continued to appreciate the daily communications and updates. Concerns included remote working arrangements with shielding staff feeling isolated and disengagement from those working onsite. The Home

	Working policy was under review and the task group would incorporate lessons from the recent rapid roll out of IT to support these arrangements. Staff felt that the regularly changing national guidance was frustrating. A significant amount of work had been completed in order to implement social distancing guidance amongst staff and further guidance was expected on this following the previous day's government announcements. ST enquired whether agency costs resulting from international recruitment difficulties were recoverable from COVID funding. MW confirmed that they were. IM asked about team working and inclusion initiatives to support remote workers. MW advised that teams were reporting positively on recent IT improvements and noted the need for appropriate risk assessments to be undertaken. NL added that she undertook short 'catch up' sessions with staff where no formal business was undertaken as these provided an opportunity for social interaction with team members. VH remarked that inclusion reports would be presented to the Workforce Committee in July; noting further positive action requirements post COVID.	
	Resolved: that the Integrated Performance Report be received and noted.	
BoD02/092	**COVID-19 Update – Overview Response Report**	
	IR noted that whilst the national alert level had reduced to 3, the NHS had been mandated to remain at level 4 and the Incident Management Team arrangements remained in place. There had been a total of 27 COVID-19 related deaths at DCH; the last being on 12th June and there were no inpatients with COVID related illness currently. One patient admitted to the Maternity Unit had been found to be COVID positive the previous week. ED remained segregated and the Critical Care Escalation Plan had been reviewed – DCH was able to accommodate 25 ventilated beds; an optimal figure based on current modelling. Anaesthetic ventilators would provide a contingency should additional ventilators be required and there remained adequate mortuary capacity. IR reported that the availability of PPE continued to be closely monitored and that there had been some issues regarding capacity and the need for revised fit mask testing and mutual aid between organisations. She commended the work of the Procurement team	

	in responding to the significant increase in demand on their workload. MA enquired about the impact of changing social distancing guidance on bed capacity and NL advised that further guidance on the application to healthcare setting was awaited. Current arrangements would be reviewed with a focus on higher risk areas.	
	Resolved: that the COVID-19 Update be received and noted.	
BoD20/093	**Restart, Redesign and Reset**	
	NJ advised that the purpose of item was to assure the Board of the Restart, Redesign and Reset process and that appropriate governance and management arrangements were in place. The overarching objectives remained unchanged and weekly SMT discussion ensured ownership of decision making. A number of Executive led 'Task and Finish' groups had been established to address areas of work and provided an agile and tactical response. VH enquired whether a task and finish group would review meetings, reporting arrangements and learning and it was confirmed that this remained within the remit of Board committees. SA commented on the need to include new ways of working and NJ advised that both the divisions and a Learning and Innovation Cell would consider this. JG noted the major digital advances undertaken in a short period of time and asked how these advances would be maintained and protected in the future. The committee noted particularly these advances in the operation of outpatient services, the need for a clearer strategy and further staff training. SS advised that a number of projects were under consideration to support further digitisation and that there was a keenness to continue with the MS Office suite of programmes. The cost implications of this were also noted. Enquiries were made in respect to the timescales for completing work, when the benefits might be realised and whether staff were comfortable and engaged in the process. NJ outlined that the Quality Improvement approach had been adopted and that SMT reviewed plans and the approach on a weekly basis. Outcomes would be reported through existing report mechanisms. AH advised that Restart, Redesign and Reset plans were contingent on there not being a second pandemic wave and noted the potential influx of visitors to the South West as a result of the recent government announcements and the opening up of the hospitality sector, with a potential COVID impact in four to five weeks-time. Acknowledged the need to restart services but urged some caution.	

	JM acknowledged that staff anxiety levels, competing demands, capacity constraints and reduced efficiency could impact staff confidence in progressing plans. MA noted work in progress and the need for further discussion to monitor developments as plans emerged.	
	Resolved: that the discussion of Restart, Redesign and Reset be noted.	
BoD20/094	**Board Review and Messaging**	
	SB had left the meeting. MA extended his thanks to organisation and staff for responding to the constantly changing guidance and for maintaining compliance. He noted the need for the Board to be assured that BAME staff risk assessments had been completed and that clear plans were in place. MA commended recent ED performance and target compliance which was a tribute to the team. He similarly recognised and commended the performance of the Procurement team. NJ reiterated the need to thank staff and to recognise that ongoing challenges remained. He also acknowledged the need to ensure a balanced Restart. MA reiterated the public health and patient self-help messages; acknowledging the ongoing operational challenges. These would be included in the weekly CEO Brief to staff.	**NJ**
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD20/095	**Mortality Report**	
	The Mortality Report was approved.	
BoD20/096	**Any Other Business**	
	TH advised members of the Board that the Annual Report and Accounts had been laid before Parliament and that consideration was being given, pending further national guidance, to the Annual General Meeting / Annual Members meeting to be held in the Autumn. The date and format of the meeting would be advised to the Board following further planning discussions.	
BoD20/097	**Date and Time of Next Meeting**	
	The next meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust will be held on **29th July 2020** at **10.30** via Lifesize.	

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Signed by Chair …….. Date ……..

Action Log – Board of Directors.

Presented on: 29th July 2020

Minute	Item	Action	Owner	Timescale	Outcome	Remove ? Y/N
Meeting Dated: 24th June 2020						
BoD20/089	**Matters Arising: Action Log**	Board Committee work plans to be revised and presented to respective committees and Board	**Committee Chairs**	**July 2020**	Agenda Item for respective Committees and Board in July.	Yes
BoD20/094	**Board Review and Messaging**	Public Health and Self-help messaging to be included in CEO weekly briefing.	**NJ**	**26.6.20**	Action Complete.	Yes
Meeting Dated: 25th March 2020						
BoD20/046	**-**	The Board to come back to the staff survey results after the COVID-19 pandemic.	**TH**	**Post-COVID**	**Paused due to COVID-19**	
Part One Actions from Previous Meetings						
BoD20/001	**-**	The Director of OD and Workforce to check with the education team what basic life support training was available Board members.	**MW**	**March 2020**	**Paused due to COVID-19**	
BoD20/006	**-**	Report front sheets to be updated to include risk appetite statement and social values.	**PM/TH**	**April 2020**	**Paused due to COVID-19**	
BoD20/007	**-**	Dates of the series of events being planned to celebrate the contribution of EU staff to be circulated to the Board once finalised.	**PM/TH**	**When available**	**Paused due to COVID-19**	
BoD20/008	**-**	The work plans and agreed objectives from Finance and Performance Committee, Quality Committee and Risk and Audit Committee to be brought to the March Board of	**TH - MR, JG, IM**	**March 2020**	**Paused due to COVID-19**	

		Directors meeting.				
BoD20/008	**-**	The Wessex Deanery had made it explicit that they wanted a change in the allocation of supervisory PAs in the Trust's consultant job plans. The Chief Executive to discuss this further with the Director of OD and Workforce.	**PM/MW**	**March 2020**	**Paused due to COVID-19**	
BoD20/008	**-**	ICS Performance Report: clarification required regarding the risk perception evaluation relating to Prevention at Scale and clarification required on where this work feeds in to.	**NJ**	**March 2020**	**Paused due to COVID-19**	
BoD20/008	**-**	Integrated Performance Report amendments: • the 9 Must-Dos needed refreshing in line with the new guidance, • the Chief Executive to review the narrative and move away from performance reporting in siloes, • the pan-Dorset quality dashboard to feed into the Performance Report once received approved by the Quality Committee.	**PM**	**TBC**	**Paused due to COVID-19**	
BoD20/009	**-**	The Director of OD and Workforce to review and score the issues relating to staff resilience, to see if this was an emerging risk which needed adding to the Corporate Risk Register.	**MW**	**March 2020**	**Paused due to COVID-19**	
Actions from Committees…(Include Date)						

Board Strategic Work Programme Items Suspended due to COVID-19

Meeting	Items from Work Plan
April 2020	• Social Value • Quality Improvement • Equality and Diversity • Wellbeing • Sustainability
May 2020	• Estates Strategy
June 2020	• Nil
July	• Annual Complaints Report • Annual Clinical Audit Report

Title of Meeting	**Board of Directors**
Date of Meeting	**29 July 2020**
Report Title	**Chief Executive's Report**
Author	**Patricia Miller, 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 included reflections on how the Trust is performing and the key areas of focus.

The key developments nationally are as follows:

Phase 3 – NHS Response to COVID-19

The launch of phase 3 of the NHS response to COVID-19 is expected this month. It has become clear that Infection Prevention and Control measures are the top priority to maintain the safety of patients, staff and the wider community. As a consequence social distancing and enhanced cleaning regimes will be with us for quite some time. It is expected that the current block contact arrangement will remain in place for the rest of the financial year.

Capital Investment

The Government announced on 30 June 2020 there will be £1.5bn this year for hospital maintenance, eradicating mental health dormitories, enabling hospital building, and improving A&E capacity. With the aim to improve patient care, make sure NHS hospitals can deliver world-leading services and reduce the risk of coronavirus infections.

Potential Health and Care Visas

The Home Secretary, Priti Patel is expected to give foreign care workers "special visas" to move to Britain after Brexit following warnings of the detrimental impact on the health and social care sector, previously only an NHS visa was proposed. The "health and care visa" could allow professionals in the sectors and their families to move to Britain even if their salaries don't meet the minimum threshold of £25,600 a year, which will be required for most other roles.

DCH Performance

In terms of performance the Trust will face a number of challenges over the coming nine months, they are managing winter safely and this will include the flu season, the potential of a second strain of flu which has been identified in Asia and the possibility of a second wave of COVID. We will also need to expand plans to restart routine NHS services and this will be underpinned by a reduction in productivity as result of the Infection Prevention and Control measures in place, this will also involve moving services around the organisation therefore staff will require a lot of support to deal with those changes.

Staff Wellbeing My greatest concern is staff wellbeing. Our staff have been on an emotional roller coaster through COVID and each staff member's experience will be different. They are tired both emotionally and physically and whilst we are encouraging them to take leave we are also moving into summer season with increases in visitor numbers. This will lead directly into winter. We need to continue to find new ways to support them as their wellbeing is critical.	
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 lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators.	
Governance Implications (legal, clinical, equality and diversity or other): Failure to address significant strategic and operational risks could lead to regulatory action and significant deterioration in the Trust's performance against the 'Well Led' domain.	
Financial Implications Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	The Board is asked to note the information provided.

Chief Executives Report

Strategic Update

National Perspective

Phase 3 – NHS Response to COVID-19

The launch of phase 3 of the NHS response to COVID-19 is expected this month. It is anticipated that this will outline the resources that will be available to the NHS for the coming 9 months. It has become clear that Infection Prevention and Control measures are the national top priority to maintain the safety of patients, staff and the wider community. As a consequence social distancing and enhanced cleaning regimes will be with us for quite some time. It is also expected that the current block contact arrangement will remain in place for the rest of the financial year

It is anticipated that private sector capacity will be available until March 2021 with field hospitals remaining open. Itis important that providers utilise these facilities as much as possible. Any failure to do so will create difficulties in demonstrating the value of this additional capacity to the HMT. It is very likely there will be two Nightingale hospitals in the South West, namely Exeter and Bristol. There are currently no plans for such a facility in Dorset, which given the size of the waiting list backlog for cold elective surgery, leaves Dorset in a vulnerable position in terms of system reset.

Elective Care and Diagnostics

As the COVID-19 pandemic accelerated, both routine, and urgent planned procedures and diagnostics were paused along with routine screening programmes. As the NHS moves to the 'new normal' there in an increased focus on reducing the backlogs created and improving performance across the country.

As well as the backlogs currently within acute providers and the anticipated referrals coming from screening backlogs there are concerns regarding latent demand i.e. patients who have not accessed care during the lockdown period. Providers are working with their Regional Teams to identify those interventions which could improve the position including clinical pathways, efficiency, workforce, digital agenda, estates and infrastructure.

111 First

The NHS is running pilot schemes of the '111-First' model which encourages patients to phone and book an appointment with the aim to reduce the burden on Emergency Departments. This will allow Emergency Departments to focus on those patients with the most severe, life-threatening, conditions. Patients with less severe conditions will be given an appointment and be directed to the most appropriate service and avoid unnecessary waits in Emergency Departments. In the South West region a pilot is taking place in Cornwall and the Isles of Scilly which will provide shared learning and experiences from a rural provider.

We are expecting the '111-First' model to be rolled out universally with the learning from all pilot sites across the country shared. The SW Regional Team is looking, with involvement from providers, at what action is needed to strengthen 111 service. Having a robust, sustainable 111 service is pivotal to enabling the booking of urgent care appointments and reducing the burden on Emergency Departments.

Capital Investment

The Government announced on 30 June 2020 there will be £1.5bn this year for hospital maintenance, eradicating mental health dormitories, enabling hospital building, and improving A&E capacity. With the aim to improve patient care, make sure NHS hospitals can deliver world-leading services and reduce the risk of coronavirus infections.

Local Authority Funding

Local authorities are facing an income shortfall in excess of £9bn for this financial year and it is unclear at present how much of this expenditure will be met with government funding. Local authorities have a legal requirement to balance their books and there are concerns from NHS Trusts that significant cuts to community health and public health services commissioned from the NHS will follow. Some local authorities are seeking to retender contracts for NHS community health services. There is a call to pause any retendering of these services until the end of 2020/21 to allow services and staff to have time to recover from the pandemic. NHS Providers, the NHS Confederation and the Community Network wrote a joint letter to Matt Hancock, Secretary of State for Health and Social Care and Robert Jenrick, Secretary of State for Housing, Communities and Local Government at the end of June to request a meeting to discuss these issues and find a solution.

Equality, Diversity and Inclusion

In response to the Black Lives Matter campaign, NHS Providers have held a series of safe space discussion meetings with provider Chairs and Chief Executives on the topic of race inequality and supporting our BAME colleagues. The aim is to look at what action is required to move the race and equality agenda forward at pace.

The first meeting of the newly formed BAME Chair and CEO Network took place on 10 July 2020. This is an independent group with an independent voice. Raj Jain, CEO of Northern Care Alliance NHS Group and Patricia are leading this group as co-chairs. The purpose of the group is to harness the collective will of the most senior BAME leaders of NHS Trusts to drive a significant change in the experience of and outcomes for both BAME staff and communities, both in terms of the NHS as a place to work and also receive care.

Potential Health and Care Visas

The Home Secretary, Priti Patel is expected to give foreign care workers “special visas” to move to Britain after Brexit following warnings of the detrimental impact on the health and social care sector, previously only an NHS visa was proposed. The “health and care visa” could allow professionals in the sectors and their families to move to Britain even if their salaries don't meet the minimum threshold of £25,600 a year, which will be required for most other roles.

Local Relevance

Capital Investment

Following the announcement the SW Regional Team requested system level capacity bids to be submitted which demonstrated where capacity could be increased to support the reset of services and mitigate for losses in productivity from enhanced infection control measures and social distancing. DCH’s schemes focused on our priority areas including increasing bed capacity, expanding our Critical Care and Emergency Department footprints and diagnostics, particularly Endoscopy. We expect to receive a response by the end of this month.

Local Authority Funding

Dorset partners received a letter from Graham Farrant, Chief Executive at Bournemouth, Christchurch and Poole (BCP) Council advising they have taken the decision to pause BCP Council's engagement in the forthcoming releases and further development in the Dorset Care Record for this financial year.

It was very clear that BCP Council recognise they are a fundamental partner in the Dorset Care Record. However due to the unprecedented financial situation they find themselves in as a result of the COVID-19 pandemic they are unable to make any further capital payments or recruit into the additional staffing capacity required to work on further releases of the Dorset Care Record.

They are focussing their expertise on moving towards one IT case database for Children's and Adults Social Care. As a result of this decision there will be a delay in uploading children's demographic data to the Dorset Care Record. They will formally review this decision in spring 2021.

Winter Planning and Second Wave – COVID-19

National modelling shows it is highly likely that a second wave of COVID-19 will occur in winter, coinciding with the flu season. Hopefully a vaccine will be available in the coming months, but there are no guarantees. Within the Trust and the Dorset system work will take place with some of our staff to plan a number of scenarios and incorporate them in our winter plan. Once developed table top exercises will take place with teams across the hospital to prepare for winter and ensure they feel confident to deal with the challenges outlined above, should they arise.

DCH Performance

In terms of performance the Trust will face a number of challenges over the coming nine months. They are managing winter safely and this will include the flu season, the potential of a second strain of flu which has been identified in Asia and the possibility of a second wave of COVID. We will also need to expand plans to restart routine NHS services and this will be underpinned by a reduction in productivity as result of the Infection Prevention and Control measures in place. This will also involve moving services around the organisation. Therefore staff will require a lot of support to deal with those changes as their input into what will work best is essential.

Other News

We received some positive news; the SW Regional Team has prioritised our Emergency Department new build as top priority for the region in terms of its capital submission.

We had a remote assessment for our in house COVID-19 test this month which was undertaken by UKAS Assessors, and subject to 3 minor findings, our in house testing method will become a UKAS accredited one. The assessor noted that the evidence/information provided by our team was excellent.

Our mortality rates have been of concern for some months due to them being much higher than the expected range. I am very pleased to report they are now within the expected range. This improvement is due to a lot of hard work by many members of staff, from clinicians to coders who have all worked tirelessly over the last year in particular to improve this performance. A huge thank you also to Alastair for his leadership, diligence and perseverance in this area and also to our Area and Regional teams who have shown us patience, support and confidence in our ability to tackle what has been a big challenge.

Balanced-Score Card Performance Report

Report to Board: 29 July 2020

Performance Summary:

The Trust over achieved against the four hour Emergency Access Standard (EAS) in July 2020 with performance of 96.3% (combined with MIU); the standard was also achieved for Quarter 1 with performance of 95.21%. Performance of Type 1 activity was 94% which was a further improvement compared to June 2020. In June 2020 the department achieved one of the lowest ambulance handover delays with zero chargeable delays and only 4.7 SWAST resource hours lost for the whole of the month. The department continues to run segregated areas for COVID-19 suspected and non COVID-19 suspected patients and is utilising the footprint of Surgical Admissions Lounge as a discharge area from the department. The modular build to increase the triage footprint has been delivered and installed but is yet to be handed over to the department. ED activity continues to track below historical monthly averages; there were 3,271 attendances in June 2020 compared to 4,121 in June 2019. There were 1,299 ambulance arrivals in June 2020 which is only marginally lower than 1,365 in June. The RTT constitutional standard was not achieved and the performance deteriorated further – 40.37% versus 46.42% in May 2020. Whilst the total waiting list reduced further by 28 patients, the backlog of patients waiting over 18 weeks from referral to treatment increased by 1143 and there were 713 patients waiting over 52 weeks at the end of June 2020 which is reflective of the national suspension of routine elective activity due to COVID-19. Elective admissions to the DCH site increased by 17.92% in June 2020 compared with May 2020, however this still remains 30.2% below pre-COVID activity levels (January 2020). The trust also continues to utilise private sector capacity made available at BMI Winterbourne; it is anticipated that the current contractual arrangements with BMI Winterbourne will continue till at least October 2020. Patient uptake of offers of dates for routine surgery remains impacted by the nationally mandated requirement for patients and their households to self-isolate for 14 days prior to elective surgery. The Trust's performance against the 62 day cancer standard currently stands at 68.69% and will not be finalised until the first week of August. Total 62 day cancer PTL stands at 610 compared to 428 as at the end of May 2020, however, the number of patients waiting over 62 days has decreased from 194 to 126. The main reasons for extended waiting times remain either patients choosing to delay diagnostics/treatments or where the clinician responsible for patient's care has deemed that an extended waiting time presents less risk to the patient's outcome than the risk of catching COVID-19. All tumour sites continue to regularly review and risk stratifying patients on the PTL. The Trust achieved the 2 week wait standard for breast symptomatic at 96.8%; the performance against the 2 week wait standard for all cancers was 82.6%. The referral numbers remain lower than historical averages, but there was an increase of 208 referrals in June 2020 compared to May 2020. Performance against the 6 week diagnostic standard was 58.33% which is a 17.48% improvement compared to May 2020 (40.85%). The biggest improvement has been in endoscopic procedures and imaging whilst the highest backlog number remains in Audiology.

Main Performance Risks facing the Trust in 2020/21

Quality and Access risks:

- Whilst the current ED attendances remain below historic levels of activity and the COVID-19 activity in South West is below national levels, there is a significant risk of a future surge of either COVID or non-COVID emergency activity (or both simultaneously).
- Public behaviours, in particular, reluctance to access acute services poses a risk of deterioration of existing conditions in the population and potential presentation of more complex cohorts of patients in the future.
- Growing waiting times on RTT and diagnostic waiting lists pose clinical risk to patients despite clinical prioritisation and mitigation measures in place
- The need to segregate COVID and non-COVID clinical activity in all care settings for the foreseeable future has significant efficiency and resource implications.

Financial risks:

In response to COVID-19, the national finance regime has been amended with effect from 1 April 2020, initially until 31 July 2020, but now we understand until the end of August or possibly September. Beyond that period there will be some changes to the current process. The original changes include:

- Suspension of the National Tariff Payment System (PbR), which means that the Trust receives fixed income without any variation for patient activity
- Business Planning has been suspended and Trusts given a plan for the first four months of the year based on historic run rate
- Payments for additional costs relating to COVID 19 which are reimbursed separately
- A “True Up” payment for Trusts to maintain a breakeven position
- System wide Capital spend targets

The anticipated changes are thought to include the cessation of the ‘true up payments’ and moving the COVID 19 costs to a fixed sum based on historic spend, but the detail on this is unpublished at the time of this report. Whilst the existing process has ensured that the Trust has reported a breakeven position to date, the anticipated changes are likely to increase the risk of the Trust continuing to deliver this performance.

The Trust has reported a £25k deficit position for June 2020, after including a “True Up” payment assumed from NHS England of £1.394 million. This amount is to cover the additional costs of the Trust’s COVID19 response (£1.084 million) in the month and a residual balance of expenditure over income (£0.31 million). Receipt of this funding will only be confirmed in mid-August 2020.

The year to date performance represents a £0.074 million deficit which is entirely driven by depreciation on donated assets which does not qualify for ‘true up’ funding. The regulator adjusts for this and effectively considers the Trust to be at break even.

The cash balance at 31 May 2020 was £21.7 million as a result of the Trust continuing to be paid one month in advance.

Quality and FPC Recommendations

Escalation from Quality Committee in July:

- A revised committee Work Plan outlining committee priorities and noting interdependencies with other Board committee work programmes was approved and is recommended to the Board as a model for other committee work plans currently under review. Further work is planned in August to consider recent learning from changed committee operating models.
- The Mortality Report reflected significant improvements with the Standard Hospital Mortality Index (SHMI) having reduced to within the expected range, Intensive Care National Audit and Research Centre (ICNARC) indicators being rated 'green' and a higher than national average number of survivors of patients requiring Trauma Unit care.
- A system wide group has been established to support the 'Discharge to Assess' programme
- The Infection Prevention and Control (IPC) Annual Report 2019/20 was received and is recommended to the Board for noting. The committee commended the excellent work undertaken in supporting clinical teams and maintaining safe care; particularly over recent months.
- The committee received the Healthwatch Annual Report and forward this to the Board for noting.

Escalation from FPC in July:

- An Extraordinary Finance and Performance Committee meeting was held on 16th June 2020 to review an Investment proposal for MS Office 365 as part of a discounted NHS programme. Approval was given to the proposal.
- Emergency Department performance had exceeded the 95% standard in June.
- Restricted capacity continues to impact the Referral to Treatment (RTT) standard and composition of waiting lists.
- Improvements were noted across all Diagnostic modalities reducing the number of people waiting greater than six weeks.
- Dorset County Hospital is to receive £2.4m capital funding to reduce backlog maintenance.
- Further discussion of staffing investment priorities was to be had by the Executive team to inform future decision making.

INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain

Safe

- There have been no Never events reported during this period.
- There were no falls resulting in severe harm during this reporting period.

Effective

- The standard of 36 hours for patients requiring surgery following a fractured neck of femur has been achieved for the second consecutive month.
- The completion of Electronic Discharge Summaries within 24 hours and 7 days has not achieved the standard required.
- Stroke standards have not been achieved during this reporting period.

Caring

- The recommendation rates for the friends and family test have achieved the standard required for Maternity, ED and Inpatient areas.

Responsive

In June 2020 the following standards were met:

- Emergency Access Standard (combined with MIU)
- Total RTT waiting list size
- 2 week wait breast symptomatic from urgent GP referral to first appointment
- All Cancers – 31 Day Diagnosis to First Treatment
- All Cancers – 31 Day Subsequent Treatment (Anti-Cancer Drugs)
- All Cancers - 31 day Subsequent Treatment (Surgery)
- All Cancers - 31 day Subsequent Treatment (Radiotherapy/Other)

Standards not met:

- RTT
  - Prioritisation of elective waiting list has been undertaken in line with national guidance
  - Specialty level plans in development for gradual restart of activity
  - Utilisation of Independent Sector capacity at BMI Winterbourne
  - Significant interdependencies with PPE and consumable availability
  - Self-isolation and swabbing requirements prior to surgery will significantly impact patient readiness and willingness to proceed with elective surgery
- All Cancers – 62 day referral to treatment following an urgent GP referral
  - Prioritisation of the cancer PTL has been undertaken in line with national guidance and continuous clinical reviews in place
  - Significant increase in backlog due to patient choice to delay treatment or a clinical decision to delay treatment following a risk assessment
  - Weekly tracking meeting taking place chaired by COO
  - RCA process in place for patients with a confirmed diagnosis of cancer who have waited over 104 days for treatment
- Two week wait (all cancers)
  - Patient choice to delay treatment in a small number of cases
  - Increase in referral numbers particularly in skin and breast

- Diagnostic 6 week wait
  - Deterioration against the standard due to suspension of routine diagnostic activity
  - New CT scanner has been delivered and is operational
  - Additional endoscopic capacity has been insourced and commenced at the end of May 2020
  - Utilisation of all available independent sector diagnostic capacity

Well Led

Total workforce capacity (substantive plus bank) increased by 12.17 FTE in Month 03 and was 268.90 FTE above prior year. Substantive workforce capacity increased in Month 03 (+7.10 FTE) and was 250.41 FTE above prior year.

Agency spend increased by £29.3k due to an increase of £74.1k in qualified nursing and £9.8k in scientific, therapeutic and technical staff – these figures were offset by a reduction of £52.4k in manager/infrastructure staff spending. The monthly spend included Covid related agency spend, and net of that agency spend was £149K below the corresponding figure for M03 2019/20. On framework vs off framework agency cover now sits at 99% vs 1%.

In terms of nursing trajectories, we are now expecting the 23 overseas nurses to be able to join the Trust from September. This is likely to be in 3 cohorts over 3 months to ensure we are able to support the overseas nurses appropriately. We were pleased to receive the news that the examination centres are reopening from the end of July and our 33 overseas nurses are now booked to take their OSCE exam.

The sickness absence rate for Month 2 (May) decreased by 1.79% to 3.12% which is below the Trust target of 3.3%. The annual appraisal rate (i.e. the percentage of the substantive workforce having received a performance appraisal within the previous 12 months) decreased by 4% to 71%, which is below the Trust target

Metric	Threshold/ Standard	Type of Standard	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Q1	YTD	Movement on Previous Perio	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)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	Contractual (National Quality Requirement) 2019/20	**2 (0.2)**	0 (0.0)	**2 (0.3)**	0 (0.0)	0 (0.0)	1 (0.2)	1 (0.1)	1 (0.1)	↓	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	95.3%	**94.1%**	**94.4%**	N/A	N/A	N/A	N/A	N/A	↑	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	0	3	1	0	0	1	1	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	0	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	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	**2**	**2**	**2**	**2**	**4**	**2**	**8**	**8**	↑	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.2)	2 (0.2)	0 (0.2)	3 (0.2)	3 (0.2)	↑	
Emergency caesarean section rate			23.1%	12.2%	16.2%	14.5%	15.0%	17.5%	15.7%	15.7%	↓	
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)	91.4%	96.2%	**76.9%**	N/A	N/A	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	96.4%	100%	100%	N/A	N/A	N/A	N/A	N/A	↔	
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)	**82.1%**	95.0%	**88.9%**	N/A	N/A	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	100%	100%	100%	N/A	N/A	N/A	N/A	N/A	↔	
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**	2	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]	**≤1.14 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	**1.15**	1.14	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)	**119.2**	**118.0**	**118.4**	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)	**118.5**	**116.6**	**119.4**	N/A	N/A	N/A	N/A	N/A	↓	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency	**90%**	Contractual (Local Quality Requirement)	**34.0%**	**43.5%**	**44.1%**	**31.8%**	**31.7%**	**35.7%**	**31.7%**	**31.7%**	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately	**90%**	Contractual (Local Quality Requirement)	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	**90%**	Contractual (Local Quality Requirement)	**85.7%**	**50.0%**	**78.6%**	**57.1%**	**84.6%**	**47.1%**	**70.4%**	**70.4%**	↓	
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	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	34	39	24	10	17	14	41	41	↑	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	N/A	N/A	N/A	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	98.5%	97.7%	97.1%	100.0%	100.0%	98.9%	99.4%	99.4%	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	83.4%	86.9%	91.4%	93.1%	90.4%	92.0%	91.8%	91.8%	↑	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	94.5%	94.4%	**93.8%**	**91.9%**	**91.2%**	**91.7%**	**91.6%**	**91.6%**	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**16**	**14**	**10**	**11**	N/A	N/A	**11**	**11**	↑	

Metric	Threshold/ Standard	Type of Standard	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Q1	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'	92%	Contractual (National Operational Standard)	66.6%	65.6%	60.7%	52.6%	46.4%	40.4%	40.4%	40.4%	↓	
RTT Incomplete Pathway Waiting List size	11,991		15,699	15,791	15,190	14,479	14,210	14,182	14,182	14,182	↑	
Cancer (ALL) - 14 day from urgent gp referral to first seen	93%	Contractual (National Operational Standard)	82.0%	87.6%	89.0%	81.9%	95.5%	82.3%	86.4%	86.4%	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	93%	Contractual (National Operational Standard)	100.0%	100.0%	84.2%	100.0%	93.5%	96.8%	95.9%	95.9%	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	96%	Contractual (National Operational Standard)	98.3%	97.6%	95.0%	97.5%	91.5%	98.7%	95.9%	95.9%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	94%	Contractual (National Operational Standard)	100.0%	100.0%	90.9%	88.9%	100.0%	100.0%	94.4%	94.4%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	98%	Contractual (National Operational Standard)	100.0%	96.3%	100.0%	94.7%	100.0%	100.0%	98.2%	98.2%	↔	
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%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	85%	Contractual (National Operational Standard)	64.0%	86.1%	90.5%	69.4%	71.6%	68.0%	69.6%	69.6%	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	90%	Contractual (National Operational Standard)	63.6%	16.7%	100.0%	64.7%	33.3%	-	60.0%	60.0%	↓	
% patients waiting less than 6 weeks for a diagnostic test	99%	Contractual (National Operational Standard)	97.6%	96.0%	84.4%	40.9%	40.9%	58.4%	56.7%	56.7%	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	95%	Contractual (National Operational Standard)	81.0%	85.9%	88.7%	89.4%	92.8%	93.8%	91.4%	91.4%	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from	95%	Contractual (National Operational Standard)	90.6%	93.2%	94.1%	93.2%	95.4%	96.3%	94.5%	94.5%	↑	
Well Led												
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	11.5 - 17.5%		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Sickness rate (one month in arrears)	3.3%	Internal Standard reported to FPC	4.45%	3.76%	5.81%	4.91%	3.12%	N/A	4.02%	4.0%	↑	
Appraisal rate	90%	Internal Standard reported to FPC	86%	83%	77%	82%	75%	71%	76%	76%	↓	
Staff Turnover Rate	8 -12%	Internal Standard reported to FPC	10.1%	10.3%	10.1%	9.4%	9.4%	8.9%	9.3%	9.3%	↑	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,493.06	2,520.8	2571,40	2,620.5	2,632.5	2,639.6	2,630.9	2,630.9	N/A	
Vacancy Rate (substantive)	<5%	Internal Standard reported to FPC	7.7%	9.2%	7.8%	7.7%	5.8%	5.7%	6.4%	6.4%	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	9,955.6	9,725.3	10,035.6	10,537.1	10,658.3	10,638.5	10,611.3	10,611.3	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	N/A	Internal Standard reported to FPC	0	0	1	0	0	0	0	0	N/A	
Essential Skill Rate	90%	Internal Standard reported to FPC	89%	89%	90%	88%	87%	87%	87%	87%	↔	
Elective levels of contracted activity (activity)	2019/20 = 30,584 2548/month		2,453	1,973	2,244	585	633	1,516	2,734	2,734	↑	
Elective levels of contracted activity (£) Including MFF	2019/20 = £30,721,866 £2,560,155/month		£2,277,318	£2,147,020	£2,269,226	£598,264	£527,626	£1,527,628	£2,653,518	£2,653,518	↑	
Surplus/(deficit) (year to date)	2020/21 = Breakeven YTD M3 = Breakeven	Local Plan	(2,316)	(1,652)	205	0	0	0	0	0	N/A	N/A
Cash Balance	2020/21 - 1,784 M3 = 4,272		13,132	14,020	7,335	21,269	N/A	21,657	21,657	21,657	↑	
CIP - year to date (aggressive cost reduction plans)	2020/21 = N/A under current plan YTD M1 = N/A	Local Plan	4,608	5,085	5,710	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Agency spend YTD	2020/21 = No Annual value YTD M3 = 1,992		5,743	6,499	7,837	806	1,393	2,009	2,009	2,009	N/A	N/A
Agency % of pay expenditure	2020/21 = No Annual value YTD M3 = 5.9%		5.4%	5.5%	7.8%	6.7%	5.8%	5.6%	5.6%	5.6%	↑	

Movement Key

Favourable Movement ↑
Adverse Movement ↓
No Movement ↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Apr-20	May-20
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**	0 (0.0)	1 (0.2)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	0 (0.0)	1 (0.2)
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	3	0
	SHMI - Rolling 12 months, 4 months in arrears (Mar-19 to Feb-19)	**≤1.14**	1.14	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-19 to Mar-20)	**100**	**118.4**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**46.4%**	**40.4%**
	RTT Incomplete Pathway Waiting List size	**11,991**	**14,210**	**14,182**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**71.6%**	**68.0%**
	Maximum 6 week wait for diagnostic tests	**99%**	**40.9%**	**58.4%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	95.4%	96.3%
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**527,626**	**1,527,628**
	Surplus/(deficit) (year to date)	**2020/21 = Breakeven YTD M3 = Breakeven**	0	0
	CIP - year to date (aggressive cost reduction plans)	**2020/21 = N/A under current plan YTD M1 = N/A**	N/A	N/A
	Agency spend YTD	**2020/21 = No Annual value YTD M3 = 1,992**	**1,393**	**2,009**

Rating Key

Title of Meeting	**Trust Board**
Date of Meeting	**29 July 2020**
Report Title	**COVID 19 – Overview Response Report**
Author	Inese Robotham, Chief Operating Officer
Responsible Executive	Inese Robotham, Chief Operating Officer

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

Summary
NHS has been in Level 4 Incident due to COVID-19 pandemic since 03 March 2020. In response DCH has put in place an Incident Management Team and has developed plans to scale up Emergency Department, Critical Care, Ward and Mortuary capacity to deal with increased numbers of COVID-19 positive patients. These plans are reviewed and amended on regular basis to respond in fluctuation of COVID-19 and non COVID-19 activity.
A gradual restart of elective activity has commenced with main focus on cancer, urgent and diagnostic activity; routine and follow up activity has re-commenced on a limited scale.

Paper Previously Reviewed By
N/A

Strategic Impact
The mandated need to rapidly respond to the incident resulted in displacement of routine activity and significant redesign will be required to restart routine appointments/surgery within the constraints of the need for social distancing and requirement to preserve scale up capacity in readiness for future surges of COVID-19.

Risk Evaluation
The outlined arrangements provide capacity to deal with current COVID-19 activity and mitigation against future spikes during the pandemic. Capacity to provide elective care remains reduced due to current infection control and social distancing requirements.

Impact on Care Quality Commission Registration and/or Clinical Quality
The outlined arrangements draw on best practice and latest infection control guidelines to ensure clinical quality of care for the patients and safety and reduced risk of exposure for both staff and patients.

Governance Implications (legal, clinical, equality and diversity or other):
It is a legal requirement to have appropriate Emergency Planning Response and Resilience structures in place to enable the organization to effectively respond to and manage an incident

Financial Implications
The NHS COVID-19 response is funded centrally; however, robust financial management remains paramount in order to withstand scrutiny and subsequent reimbursement of COVID-19 related expenditure. A number of bids to fund additional out of county independent sector activity have been submitted as part of a system wide submission. To date there has been no confirmation of additional funding.

Freedom of Information Implications	Yes

– can the report be published?	

Recommendations	To NOTE the update on Incident Management structure in place and current operational response to the COVID-19 Incident including the gradual restart of elective activity.

Title of Meeting	**Trust Board**
Date of Meeting	**29 July 2020**
Report Title	**COVID 19 – Overview Response Report**
Author	**Inese Robotham, Chief Operating Officer**

1 Introduction

NHS England and NHS Improvement declared the spread of COVID19 a **Level 4 incident** on 03 March 2020. This is the highest level of emergency and means that emergency response is coordinated at national level.

All NHS provider and commissioning organisations were mandated to implement a 24/7 incident management team structures at organisational and system levels to receive and act on national instructions and information requests.

Both the Dorset wide command and control structure and internal DCH Incident Management Team structure were presented at the previous Trust Board meeting and remain in place as per NHS England and NHS Improvement letter dated 29 April 2020 instructing that NHS organisations need to fully retain their Emergency Planning Response and Resilience (EPRR) incident coordination functions given the uncertainty and ongoing need. This paper provides an update on the Trust's EPRR response to date and plans to retain COVID 'surge' capacity should it be needed again.

2 Incident Management Structure and latest Situational Report

DCH Incident Management Team remains functional 24/7. IMT meetings are taking place on Mondays, Wednesdays and Fridays with a backup rota in place to increase frequency if required; out of hours the incident management is led by the on call teams with additional support from EPRR.

To date the highest peak in COVID-19 activity at DCH was on 06 April 2020 – twenty confirmed positive inpatients of which five were on Critical Care. Currently (as on 21 July 2020) there are no confirmed COVID-19 positive inpatients at DCH. The contingency arrangements remain in place and as per latest national guidance all emergency admissions are swabbed for COVID-19 and isolated where possible; a re-swab is then undertaken 5-7 days after admission. This adds complexity in patient pathways and in management of available cubicle and bed capacity.

DCH has had twenty seven confirmed COVID-19 positive patient deaths of which one was an NHS employee. The last confirmed COVD-19 positive death at DCH was recorded on 12 June 2020.

3 Site Reconfiguration

Both DCH Emergency Department and Critical Care remains segregated into COVID and non-COVID areas. Ward escalation plan for COVID-19 activity has not changed and Moreton ward remains designated as the receiving ward followed by Ilchester ward and Inpatient Emergency Care (IPEC). DCH baseline mortuary capacity equates to 74 spaces; current mortuary usage remains on average between 10-15 spaces. The levels of PPE stock remain good and are monitored on a daily basis with escalation to IMT if required.

4 Re-start of elective activity - local and regional overview

4.1 DCH

All DCH services, with the exception of Oral Maxfax which is provided by Poole hospital, have restarted some elective activity. The Trust has also resumed insourcing for Endoscopy and Ophthalmology, with activity booked every other weekend for next couple of month. Virtual outpatient clinics are now being utilised throughout the Trust, with over 4,000 appointments delivered in a non-face to face setting during June 2020. The Trust continues to utilise theatre capacity at the BMI Winterbourne for Breast Cancer, Orthopaedics and Ophthalmology surgery, as well as outpatient Orthopaedic activity, ultrasound, X-ray and MRI scans. Additional orthopaedic surgery capacity was also sourced with Independent sector providers outside of the Dorset system and 46 patients were transferred to Shepton Mallett and 53 patients to New Hall.

The ability to deliver elective activity volumes has been greatly reduced due to increased cleaning, PPE and social distancing measures in Theatres, Wards and Outpatient settings. The restart cells are reviewing all possible options for alternative locations for delivery of services, however the main constraint remains workforce as efficiency and throughput are significantly reduced.

The table below illustrates month on month increase of activity volumes from May 2020 to June 2020, however the overall volumes remain circa 30% below pre-COVID 19 activity levels.

Type of activity	May 2020	June 2020	% increase
Elective including day case	633	1516	139.49%
Regular day attenders	4185	4385	4.78%
Non-elective admissions	947	1847	95.04%
Chemotherapy	233	399	71.24%
1st OPA	3387	3941	16.36%
Follow up OPA	8693	10786	24.08%
OP procedure	442	1160	162.44%

4.2 Regional overview

The table below shows the ranking between all seven regions nationally and illustrates how South West compares with other regions for main performance indicators. The region compares favourably for cancer breast symptomatic and cancer 62 days performance. The most challenged performance for South West remains RTT 18 week Incomplete standard as well as number of patients waiting over 52 weeks.

		Performance/Activity							Rank						
		East of England	London	Midlands	North East and Yorkshire	North West	South East	South West	East of England	London	Midlands	North East and Yorkshire	North West	South East	South West
Diagnostics	May-20	60.3%	59.2%	56.5%	63.9%	60.0%	51.2%	59.2%	6	3	2	7	5	1	4
A&E 4 Hour Performance	Jun-20	93.5%	93.9%	90.4%	95.0%	91.8%	95.0%	94.1%	5	4	7	1	6	2	3
A&E 12 Hour Trolley Waits	Jun-20	2	113	7	0	12	14	13	2	7	3	1	4	6	5
RTT 18 Week Performance (Incomplete)	May-20	58.3%	61.2%	63.8%	62.8%	62.3%	61.3%	60.8%	7	5	1	2	3	4	6
RTT Total Waits (Incomplete)	May-20	400,114	670,164	673,770	518,035	544,182	506,824	360,093	0.1%	-4.7%	-2.0%	-3.4%	-0.9%	-4.9%	-2.3%
RTT 52 Week Plus (Incomplete)	May-20	3,801	5,248	2,455	3,356	3,330	3,324	4,185	5	7	1	4	3	2	6
Cancer 2 Week Wait Performance (All Suspected)	May-20	95.0%	93.4%	91.2%	94.1%	95.7%	95.9%	95.3%	4	6	7	5	2	1	3
Cancer 2 Week Wait Performance (Breast Symptoms)	May-20	95.0%	96.4%	97.4%	83.3%	88.8%	96.6%	98.6%	5	4	2	7	6	3	1
Cancer 31 Day Wait Performance (First Treatment)	May-20	91.5%	93.2%	92.1%	95.1%	94.5%	95.6%	95.0%	7	5	6	2	4	1	3
Cancer 31 Day Wait Performance (Surgery)	May-20	83.9%	93.8%	86.1%	88.4%	87.2%	90.0%	89.8%	7	1	6	4	5	2	3
Cancer 31 Day Wait Performance (Drug)	May-20	98.1%	99.5%	98.6%	98.4%	99.3%	99.4%	99.6%	7	2	5	6	4	3	1
Cancer 31 Day Wait Performance (Radiotherapy)	May-20	95.8%	97.2%	96.7%	95.6%	99.0%	94.1%	95.9%	5	2	3	6	1	7	4
Cancer 62 Day Wait (Consultant Upgrade)	May-20	76.2%	80.8%	78.0%	74.2%	77.8%	72.3%	81.9%							
Cancer 62 Day Wait (Screening)	May-20	32.0%	41.8%	44.8%	42.2%	51.0%	64.2%	59.7%	7	6	4	5	3	1	2
Cancer 62 Day Wait (Standard)	May-20	68.2%	66.7%	62.4%	71.2%	68.3%	75.4%	75.2%	5	6	7	3	4	1	2

In terms of restarting elective activity South West ranks second nationally with delivery of 41.9% of pre Covid-19 levels of activity.

Region	Average baseline pre C19 per wd	W/end 5 July	% recovery	Rank
East of England	4,120	1,888	45.8%	1
London	6,661	2,467	37.0%	4
Midlands	6,656	2,125	31.9%	6
North East and Yorkshire	5,725	1,964	34.3%	5
North West	5,089	1,618	31.8%	7
South East	5,844	2,174	37.2%	3
South West	**3,280**	**1,375**	**41.9%**	**2**

Currently the Phase Three recovery letter to acute providers still remains pending. It is anticipated that it will outline ongoing shift in focus from longevity to acuity (i.e. waiting list review from perspective of reducing harm by prioritising those with the greatest clinical need), waiting lists and performance increasingly being managed at a system level, ambition to return activity for time critical conditions to 100% of pre-COVID 19 levels, prioritising patients who have been waiting over 52 weeks.

5 Recommendations

The Trust Board is asked to:

NOTE the update on Incident Management structure in place and current operational response to the COVID-19 Incident including the gradual restart of elective activity.

Title of Meeting	**Board of Directors**
Date of Meeting	**29 July 2020**
Report Title	**Mortality Report: Learning from Deaths Qtr 1 2020/21**
Author	Prof. Alastair Hutchison, Medical Director
Responsible Executive	Prof. Alastair Hutchison, Medical Director

Purpose of Report (e.g. for decision, information)
To inform the Quality Committee of the learning that has occurred as a result of deaths being reported, investigated and disseminated throughout the Trust.

Summary
The Trust's SHMI remains elevated although just within the 'as 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 last year, and the appointment of Alison Cooper (Taunton consultant) the post of Associate medical Director with specific responsibility for M&M meeting governance.

Paper Previously Reviewed By
Quality Committee, 21st July 2020

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 an elevated 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 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 elevated 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.

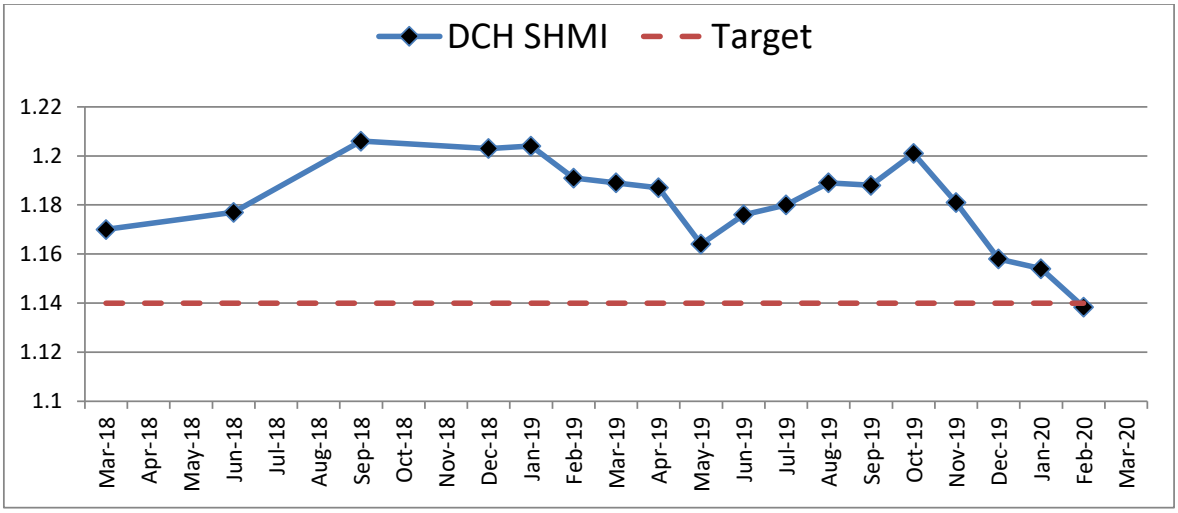
Freedom of Information Implications – can the report be published?	Yes

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

MORTALITY DATA AND STATISTICS

1.1 Summary Hospital-level Mortality Indicator (SHMI)

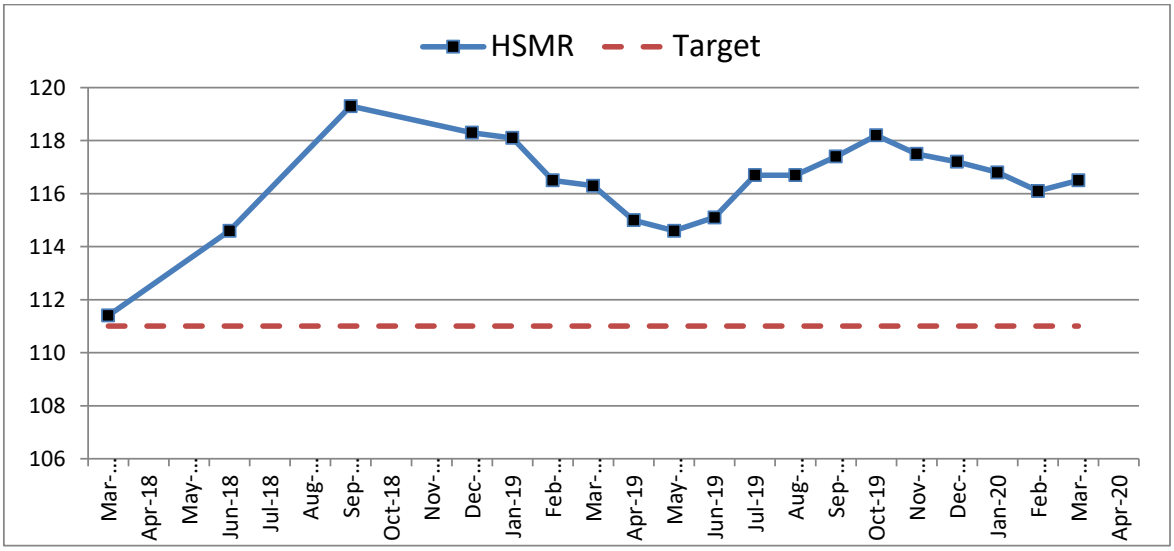
SHMI is provided by NHS Digital for a 12 month rolling period, and usually 5 months in arrears. It takes into account all diagnostic groups and in hospital deaths, and also deaths occurring within 30 days of discharge from hospital. The SHMI for the rolling years from October 2019 through to February 2020 has been reducing such that the latest figure is now within the expected range at 1.1384 (Feb 2020) which represents its lowest level (bar one month) since June 2015. Changes to staffing and development within the coding department came into effect in October 2019.



SHMI is calculated by comparing the ratio of observed (actual) deaths in a 12 month period to the expected deaths (predicted from coding data). The SPC below shows observed deaths over the past 2 years (rolling years from March 2018 to Feb 2020). Time axis is not to scale because NHS Digital switched from quarterly to monthly reporting in January 2019.

1.2 HSMR – rolling year to March 2020

The HSMR remains statistically significantly higher than expected, at 116.5 (March 2020). Compared to all acute, non-specialist Trusts across the UK, the Trust is one of 50 with a statistically significantly higher than expected HSMR (HSMR range 106 – 129). SHMI has largely replaced HSMR which is not reported by NHS Digital.



2.0 OTHER INDICATORS OF CARE

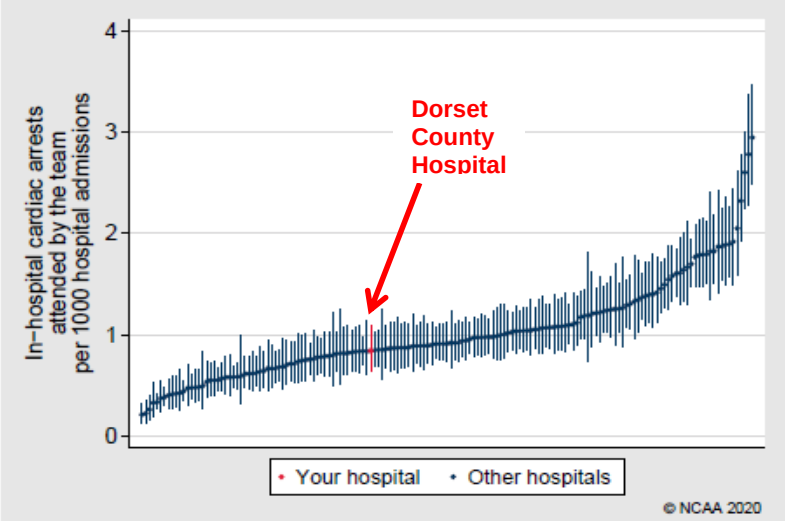
The DCH Learning from Deaths Mortality Group regularly examines any other data which might relate to standards of care, and has continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies who report on individual Trust 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 published June 2020

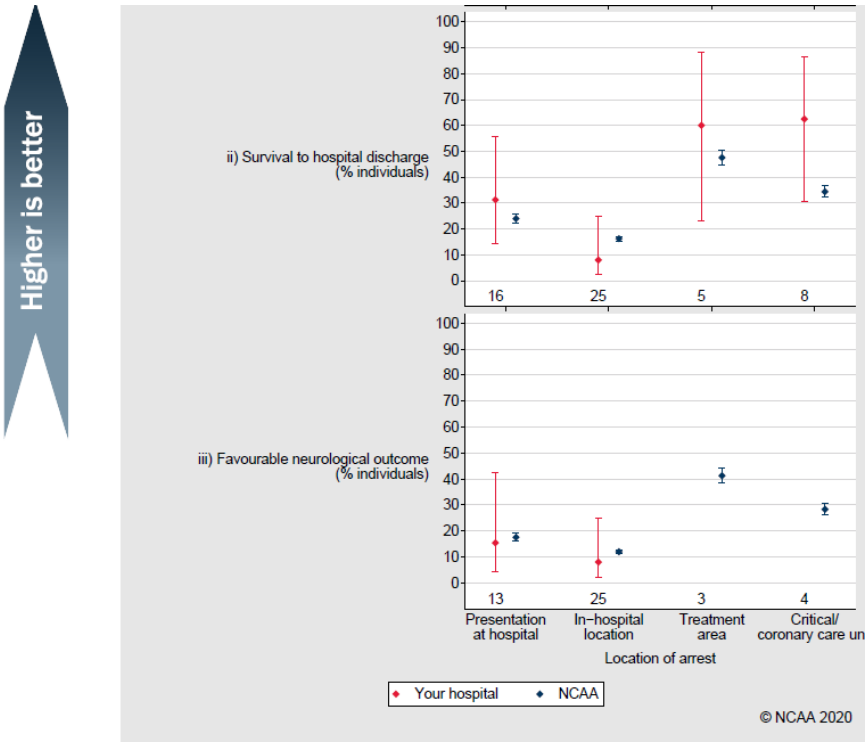
12 month Cardiac Arrest data for 01 April 2019 to 31 March 2020 was published in June 2020. 58 cardiac arrests were attended by the arrest team in this time. A proportion of in-hospital cardiac arrests are probably preventable, therefore the number per 1,000 admissions is a guide to quality of monitoring and intervention in deteriorating patients.

Rate of in-hospital cardiac arrests

The following graph presents the reported number of in-hospital cardiac arrests attended by the team per 1,000 hospital admissions for adult, acute hospitals in NCAA.



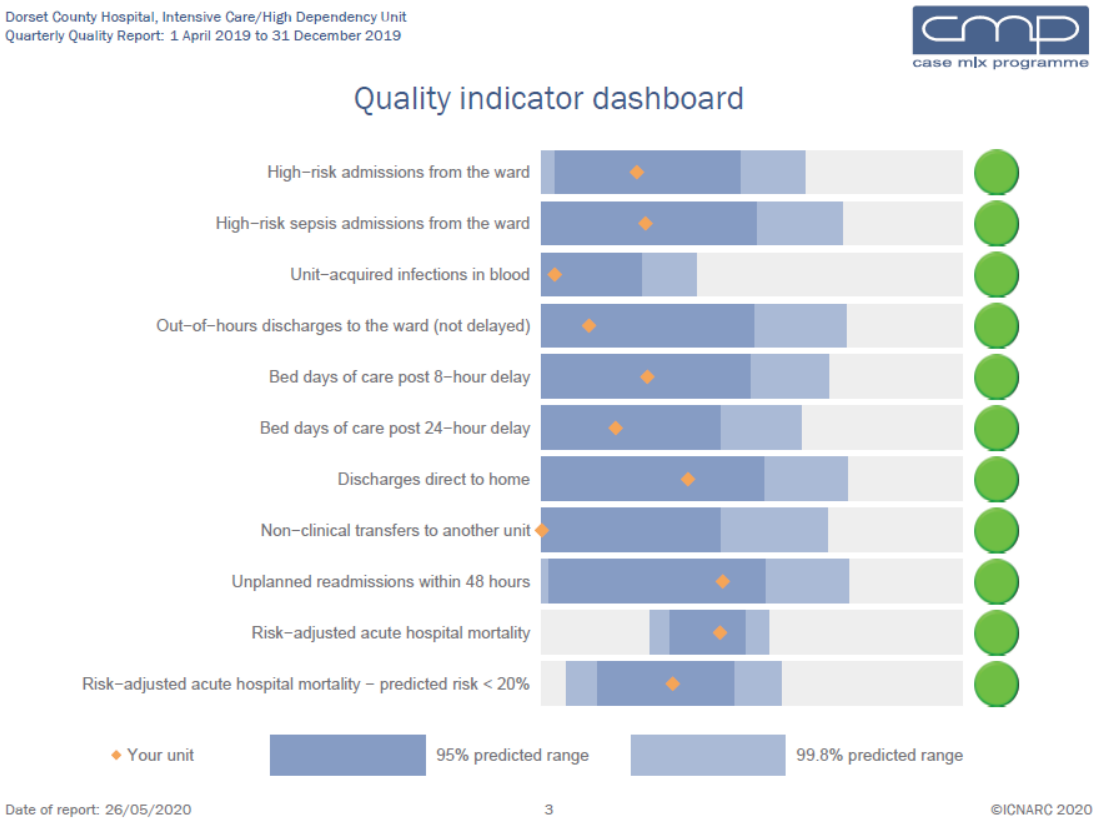
Cardia Arrest survival vs national averages by location of arrest



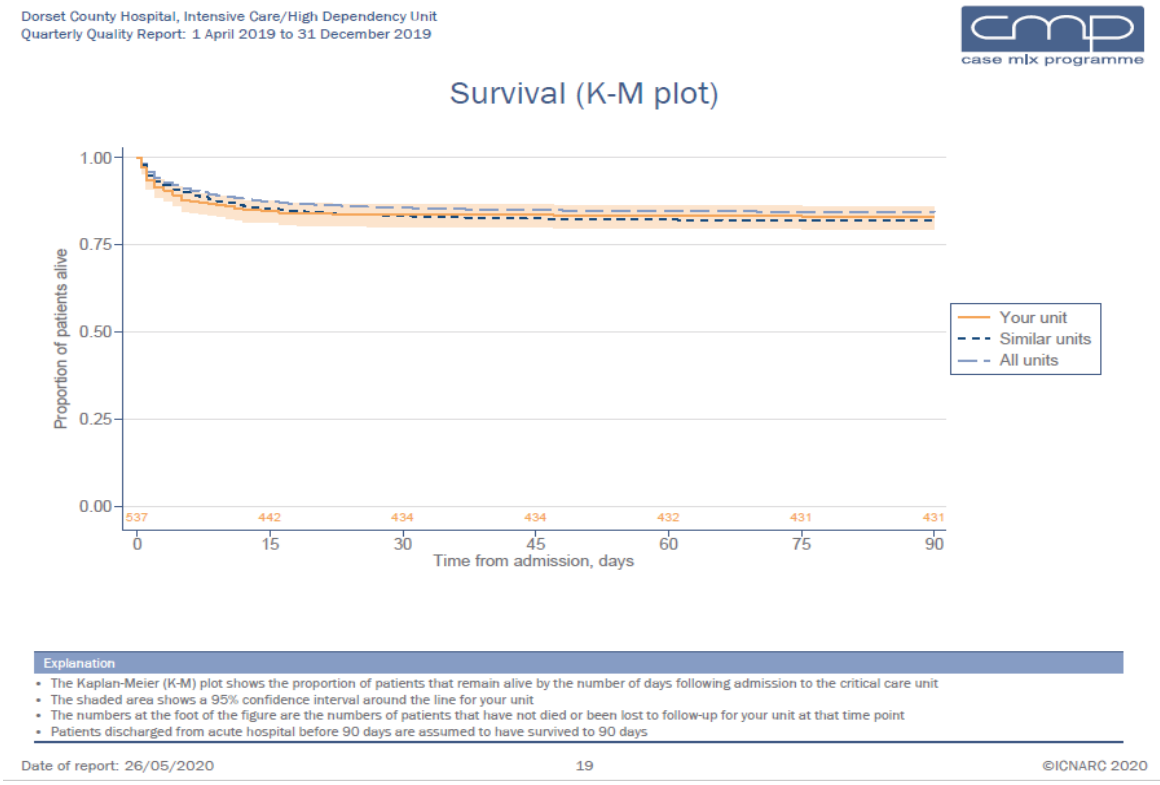
2.2 Pneumonia mortality latest data - published November 2019

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%

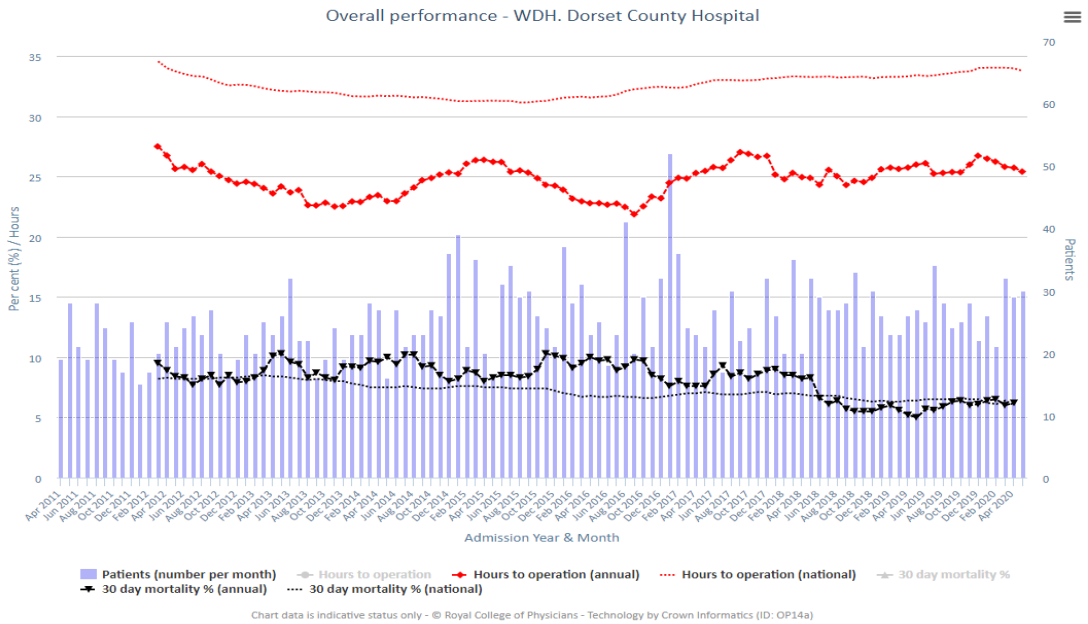
2.3 ICNARC Intensive Care survival data published 26 May 2020



The Kaplan-Meier (K-M) plot shows the proportion of patients that remain alive by the number of days following admission to the critical care unit. The shaded area shows a 95% confidence interval around the line for our unit



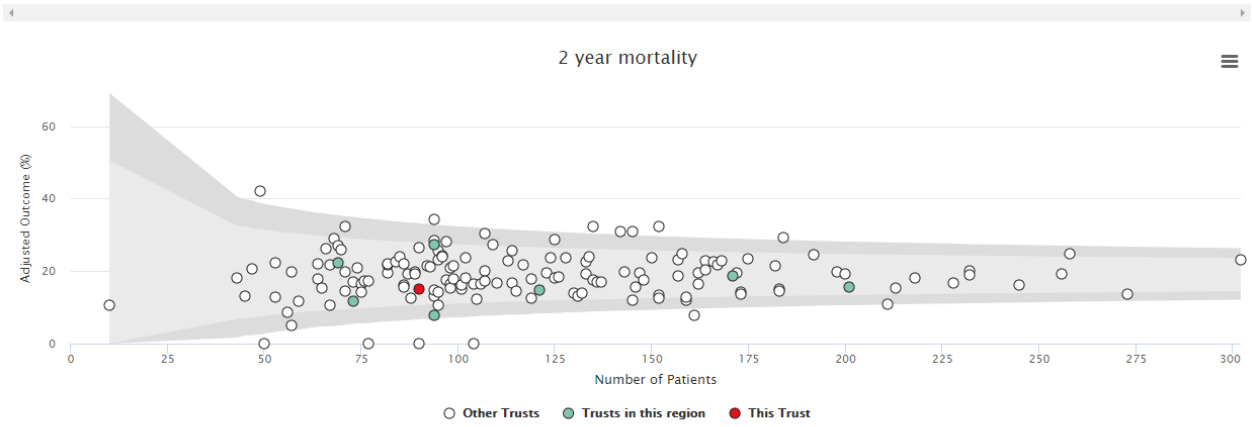
2.5 National Hip Fracture database to April 2020



Time from admission to operation remains significantly better than the national average, with 30 day mortality at 6.2% versus the national average of 6.0%.

2.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available data for 2017/18 – 2 year survival compared to all other NHS Trusts.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	90	15.1%	15.6%

2.7 Getting it Right First-Time reviews in Q1

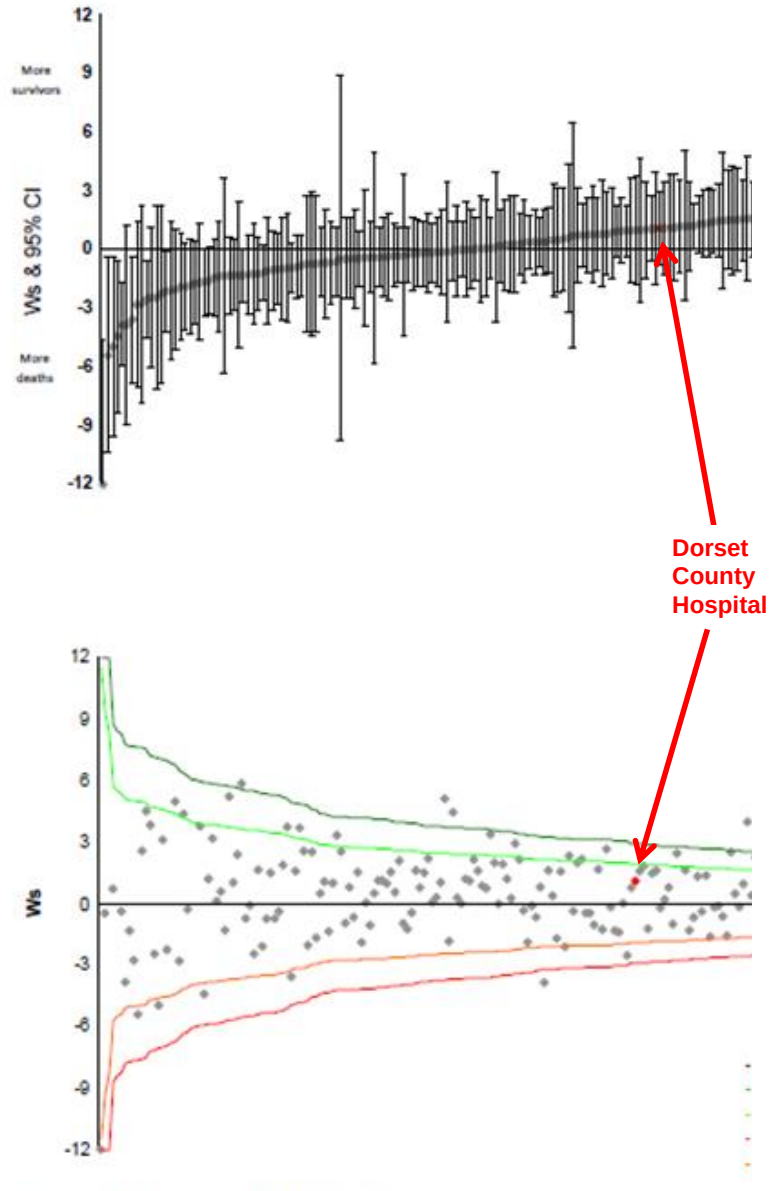
No GIRFT reviews were undertaken at DCH during this quarter, and from March 2020 all future visits were suspended because of COVID-19.

Full reports from previous GIRFT visits are available, and feedback from each review has previously been very positive. Action plans have been developed and are being worked through at present.

2.8 Trauma Audit and Research Network

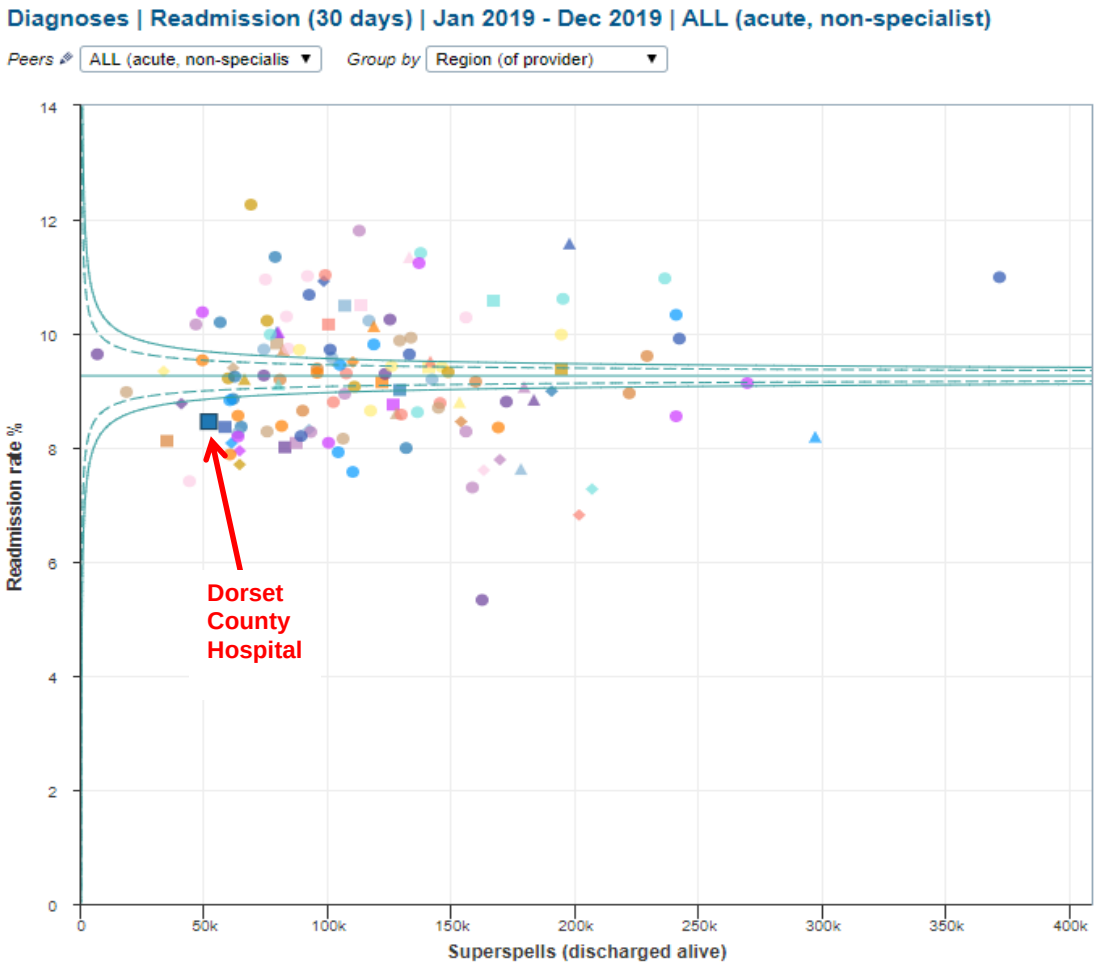
DCH is a designated Trauma Unit (TU) and provides care for most injured patients has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. A summary of the latest published data is shown below, and in both graphs higher is better.

TARN registered sites (excluding Major Trauma Centres)
Comparative Outcome Analysis - 01 January 2018 to 31 December 2019
Outcome at 30 days or discharge
Dorset County Hospital is highlighted
The Ws must be reviewed in conjunction with the Data Completeness and Accreditation figures.



Hospitals are plotted in order of precision (1 / standard error).

2.9 Readmission to hospital within 30 days, latest available data (Dr Foster) – lower is better



2.10 Dr Foster Safety Dashboard

The Dr Foster safety dashboard compares DCH with other England and Wales Trusts for a variety of complications that might occur during their in-patient stay. Where the confidence intervals include the national mean there is no difference from the national average). DCH has a higher caesarean section rate than expected (7 versus 2) and a lower number of decubitus (pressure) ulcers (204 versus 269). In this latest data "Deaths in Low Risk diagnosis groups" has also shown an alert and each of these 17 cases is now undergoing an SJR. Preliminary data suggests that the diagnosis group is incorrect in several of these cases, and the full findings will be presented to the Hospital Learning from Deaths Mortality Group and included in the next quarterly report.

Quality Safety

Patient Safety Indicators

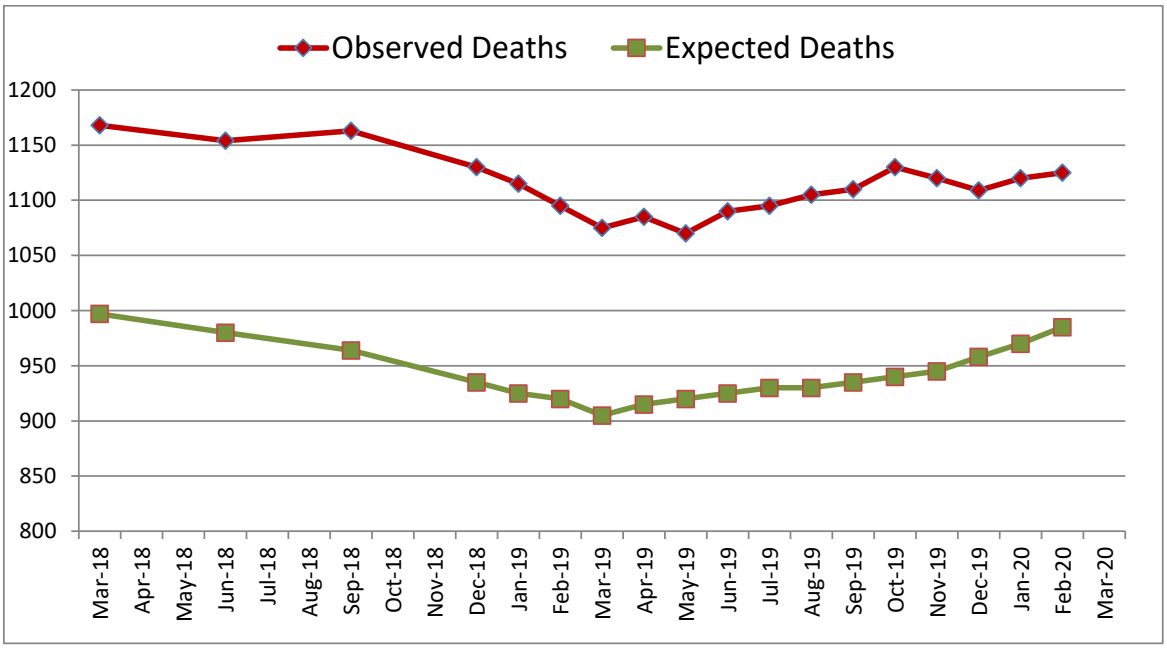
Period: 12 months (Apr 19 to Mar 20) | Data lag: No lag

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	41170	62	65.1	1.5	1.6	95.3	
Deaths after surgery	231	21	15.8	90.9	68.3	133.1	
Deaths in low-risk diagnosis groups	21422	17	9.4	0.8	0.4	181.6	
Decubitus ulcer	4906	204	269.0	41.6	54.8	75.8	
Infections associated with central line	7715	0	0.5	0	0.1	0.0	
Obstetric trauma - caesarean delivery	419	7	1.8	16.7	4.4	383.9	
Obstetric trauma - vaginal delivery with instrument	134	9	9.0	67.2	67.1	100.1	
Obstetric trauma - vaginal delivery without instrument	789	20	22.6	25.3	28.6	88.6	
Postoperative haemorrhage or haematoma	16257	5	5.7	0.3	0.4	87.1	
Postoperative hip fracture	21303	1	1.2	0.0	0.1	86.9	
Postoperative physiologic and metabolic derangement	14194	2	1.9	0.1	0.1	105.2	
Postoperative pulmonary embolism or deep vein thrombosis	16395	39	37.5	2.4	2.3	104.1	
Postoperative respiratory failure	13098	9	10.2	0.7	0.8	88.2	
Postoperative sepsis	289	1	4.0	3.5	13.9	24.9	
Postoperative wound dehiscence	431	0	0.3	0	0.8	0.0	

3.0 CODING

3.1 Depth of coding

The DCH depth of coding for Charlson Co-morbidities remains around the lowest in the country. However the Trust's expected death rate has been rising over the past 10 months suggesting that coding accuracy overall is probably improving. The graph below plots Observed (actual) deaths and Expected deaths against rolling 12 month time points.



3.2 PWC Artificial Intelligence

PWC have produced an AI model to assist Trusts in understanding technical issues relating to elevated HSMR and SHMI figures. Initial discussions with PWC were halted on grounds of cost in 2019, but during Q4 these were restarted after a reduced price offer and discussions between the Medical Directors of DCH and The Royal Wolverhampton Trust (a current client of PWC). RWT were very complimentary about PWC's assistance which they feel is largely responsible for their SHMI improvement over the past 12 months from the highest in the country to well within the expected range for the past 3 published months of data.

Discussions within the Executive Team led to a request for PWC to submit an options paper for future collaboration and pricing, which has been accepted in principle and is being passed to Procurement.

4.0 LEARNING FROM DEATHS

4.1 Structured Judgement Reviews

Although the Hospital mortality Group has continued to meet (virtually) over the past 4 months, work on SJRs was temporarily suspended (as in all Trusts), and so as noted in the previous quarterly report it has not been possible to collate accurate data. It is intended that the next Quarterly Report will include this omitted data.

4.2 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. Since the early weeks of the CoVID-19 crisis the Medical Examiner numbers were reduced to 2 and more recently 3, but they continue to provide a full 5 days service between them. It is anticipated that other Medical Examiners will return in the coming weeks as COVID has subsided.

5.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been identified from SJRs and are being translated into quality improvement projects:
1. Recognition and management of AKI
2. Poor quality of some admission clerking notes, particularly in surgery
3. Morbidity and Mortality meetings - standardization and governance (see 6.0 below)

6.0 MORBIDITY and MORTALITY MEETINGS

Dr. Alison Cooper has returned to DCH as an Associate Medical Director for 1 day per week, with responsibility for M&M meeting governance. She commenced in post on 02/07/20. All departmental Clinical Leads have been asked to ensure that M&M meetings are continuing on a regular basis during the CoVID-19 pandemic (depending on the number deaths within each department), using the Royal College of Surgeons M&M meeting Best Practice document as their template.

7.0 LEARNING FROM CORONER'S INQUESTS

DCH has been notified of 19 new Coroner's inquests being opened in the period 01.04.20 – 30.06.20. All Inquests that were listed have been adjourned until September 2020 because of COVID-19. Therefore we currently have 51 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. Six cases have been heard. New cases are now being listed for September onwards.

A virtual meeting has been arranged by the Coroner w/c 13.07.20 to review their current position and to discuss how Inquest hearings will be held in future and to consider whether holding virtual Inquests is an option.

8.0 SUMMARY

SHMI and HSMR remain higher than expected, but with evidence of a steady improvement in SHMI over the past 4 months, to its best figure for around 2 years. 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 an Associate Medical Director with responsibility for governance of M&M meetings from 02/07/2020, and the anticipated engagement of PWC to provide additional advice around mortality metrics in general and coding specifically.

Title of Meeting	**Board of Directors**
Date of Meeting	**29 July 2020**
Report Title	**Annual Equality, Diversity and Inclusion Report**
Author	**Bernadette Pritchard, Inclusion & Wellbeing Lead**
Responsible Executive	**Mark Warner, Director of Workforce and Organisational Development**

Purpose of Report (e.g. for decision, information)
To advise of mandated equality, diversity and inclusion (EDI) reporting data over the past 12 months, including the 2020 Workforce Race Equality Standard (WRES) and the 2020 Workforce Disability Equality Standard (WDES) and highlight issues arising. To confirm EDI activity and actions and present workforce data across protected characteristics as defined in the Equality Act 2010 (2010)

Summary
Under the Equality Act (2010), public bodies have very specific duties and in particular, the Trust has a duty to promote equality and diversity and to publish information on compliance to demonstrate how it is delivering improvement.

The report details the work undertaken by the Trust during 2019/20 to demonstrate its commitment to promoting equality, diversity, inclusion and human rights. An analysis of the workforce and the 2019/20 recruitment cycle are also included. Data contained within this report refers to the April 2019 – March 2020 reporting cycle.

It also includes drafts of the Workforce Race Equality Standard and Workforce Disability Quality Standard Action Plans to address the inequalities highlighted in the report.

Paper Previously Reviewed By
Workforce Committee, 20 July 2020

Strategic Impact

Risk Evaluation
Unsatisfactory performance in providing services and employment which reflects the diverse nature of the population served by the Trust will be a risk to reputation and can leave the Trust open to legal challenges. The Trust is required to demonstrate its compliance with the Equality Act 2010, and the various frameworks, including compliance with the Care Quality Commission (CQC) standards.

Impact on Care Quality Commission Registration and/or Clinical Quality
See above. There is an established and widely accepted body of evidence that promoting and supporting diversity in the workplace, with the UK legislation covering age, disability, race, religion, gender and sexual orientation, contributes towards employee wellbeing and engagement.

Governance Implications (legal, clinical, equality and diversity or other):
In accordance with the Equality Act Public Sector Equality Duty, the Trust has a legal obligation to promote equality and diversity and to produce and publish information on compliance.

Financial Implications
There are no direct financial implications although failure to comply with legislation could result in fines being levied on the Trust and successful discrimination claims brought against the

Trust at employment tribunal.	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	a) Note the content of this report and support the actions. b) Provide continued support to the Trust in seeking to embed equality, diversity, inclusion and human rights.

Annual Equality and Diversity Report July 2020

1.0 Equality, Diversity and Inclusion at Dorset County Hospital NHS Foundation Trust

1.1 Language and terminology used in this report

The terms BAME (Black, Asian and minority ethnic) and BME (Black and minority ethnic) are used in this report to reflect the language used by the Workforce Race Equality Standard (WRES) to define those of all ethnicities other than white. It is acknowledged, however, that the groups to whom these terms are applied are culturally and ethnically distinct. The use of a 'catch-all' term is not considered acceptable by everyone, and the Trust will be led by our staff of ethnic minorities to ensure that we use the most appropriate and inclusive terminology.

'LGBT+' is used to refer to people who are lesbian, gay, bisexual, and transgender, with the '+' including those people who define their sexual orientation as other than heterosexual or any of the above.

1.2 DCHFT has a firm commitment to equality, diversity and inclusion. The Trust acknowledges our responsibility to provide a supportive environment where all staff and patients can feel they belong.

1.3 Progress on ED&I activity is monitored by the Trust's Equality, Diversity and Inclusion Steering Group (EDISG), along with the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). This report contains the results for the WRES and WDES, plus other findings of note and key staff diversity data.

1.4 Mark Warner, Head of Workforce and Organisational Development is the 2019/20 board lead for the WRES and WDES. He is supported by Bernadette Pritchard, Inclusion and Wellbeing Lead.

1.5 The Trust, along with Dorset CCG, Royal Bournemouth and Christchurch Hospitals, Poole NHS Foundation Trust, and Dorset Healthcare, form the Dorset NHS Inclusion Network. The Trust is also an active member of the South West Inclusion Network, which brings together EDI leads from across the public sector.

1.6 All staff receive training in EDI and human rights, delivered via e-learning through the general induction programme, followed by core skills training every three years. As part of our EDI work, we will be re-developing this training for 2020/21.

1.7 The Trust's Equality, Diversity and Inclusion Steering Group (EDISG), established in 2016, hold responsibility for the equality and diversity and inclusion agenda. This group will be chaired by Patricia Miller, Chief Executive, from July 2020 onwards. It has representation from diverse staff groups, including those with disabilities and the BAME network. It works with Dorset diversity networks to promote equality and inclusion, establish and support accessible staff support networks.

The work of the EDISG is informed by the Black, Asian and Minority Ethnic (BAME) Staff Network, which has increased its membership over the past 12 months and is currently focusing on:

- Engagement and communication with our BAME staff
- Support with career progression and leadership skills
- Working with the Freedom to Speak Up Guardian to ensure that BAME staff are encouraged and thanked for speaking up.
- Support in the recovery phase of Covid-19

Future work will be led by outcomes of this report, the WRES action plan, and further BAME staff engagement.

1.8 A Mental Health First Aiders network has also been established to support these roles and provide opportunity for shared good practice, learning and development. Mental illnesses are the second largest cause of burden of disease in England. Evidence is pointing to the consequences of the COVID-19 pandemic on mental health being considerable[1], and past studies of epidemics have shown a higher mental health burden on healthcare workers. Mental illnesses are known to be more long-lasting and impactful than other health conditions[2].

1.9 We will work to engage with our staff with disabilities and LGBT+ staff in 2020/21 – first to better identify them and then to explore the interest in a network and other inclusion/awareness work.

2.0 The Communities we Serve – Demographics

2.1 Age

The West Dorset area has a total population of 102,064[3]; the table below shows the age demographics of this population compared to the national average. Dorset has a much greater proportion (31%) of the population aged 65 and over than England and Wales (18%)[4] .

Table 1: A comparison of age breakdown for West Dorset, England and Wales, and DCHFT patients

	Aged 0-15	Aged 16-64	Aged 65+
West Dorset*	15%	54%	31%
England & Wales*	19%	63%	18%
Our patients	17%	46%	37%

2.2 Disability

One in five of Dorset's population and 22% of people living in Weymouth (highest rate in Dorset Council region) have a long term health condition or disability.

2.3 Ethnicity

4.4% of the Dorset population is of Black, Asian or other minority ethnicity compared to the national average of 19.5%.

[1] https://www.bmj.com/content/369/bmj.m1515
[2] https://www.gov.uk/government/publications/health-profile-for-england-2019
[3] Census 2011, ONS
[4] Mid–year population estimates (2017), ONS

This includes the classification 'White Other' which make up approximately 41% of Dorset's ethnic minority population. This classification includes people who identify as white but who do not have UK national identity (English, Welsh, Scottish, Northern Irish and British). An example would be Polish[3].

It must be noted that the Trust data presented in this report does not include white minority ethnicities. This is in line with the data requirements for the Workforce Race Equality Standard which defines between 'White' and 'Black and Minority Ethnicity' (BME).

3.0 Our Workforce Demographics

3.1 Age

The largest age cohort of Trust staff is between 51 and 55 years old, with 14% of staff being between these ages; this is a change from the previous year when the largest age cohort was 46-50 yrs. 43.5% of the workforce is under 40 yrs.

3.2 Disability

In the 2019 Staff Survey, 21% of Trust staff reported that they have a 'Physical/Mental illness or Disability expected to last more than 12 months'. Only 3% of staff are recorded on ESR as having a disability. However, 23.4% of all staff have not declared their status or are recorded on ESR as 'not defined'. The staff survey results reflect the one in five of Dorset's population who have a long term health condition or disability.

3.3 Gender

77.1% of staff are women in the Trust, the same as the NHS as a whole where 77% of staff are women.

An increasing number of organisations now offer staff whose gender is not the same as the sex they were registered at birth a way to record this. This is inclusive of a range of genders, including:

- binary male or female genders when not the same as registered at birth
- non-binary genders such as those on a continuum between male and female
- non-gendered identities (neither male nor female).

Language around this area is still developing, but the most acceptable alternative category to Male and Female genders is currently 'Other', (with some organisations then offering a free text response to self-describe) which would be inclusive of those identities above. DCH patients can choose to record their gender as 'other'. This is not currently an option for staff as ESR only offers the categories 'male or female'.

ACTION: We will work closely with NHS England SW inclusion network and national LGBT+ organisations to ensure our practice is up to date and inclusive.

Our Gender Pay Gap Report will be published separately in August 2020.

3.4 **Ethnicity**

The percentage of BAME staff working for the Trust is increasing. BAME staff account for 10.34% of the total staff population, half of the percentage of BAME staff in the NHS (20.7%[5]), but more than double that of the Dorset population (4.5%), meaning our Trust is much more ethnically diverse than our local population.

3.5 **Religion/Belief**

Diversity in religion/beliefs of our staff continues to increase, with less than half (46.4%) of our staff who disclosed their religion/belief identifying as Christian (a decrease of 2.1% from 2018/19), followed by Atheism (17.2%), 'Other' (7.3%), and Islam (1.4%) However, 25.9% of staff chose to not disclose their religious belief, or did not specify.

3.6 **Sexual Orientation**

77.5% of staff reported their sexual orientation as heterosexual, Those who recorded their sexuality as other than heterosexual (gay, lesbian, bisexual, undecided, other sexual orientation not listed) make up 1.64% of the workforce. However, 20.8% of staff did not declare their sexual orientation.

3.7 It should also be noted that high levels of non-disclosure exist, particularly in regard to sexual orientation and disability, where 20.8% and 23.4% of staff respectively did not declare. Given that staff are able to self-report anytime on ESR, it is to be assumed that there are barriers to disclosure for these groups. If we are to effectively support our staff to be themselves at work, we need to work on improving disclosure rates across all protected characteristics.

4.0 **ED&I Practice in the Workplace**

4.1 **Data and Disclosure**

Organisations which have been successful in improving the rate of disclosure of sexual orientation and other protected characteristics have emphasised the importance of building trust. Positive practices include:

- referring to 'sharing' rather than self-disclosure or recording
- Being clear who will access this information
- Communicating how the data will be used, and how it will make the organisation become more inclusive.
- Regularly sharing the evidence and progress made with staff.

This report and WDES action plan highlights the need to improve our reporting rates for disability in particular, but action will also seek to improve the percentage of staff sharing information on their ethnicity, sexual orientation and gender using the approaches above.

4.2 **Learning and Development**

The Trust is committed to promoting equal and fair access to learning opportunities for all staff and providing appropriate learning and development (L&D) interventions

[5] https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#title

that suit different learning styles and work patterns. All staff members receive Trust training in a number of key areas to meet mandatory requirements. Requests to fund additional training are decided by assessment of prospective learners' applications based on the relevance of training to Trust business and service plans, delivering improved quality to patients, improvement of staff wellbeing, and increased productivity and innovation within the workplace.

See the WRES and WDES action plans below for specific actions related to L&D.

4.3 Recruitment and Resourcing

40% of all applicants in 2019/20 were BAME, and 58% White. This in an increase in percentage of BAME applicants from 27%, and a reduction on the percentage of white applicants from 70% compared to 2019.

Unfortunately, this percentage increase does not positively influence the chance of BAME applicants being shortlisted or appointed. 11% of BAME applicants were shortlisted, compared with 41% of white applicants. Of all BAME people shortlisted, 11% went on to be appointed. Of all white people shortlisted, 25% were appointed. This includes both internal and external appointments. (See 5.2 below).

Applications from candidates indicating their sexual orientation as heterosexual represent 92% of all those received while 4% of respondents did not respond or chose not to disclose their sexual orientation. 4% of applicants described their sexual orientation as other than heterosexual. The data shows a slight increase in the proportion of applicants declaring their sexual orientation.

Male applicant numbers remain lower than those for female candidates when compared to the relatively even gender split of the local population. This trend is representative of the NHS staffing population generally, where women are over represented.

For 2019/20, 5.6% of applicants declared a disability. 33% of applicants with a disability were shortlisted, compared to 29% of non-disabled applicants. Of those shortlisted, 21% of those with a disability were appointed, and 23% of those who did not declare a disability.

4.4 National NHS Staff Survey

Equality, Diversity and Inclusion (EDI) is one of the 11 NHS Staff Survey themes. The Trust scores 9.4 for EDI, equal to 'best' of the 85 Acute Sector organisations with the worst score being 8.3, and the average 9.0. The Trust scores above average on all four key questions on EDI.

Table 2 below shows the Trust's position in relation to key questions from the Survey as compared to the Trust position in 2017, 2018 and 2019 and also the ranking relevant to all other acute trusts that participated.

RAG ratings are compared with the Trust's 2018 performance, benchmark is comparison with the other 85 Acute trusts.

Table 2: Staff Opinion Survey Key questions

Key Question from National Staff Survey	2017	2018	2019	Benchmark compared with other Acute trusts in 2019
All Staff believing the Trust provides equal opportunities for career progression or promotion	92%	91%	92%	Much better than average
BAME Staff believing the Trust provides equal opportunities for career progression or promotion	92%	92%	81%	Better than average
All Staff experiencing discrimination from patients/members of the public in the last 12 months	4.2%	3.7%	2%	Much better than average
BAME Staff experiencing discrimination from patients/members of the public in the last 12 months	18%	23%	18%	Much better than average
All Staff experiencing discrimination from managers/team leaders in the last 12 months	6.7%	6.1%	5%	Better than average
BAME Staff experiencing discrimination from managers/team leaders in the last 12 months	19%	14%	19%	Much worse than average (Median for the benchmark group is 13.8%)

5.0 Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is a mandated NHS assessment that requires NHS organisations to provide a detailed analysis of their existing staff and board compositions as relates to their ethnic origin, using a standard template and WRES calculator.

The assessment requires organisations to submit information about their BME staff, such as their representation per pay band and access to development and promotion opportunities. The standard was launched to ensure that employees from Black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

5.1 WRES Indicator 1: Staff in Agenda for Change pay bands

5.1.1 The percentage of staff in each of the Agenda for Change pay bands 1-9 and very senior managers (including executive Board members) compared with the percentage of staff in the overall workforce is included in Table 3 below.

Table 3: Clinical Staff (non-medical and medical) by Pay Band, white and BAME for 2020 and 2019

Pay Band	2020 White (n)	2020 White (%)	2020 BAME (n)	2020 BAME (%)	2019 White (n)	2019 White (%)	2019 BAME (n)	2019 BAME (%)
Non-medical staff	**1691**		**155**		**585**			
1	0	0%	0	0%	0	0%	0	0%
2	480	92%	24	5%	428	92%	23	5%
3	114	93%	6	5%	104	90%	8	7%
4	11	23%	35	73%	9	64%	5	36%
5	432	81%	73	14%	436	84%	60	12%
6	384	96%	10	3%	353	97%	6	2%
7	213	95%	6	3%	200	95%	6	3%
8a	41	98%	1	2%	40	98%	1	2%
8b	12	100%	0	0%	10	100%	0	0%
8c	2	100%	0	0%	2	100%	0	0%
8d	0	0%	0	0%	0	0%	0	0%
9	0	0%	0	0%	0	0%	0	0%
VSM	2	100%	0	0%	3	100%	0	0%
Medical staff	**293**		**135**		**282**		**121**	
Consultant	110	61%	36	20%	109	62%	32	18%
of which senior medical manager	0	0%	0	0%	0	0%	0	0%
Non-consultant career grade	61	58%	27	25%	46	52%	28	32%
Trainee grades	122	57%	72	33%	127	64%	61	31%
Other	**11**	**100%**	**0**		**14**	**100%**	**0**	

Table 4: Non-Clinical staff by pay band, White and BAME for 2020 and 2019

Pay Band	2020 White (n)	2020 White (%)	2020 BAME (n)	2020 BAME (%)	2019 White (n)	2019 White (%)	2019 BAME (n)	2019 BAME (%)
1	30	94%	2	6%	146	92%	12	8%
2	525	95%	22	4%	401	95%	12	3%
3	286	96%	5	2%	264	96%	6	2%
4	167	98%	1	1%	159	98%	1	1%
5	122	92%	7	5%	120	96%	3	2%
6	109	85%	14	11%	104	86%	10	8%
7	78	96%	2	2%	78	94%	3	4%
8a	46	94%	2	4%	37	95%	2	5%
8b	18	100%	0	0%	18	95%	1	5%
8c	4	80%	0	0%	5	100%	0	0%
8d	5	83%	1	17%	6	100%	0	0%

9	2	100%	0	0%	2	100%	0	0%
VSM	11	92%	1	8%	11	92%	1	8%

5.1.2. Clinical: BAME staff (who make up 10% of the overall staff population) are over-represented at Bands 4 and 5 and under-represented at all other grades with the exception of medical staff.

Non-clinical: BAME staff are under-represented at all grades, with the exception of Bands 6 and 8d.

5.2 WRES Indicator 2: Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants

Table 5: A comparison of White and BAME applicants across all posts, showing likelihood of shortlisting and appointment by percentage.

Candidates:	Applied	Shortlisted (% of those who applied)	Appointed (% of those shortlisted)
White	2095	862 (41% of white applicants)	216 (25% of white shortlistees)
BAME	1423	161 (11% of BAME applicants)	18 (11% of BAME shortlistees)

- BAME applicants have a 1 in 79 chance of appointment
- White applicants have a 1 in 10 chance of appointment

- BAME shortlistees have a 1 in 9 chance of appointment
- White shortlistees have a 1 in 4 chance of appointment

Relative chance of appointment from shortlisting is therefore 2.25. The average for Acute Trusts is 1.44. Of all 226 Trusts whose data is included in the 2019 NHS WRES Data Analysis Report[6], 27 scored over 2.

5.2.1. A total of 3597 applications were received over the 2019/20 year from those hwo disclosed their ethnicity. 79 applicants did not disclose. BAME applicants were 73% less likely to be shortlisted than white applicants, and those shortlisted were 56% less likely to be appointed than white shortlistees.

5.2.2 The Trust monitors equality data for all applicants for posts across conversion rates from application to appointment. The on-line application form used by NHS Jobs and TRAC addresses all of the protected characteristics covered by the Equality Act, with the exception of pregnancy and maternity. Managers are not made aware of applicants' age, race, religion, marital status or sexual orientation when shortlisting and interviewing.

5.2.3. **ACTION** – Increase BAME representation in recruitment process and continue recruitment training programme. See WRES Action 3 p.21.

[6] https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

5.3 **WRES Indicator 3: The relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation**

	2019/20	2018/19
White	26	40
BAME	0	3
Ethnicity not declared	9	7

Ethnicity was not recorded for 26% of those entering the formal disciplinary process for 2019/20. The Trust will need to improve data collection for ethnicity in relation to disciplinary investigations to ascertain the relative likelihood of entering this process for white and BAME staff.

5.3.1 **ACTION –** Support staff to identify bullying behaviours and speak up. Support managers and peers to understand their responsibilities and how deal with these behaviours in a timely and appropriate way. Make clear to all staff what behaviours are unacceptable in the workplace. See WRES Actions 5-8 p.23.

5.4 **WRES Indicator 4: Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff**

Information relating to non-mandatory training participation and CPD is not recorded centrally by the trust. However, 74% of white staff, staff responding to the NHS Staff Survey reported having received non-mandatory training, learning or development in the last 12 months compared to 84% of BAME making the relative likelihood 0.88. With BAME staff 13.5% more likely to have accessed non-mandatory training than white staff, this is a positive indicator for the Trust.

Indicators 5 to 8 are utilising data from the Trust's responses to the NHS Staff Survey. The Trust response rate for 2019 was 44.9%. DCH's response rate has steadily declined since 2015 whereas the national trend is the reverse. This is obviously a worrying trend and one that will be considered in more detail as part of the forthcoming culture review.

5.5 **WRES Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.**

2019 White	2019 BAME	2018 White	2018 BAME
24%	**25%**	**23%**	**29%**

25% of BAME 2019 Staff Survey respondents reported they have experienced bullying harassment or abuse from patients, relatives or members of the public in comparison to 24% of white respondents.

Incidences of bullying, harassment or abuse from patients, relatives or the public have decreased (-4%) for BAME staff, bringing figures in line with those for white staff.

5.6 **WRES Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months**

2019 White	2019 BAME	2018 White	2018 BAME
19%	**33%**	**18%**	**28%**

33% of BAME 2019 Staff Survey respondents personally experienced discrimination at work from a manager, team leader or other colleagues compared to 19% of white staff. There has been a 5 percentage point increase in the number of BAME staff reporting they had experienced bullying, harassment or abuse from staff members, which equates to an 18% increase from the 2018 survey.

5.7 **WRES Indicator 7: Percentage believing that the Trust provides equal opportunities for career progression or promotion**

2019 White	2019 BAME	2018 White	2018 BAME
92%	**81%**	**92%**	**85%**

81% of BAME respondents feel the Trust acts fairly with regard to career progression and promotion, compared to 92% of white respondents. This is a 5% decrease in the percentage of BAME staff believing that the Trust provides equal opportunities for career progression or promotion compared to 2018 survey results.

5.8 **WRES Indicator 8: National NHS Staff Survey. In the last 12 months, have you personally experienced discrimination at work from any of the following: Manager, team leader of other colleagues?**

2019White	2019 BAME	2018 White	2018 BAME
10%	**19%**	**10%**	**14%**

Almost double the percentage of BAME staff than white experienced discrimination from their manager/team leader in 2019. There has been a 5 percentage point increase for BAME staff from last year. **This equates to a 36% increase in BAME staff reporting discrimination compared to 2018 survey results.**

ACTIONS FOR 5.6, 5.7 and 5.8 - Support staff to identify bullying behaviours and speak up. Support managers and peers to understand their responsibilities and how deal with these behaviours in a timely and appropriate way. Make clear to all staff what behaviours are unacceptable in the workplace. See detailed WRES Actions 5-8 p. 23.

5.9 **WRES Indicator 9: Percentage difference between the organizations Board voting membership and its overall workforce**

Percentage of voting board membership who are:

2020 White	2020 BAME	2019 White	2019 BAME
92.3%	**7.7%**	**92.3%**	**7.7%**

The Trust's 13-strong voting board has one BAME member, which has remained the same since the Trust began reporting on WRES. BAME staff make up 10.4% of the total staff population. The percentage of BAME voting board staff members is 26% less than that of the overall workforce. This percentage of BAME representation is

equal to the national average[7] and much better than average in terms of representation of the workforce. The Trust is unique in that the percentage of BAME board membership is higher than that of the local population.

5.10 Other notable findings of the Staff Survey

A higher percentage of BAME than white staff report that they:

- look forward to going to work
- feel time passes quickly when working
- feel trusted to do their job
- are able to do their job to a standard they are pleased with
- are able to meet all the conflicting demands on their time at work

However, during the last 12 months, 47% of BAME staff felt unwell as a result of work-related stress compared to 36% of white staff, and 22% of BAME staff feel they do not have a choice in deciding how to do their work compared to 12% of white staff.

6.0 The Workforce Disability Equality Standard (WDES)

The WDES is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information is reported to NHS England, and used to develop a local WDES action plan, to enable the Trust to demonstrate progress against the indicators of disability equality.

The implementation of the WDES will enable us to better understand the experiences of our disabled staff. It will support positive change for existing employees, and enable a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it will also allow us to identify good practice and compare our performance regionally and by type of trust. Our 2019 WDES results can be found below. This is the second year we have reported against the WDES Metrics, so the first that comparison of the data is possible. ESR shows only **2.9%** of our workforce (90 staff) have declared a disability. It should be noted that **20%** staff have chosen not to declare, or have a disability status recorded as unknown or null.

21% of all our Staff Survey respondents responded 'yes' to the question 'Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?'. This is above sector average (18%), but in line with Dorset demographics. If we are to assume that the 44% of DCH staff who completed the Staff Survey are representative our whole workforce, it means that 644 of our workforce define themselves in this way, and are therefore potentially protected under the Equality Act 2010.

[7] https://improvement.nhs.uk/documents/2620/NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf

6.1 **WDES Metric 1:** Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the workforce overall

Data held on ESR was extracted for the number and percentage of both disabled and non-disabled staff in 2020 and 2019 broken down into Bands 1-9, Very Senior Managers, and 'Other' for clinical and non-clinical roles.. However, due to the low percentage of staff recorded with a disability on ESR (2.9%), it was not possible to draw any conclusions from this and it also presented a risk of identifying individuals at particular grades.

ACTION: Launch internal communication campaign to raise awareness of 'What is a disability?' and the benefits of reporting disability status. Offer staff the opportunity to self-report when taking part in mandatory training. Increase knowledge, understanding and awareness of line managers. See specific WDES actions 1-3 p 24 and 25.

6.2 **WDES Metric 2:** Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

2020				2019			
Candidates	Applied	Shortlisted	Appointed	Candidates	Applied	Shortlisted	Appointed
Non-disabled:	3324	950 (29%)	221 (23%)	Non-disabled:	Data not available	1521	399 (26.2%)
Disabled:	201	67 (33%)	14 (21%)	Disabled:	Data not available	74	18 (24%)
Don't wish to disclose not stated:	72	43 (60%)	25 (58%)	Don't wish to disclose/not stated:	Data not available	Data not available	Data not available

6.3% of shortlisted applicants and 5.4% of all staff appointed had declared a disability. Staff with a disability have a 21% chance of being appointed in comparison to 23 % of non-disabled staff. This is a relative likelihood of 1.1 which is a positive result for the Trust. Only 2% of applicants have not disclosed or stated their disability status. This means that the vast majority of our new workforce are happy to disclose.

6.3 **WDES Metric 3:** Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process.

2019/20		2018/19	
Non-disabled	1 (0.04% chance)	Non-disabled	2
Disabled	1 (0.85% chance)	Disabled	6
Not declared	5	Not declared	11

The Trust only holds disability data on 29% (two individuals) of those who entered the formal capability process in 2019/20. It is therefore not possible to draw any conclusions from these figures.

6.3.1 It is important to note that the figures for indicator 3 above are based on the rates of disability recorded on ESR, which evidence from the Staff Survey and local population data would suggest are significantly under-reported. In order to collect accurate data on our staff, the Trust needs to encourage all employees to self-report their disability status. This can be done by wellbeing & inclusion awareness events and campaigns, explaining the benefits to the workforce of self-reporting to staff attending mandatory training so they do so 'there and then', and by continuing to work on increasing awareness and reducing stigma (such as through the Mental Health First Aid programme) to support those with long term conditions to self-report. See WDES Action Plan Actions 5 and 6 p.25.

6.4 The next five indicators (4 to 8) are based in the responses given by Disabled and non-disabled Trust staff in the 2019 NHS Staff Survey. Staff who answered 'yes' to the question: 'Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?' are recorded as disabled. The above is the standard definition of disability used by the Equality Act 2010[8]

6.4.1 **WDES Metric 4a:** Percentage of staff experiencing harassment, bullying or abuse in the previous 12 months from i) patients, relatives or the public, ii) Managers/Team leaders, iii) Other Colleagues

	2019			**2018**		
	i) Patients, Relatives or Public	ii)Managers or Team Leaders	iii) Other Colleagues	i) Patients, relatives or public	ii) Managers or Team Leaders	iii) Other Colleagues
Non-disabled	24%	8%	18%	23%	8%	17%
Disabled	27%	18%	26%	27%	20%	24%

i) This is in line with the average national response for staff both with and without a disability.

ii) **More than double the percentage of disabled staff than non-disabled reported bullying from a manager** but slightly lower than previous year. Sadly, this is in line with national average for other Acute trusts.

iii) An increase, but remaining better than average compared to other Acute trusts.

ACTION: Develop and deliver Communications strategy for Freedom to Speak Up. Identify staff who may be particularly vulnerable to bullying, or have barriers to speaking up and target support from FTSU Champions. Offer line managers awareness sessions on disability, plus specific conditions/issues affecting the workforce e.g. neurodiversity, menopause. **(**See detailed WDES actions 6, 7 and 8 page 26.

[8] https://www.gov.uk/definition-of-disability-under-equality-act-2010

6.4.2 **WDES Metric 4b:** Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

	2019	2018
Non-disabled	**43%**	**57%**
Disabled	**48%**	**46%**

This is a positive increase for Disabled staff, taking the Trust from below average (2018) to in line with national average. There has, however, been a significant drop in non-disabled staff reporting bullying or abuse.

ACTION: Develop and deliver Communications strategy for Freedom to Speak Up. Identify staff who may be particularly vulnerable to bullying, or have barriers to speaking up and target support from FTSU Champions. See WDES actions 7 and 8 page 26.

6.5 **WDES Metric 5:** Percentage of Disabled staff compared to non-disabled staff believing that the trust acts fairly with regards to career progression and promotion.

	2019	2018
Non-disabled	**92%**	**92%**
Disabled	**86%**	**89%**

This is a very small negative decrease, remaining well above Acute trusts average (79%) for disabled staff.

6.6 **WDES Metric 6:** Percentage of Disabled staff compared to non-disabled staff saying they had felt pressure from their line manager to come to work despite not feeling well enough to perform their duties in the previous 12 months.

	2019	2018
Non-disabled	**18%**	**21%**
Disabled	**34%**	**31%**

The number of disabled staff who feel pressure from their line manager to come to work despite not feeling well enough to perform their duties is **almost than double that of non-disabled staff.**

ACTION: Continue to expand MHFA Programme. Offer line managers awareness sessions on disability, plus specific conditions/issues affecting the workforce e.g. neurodiversity, menopause. See WDES actions 5 and 6 page 26.

6.7 **WDES Metric 7:** Percentage of staff saying they are satisfied with the extent to which their organisation values their work

	2019	2018
Non-disabled	**53%**	**50%**
Disabled	**40%**	**34%**

This is a significant improvement from 2018, but still a large gap between disabled & non-disabled staff. Both figures are above average, showing that this gap is a national issue. Actions detailed in the WDES action plan around leadership training and communication aim to narrow this gap

6.8 **WDES Metric 8:** Percentage of staff saying their employer has made adequate adjustment(s) to enable them to carry out their work

	2019	2018
Non-disabled	N/A	N/A
Disabled	**81%**	**78%**

This is an improvement, on last year, and well above the Acute trust average (73%).

6.9 **WDES Metric 9a:** NHS Staff Survey - Staff engagement score for disabled staff, compared to non-disabled staff, and the Trust's overall score.

	2019	2018
Non-disabled	**7.3**	**7.3**
Disabled	**6.9**	**6.7**
Overall DCHFT Score	**7.2**	**7.2**

This shows a decrease in the gap between disabled and non-disabled staff scores and is above the average NHS Acute trust score of 6.6 for disabled staff.

WDES Metric 9b: Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

We have staff members with disabilities ion our EDI steering group, and support individuals with disability-related issues. However, the Trust has not yet taken specific actions to engage all our disabled staff. This features in the WDES action plan.

6.10 **WDES Metric 10:** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by voting membership of the Board and Executive membership of the Board

	2019/20 Board Membership		
	Voting	Non-voting	Executive
Non-disabled	**69%**		
Not declared	**31%**		
Disabled	**0%**		
Overall DCHFT workforce with disability	**2.9%**		

If has not been possible to obtain disability data on the voting/non-voting/executive membership. It can be noted that 31% of the Board have not declared their disability status.

ACTION: IWL to review data held on Board membership and improve reporting where confidentiality allows. Board members to be included in the work to improve reporting rates.

7.0 Covid-19 – Implications for the EDI Agenda

The current Covid-19 pandemic appears to have laid bare health inequalities across the world. According to the latest data from the ONS:

Black males are 4.2 times more likely to die from a COVID-19-related death and Black females are 4.3 times more likely than White ethnicity males and females, with people of Bangladeshi, Pakistani, Indian and mixed ethnicities also having a statistically significant raised risk of death involving Covid-19 compared to those of White ethnicity.

Of 119 NHS staff known to have died in the pandemic, 64 per cent were from an ethnic minority background (only 20 per cent of NHS staff are from an ethnic minority background)[9]

The specific reasons as to why NHS staff are three times more likely to die of Covid 19 than their white counterparts are no doubt complex, and yet to be concluded. Some people of particular ethnic groups are more likely to experience health issues such as diabetes, which is known to place people at higher risk of death from Covid-19. However, all NHS staff of ethnic minorities are culturally and ethnically distinct. There is certainly no 'genetic common-denominator' across this part of our workforce which can explain this alarming death rate. Research in this area is currently lacking, but what this pandemic seems to have shown is the increased risk across people of many ethnic minorities are related to racial inequality. These inequalities have also been brought starkly into focus by the death of George Floyd and the Black Lives Matter movement.

Professor David Williams of Harvard University has written and spoken widely on the global phenomenon[10] of non-dominant racial groups having worse health than the dominant racial group.

Males, people with long term physical and mental health conditions and learning disabilities, and those who are LGBT+ are also known to experience more barriers to healthcare access, and poorer health outcomes.

In order to safeguard those most at risk of Covid-19, NHS England has issued guidelines on Risk Assessment for at-risk staff groups, based on current data.

7.1 Actions the Trust has taken to date to support at-risk groups:

- The Acting CEO wrote to all recorded BAME staff on 1st May to outline support available from managers, how to access the HR Hub, and how to Speak Up in confidence.
- Regular listening and update sessions have been held on MS Teams to which all BAME staff have been invited.
- Managers have been instructed to complete an individual risk assessment for all at-risk staff, including every BAME staff member by 17th July 2020.
- The Trust is also submitting an application to the latest round of NHS CT funding to support those groups disproportionately affected by Covid-19. If successful, this will enable us to provide more support for these staff and patients.

[9] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
[10] https://nhsproviders.org/media/1253/prof-david-r-williams-ace-slides.pdf

7.2 Plans in place to support BAME staff through the Covid recovery period:

Work will focus around the five priorities identified by Prerana Issar, NHS Chief People Officer:

- **Protection of staff** (including returning staff)
- **Engagement with staff** and staff networks
- **Representation in decision making** to ensure that BAME staff have influence over decisions that affect them.
- **Rehabilitation and recovery** to ensure there is tailored and ongoing health and wellbeing support.
- **Communications and media** to ensure that the contribution of our BAME colleagues is not fully represented in the mainstream media.

These priorities will feature in the upcoming Equality, Diversity & Inclusion Strategy, and are reflected in the WDES Action Plan.

8.0 **Strategy development**

The Trust has started the journey to a more strategic approach to the ED&I agenda through the Board Development programme in 2019/20. This will now be built on to become a Trust wide strategic plan and associated actions plan.

The approach is still to be finalised, however the draft approach is detailed in Appendix 2.

9.0 Conclusion9.1 Recent events have brought the global impact of health, racial and social inequalities into stark focus. This has brought about a realisation that real change is needed across the NHS to address the inequalities affecting our staff. Within our own organisation, the Trust scored above average in all four EDI-related areas of the 2019 Staff Survey compared to other Acute trusts, but the data above highlights some clear inequalities in the experiences of our staff from Black, Asian and other minority ethnicities, meaning their experience falls well below average.

9.2 The draft WRES and WDES Action Plans lay out initial steps that the Trust can take to begin to redress the balance. These changes will not occur by simply acknowledging diversity – for DCHFT to be a place where all staff feel they belong, we will need act to change 'culture, behaviours, resources, processes and structures, which (can) either promote or inhibit the full and equal engagement of all individuals'.[11]

9.3 ED&I Strategy development will be for a fundamental part of the Trusts culture review programme and Ethnicity being prioritised in the initial phase.

[11] [11] https://uwe-repository.worktribe.com/output/852067/inclusion-the-dna-of-leadership-and-change p.23

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
WORKFORCE RACE EQUALITY STANDARD (WRES) ACTION PLAN 2019/20

WRES ACTION PLAN PROGRESS REPORTING TEMPLATE	
Start date:	**July 2020**
Latest update:	
Lead Manager:	**Bernadette Pritchard, Inclusion and Wellbeing Lead**
Lead Director:	**Mark Warner – Head of Workforce**
Monitoring Committee:	**Executive Board / Workforce Committee**
Sign-off date:	

1. delivered
2. on track
3. off track

What is the issue?	**The Trust workforce has 'Diversity' – the percentage of DCHFT staff from minority ethnicities is double that of the local Dorset population. However, data from the 2019 staff survey indicates the Trust does not have 'Inclusion' across its environment and culture.**
What are we doing about it already?	• Dedicated Inclusion and Wellbeing lead (IWL) appointed October 2019 • IWL regularly meets and shares good practice with other leads form across Dorset & South West. • Board Development Programme – led by Eden Charles 2019/2020 • Chief Executive is chair of EDI steering group. • Successful application to NHSE Diversity & Inclusion Partners Programme

What action will we take to address this issue in 2020/21?

ACTION	MEASURE	LEAD (S)	TIMESCALE	RAG	PROGRESS
1. Publish Equality, Diversity and Inclusion Strategy. **2. Take part in the NHS E & Leadership Academy Inclusion Programmes**	All staff know what the Trust's plans are to address inequalities and ensure this organisation a place where all staff feel they belong. Completion of the programme by IWL Lead and a board member.	IWL Lead IWL Lead	**April 2021**		IWL Lead and CEO took part in the introductory session of NHS Employers Diversity and Inclusion Partners

	Increase in number of BAME colleagues accessing mentoring and coaching.				Programme on 02/07/20 Awaiting contact from NHS LA as soon as the programme resumes.
What is the issue?	**Recruitment – Inequality in shortlisting and appointment of BAME staff.**				
What are we doing about it already?	• Shortlisting through TRAC requires rationale for shortlisting • At least 2 people required to shortlist • Interview assessment sheets require scoring • Recruitment website images representative of DCH staff population • Some EDI issues covered on recruitment training including bias – review of EDI content already part of work plan.				
What action will we take to address this issue in 2020/21?					
ACTION	**MEASURE**	**LEAD (S)**	**TIMESCALE**	**RAG**	**PROGRESS**
3. Full review and refresh of EDI element of Recruitment training focusing on inclusive culture and practice.	Recruitment training includes key elements of cultural competence and inclusion. Increase in percentage of BAME staff both shortlisted and appointed. Applicants report that the recruitment process is an inclusive experience.	Recruitment /OD/Leadership/ IWL Lead/BAME Network	**Dec 2020**		
What is the issue?	**Recruitment – Over-representation of BAME clinical staff at Bands 4 and 5, with under-representation at all others with exception of medical staff. Under-representation of BAME non-clinical staff at all Bands/grades.**				

What are we doing about it already?	• Advertise and encourage staff from ethnic minority groups to take part in leadership programmes such as the NHS Leadership Academy's 'Stepping Up' programme[12] and Florence Nightingale Foundation Windrush Nurses & Midwives Programme. • Involve senior nursing staff from ethnic minority groups in the planning and implementation of in-house career-development programmes.				
What action will we take to address this issue in 2020/21?					
ACTION	**MEASURE**	**LEAD (S)**	**TIMESCALE**	**RAG**	**PROGRESS**
4. **Include a BAME person as a panel member for as many Band 6, 7 and 8a clinical interviews as possible.**	Increase in number of BAME colleagues being appointed in Band 6, 7 and 8a clinical posts. Increase in number people of ethnic minorities appointed to non-clinical posts at all levels. Improved recruitment and retention of BAME colleagues	Recruitment Team/HR/IWL Lead/ BAME Network	**March 2021**		
What is the issue?	**High and disproportionate rates of BAME staff reporting discrimination from managers/team leaders in the last 12 months**				
What are we doing about it already?	• Established network of Freedom to Speak Up Champion Network, representing the diverse ethnicities of Trust staff. • Information on how to speak up included in all communications with BAME staff				

[12] https://www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme/

	Freedom to Speak Up Guardian is also responsible for Inclusion enabling promotion of the role across				
ACTION	**MEASURE**	**LEAD (S)**	**TIMESCALE**	**RAG**	**PROGRESS**
5. Set out clear and helpful guidelines and standards of behaviours deemed to be acceptable and un-acceptable as well as offering colleagues a safe space to talk in confidence.	Fewer incidents of discrimination and racism reported through formal processes, improved staff survey results.	**IWL Lead**	**December 2020**		Draft guidelines and standards proposal for behaviours and will be shared with the BAME Network & Freedom to Speak Up Guardians for feedback.
6. Training for line managers in what constitutes bullying/harassment and discrimination, how to deal with bullying behaviours, and have culturally competent conversations.	BAME colleagues have confidence that the Trust holds a zero tolerance approach to discrimination and racism. Line managers report increased confidence, knowledge and understanding in preventing and dealing with bullying behaviours		**March 2021**		Development of a bite-size training package that is targeted at line managers to be rolled out Trust wide. This requires dedicated focus due to the staff survey results showing an increase in the number of colleagues feeling discriminated at work from their manager/team leader or colleagues.
7. Offer information at induction and for current staff on bullying/harassment, how to identify these behaviours and Speak Up **8. Identify staff who may be isolated and vulnerable to bullying /Harassment and provide targeted support**		**IWL Lead/Freedom to Speak Up Guardian & Champions /BAME Network**	**December 2020**		

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
WORKFORCE DISABILITY EQUALITY STANDARD (WDES) ACTION PLAN 2019/20

WDES ACTION PLAN PROGRESS REPORTING TEMPLATE	
Start date:	**July 2020**
Latest update:	
Lead Manager:	**Bernadette Pritchard, Inclusion and Wellbeing Lead**
Lead Director:	**Mark Warner – Head of Workforce**
Monitoring Committee:	**Executive Board / Workforce Committee**
Date signed off as complete	

RAG: **Delivered**
On track
Off track

What is the issue?	**Under-reporting of disability status on ESR compared to NHS Staff Survey**
What are we doing about it already?	• Staff are able to self-report via ESR at any time

What action will we take to address this issue in 2020/21?

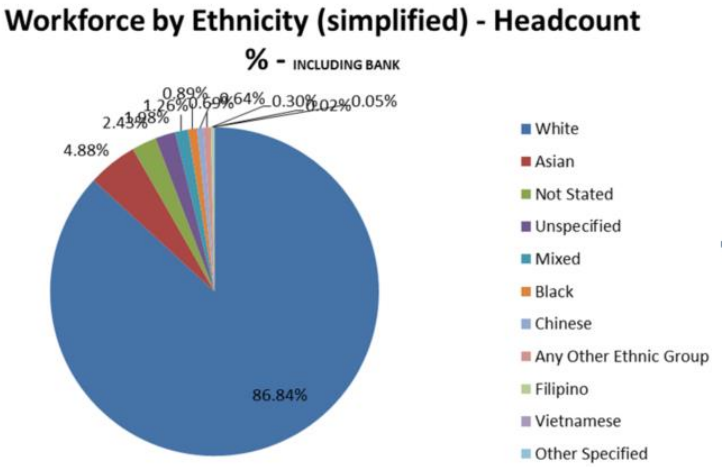
ACTION	MEASURE	LEAD (S)	TIMESCALE	RAG	PROGRESS
1. Internal Comms campaign to raise awareness of 'What is a disability?' and the benefits of reporting disability status. **2. Offer staff the opportunity to self-**	Increase in percentage of staff recorded as having a disability to nearer that reported in NHS Staff Survey ESR data used for 2020/21 WDES will be more accurate and enable Trust to identify	IWL/ Comms	**April 2021**		

report when taking part in mandatory training. **3. Increase knowledge, understanding and awareness line managers (see Actions 5&6)**	any issues.				
What is the issue?	**No dedicated forum for the voices of staff living with long term health conditions and disabilities to be heard.**				
What are we doing about it already?					
What action will we take to address this issue in 2020/21?					
ACTION	**MEASURE**	**LEAD (S)**	**TIMESCALE**	**RAG**	**PROGRESS**
4. Engage with staff to establish need for a staff network for people with disabilities.	Staff Network or alternative is established.	IWL			IWL to publicise the finding of NHS staff survey that 20+% of our staff have long term health conditions or disability.
What is the issue?	**A disproportionate number of disabled staff feel pressure from their manager to come to work despite not feeling well enough to perform their duties**				
What are we doing about it already?	• Mental Health First Aid Programme • HR Helpline to support with HR policy/processes/Flexible working/Reasonable adjustments?				

What action will we take to address this issue in 2020/21?					
ACTION	**MEASURE**	**LEAD (S)**	**TIMESCALE**	**RAG**	**PROGRESS**
5. Continue to expand MHFA Programme **6. Offer line managers awareness sessions on disability, plus specific conditions/issues affecting the workforce e.g. neurodiversity, menopause.**	Increase in percentage of Trust staff trained in MHFA. Staff report increase in confidence knowledge and understanding. Increase in line managers' knowledge and understanding of disabilities	IWL Lead/ Leadership/ Education			Application made to NHS Charities together for funding to support awareness training for managers.
What is the issue?	**Sharp decrease from 2018 in percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**				
What are we doing about it already?	• Freedom to Speak Up Guardian and Champions network • Freedom to Speak Up Vison and Strategy, plus supporting HR Policies and training in place.				
ACTION	**MEASURE**	**LEAD (S)**	**TIMESCALE**	**RAG**	**PROGRESS**
7. Develop and deliver Comms strategy for Freedom to Speak Up. **8. Identify staff who may be particularly vulnerable to bullying, or have barriers to speaking up and target support from FTSU Champions.**	Increase in percentage of staff in 2020 survey who when they experienced abuse, reported it.	**IWL Lead/** **Freedom to Speak Up Guardian & Champions/** **BAME Network**	**December 2020**		

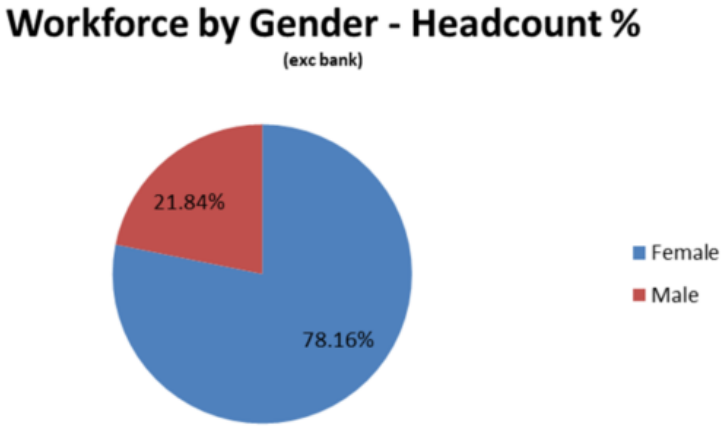
APPENDIX 1: ADDITIONAL WORKFORCE DATA

ETHNICITY	*HEADCOUNT*	*% (of headcount)*	*FTE*
Not Stated	98	2.43%	68.49
Unspecified	80	1.98%	30.57
Mixed	51	1.26%	30.36
Black	36	0.89%	29.56
Chinese	26	0.64%	17.90
Any Other Ethnic Group	28	0.69%	21.31
Filipino	12	0.30%	9.40
Vietnamese	1	0.02%	1.00
Other Specified	2	0.05%	1.80
GRAND TOTAL	**4035**	**100.00%**	**2632.85**



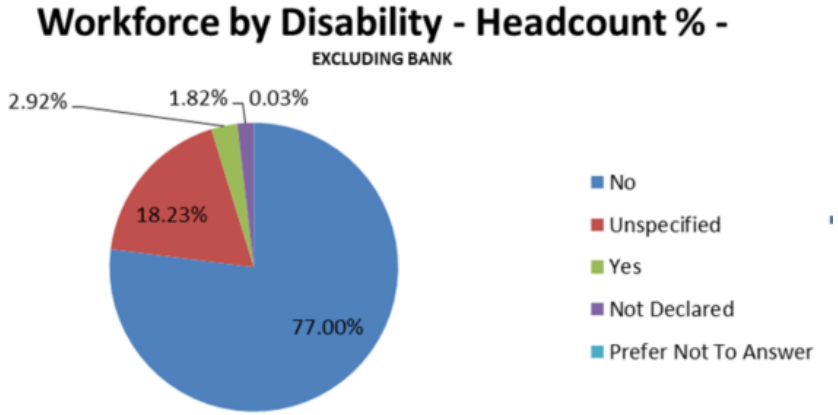
GENDER

EXCLUDING BANK				
Gender	Headcount	% (of Headcount)	FTE	% (of FTE)
Female	2409	78.16%	1999.879	76.02%
Male	673	21.84%	630.9676	23.98%
GRAND TOTAL	3082	100.00%	2630.846	100.00%



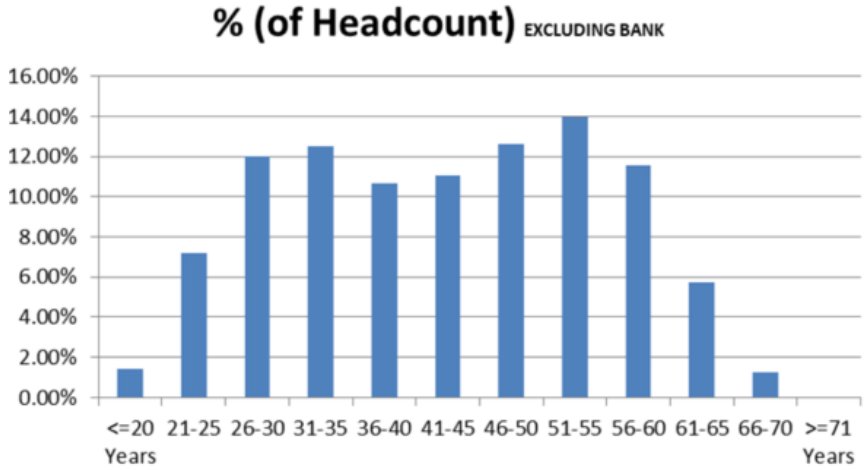
DISABILITY

EXCLUDING BANK			
Disability Flag	Headcount	% (of Headcount)	FTE
No	2373	77.00%	2049.48
Unspecified	562	18.23%	459.29
Yes	90	2.92%	77.63
Not Declared	56	1.82%	45.69
Prefer Not To Answer	1	0.03%	0.76
GRAND TOTAL	3082	100.00%	2632.85



AGE

EXCLUDING BANK			
Disability Flag	Headcount	% (of Headcount)	FTE
No	2373	77.00%	2049.48
Unspecified	562	18.23%	459.29
Yes	90	2.92%	77.63
Not Declared	56	1.82%	45.69
Prefer Not To Answer	1	0.03%	0.76
GRAND TOTAL	3082	100.00%	2632.85



EXCLUDING BANK			
Sexual Orientation	Headcount	% (of Headcount)	FTE
Heterosexual or Straight	2410	59.73%	2077.21
Unspecified	433	10.73%	349.79
Not stated (person asked but declined to provide a response)	189	4.68%	157.42
Gay or Lesbian	31	0.77%	29.91
Bisexual	18	0.45%	17.51
Other sexual orientation not listed	1	0.02%	1.00
Undecided	0	0.00%	0.00
GRAND TOTAL	3082	76.38%	2632.85

Appendix 2

Equality Diversity & Inclusion Strategy Development
July 2020 Draft Project Plan

1. Background

The need for a Trust wide ED&I strategy has been apparent for some time and it was hoped this would have been completed building on the work undertaken by the Board earlier in the year and aligned to a wider Culture Review programme. The national response to Covid caused all strategy development work to pause, however as we move into the next phase of this we can consider restarting this work. This is also appropriate given the focus given to this agenda nationally within the NHS and the international Black Lives Matter movement.

2. Methodology

It is proposed that the Johnson and Scholes culture web model is followed to carry out the strategy development. This essentially involves assessing the current culture and issues in existence, mapped against six cultural influences, describe what vision is aspired to, and identifying the actions required to move from current to the desired state – the Paradigm shift.

The six cultural influences are: stories, rituals and routines, symbols, organisational structure, power structures and control systems.

When Board members used this process with 1-2-1 discussions earlier in the year it was found difficult to follow and information needed to be 'retro fitted' to the model. Learning from this, it will be important that the discovery phase is felt relevant to people and discussions are focussed on issues and experiences that people can relate to.

The Culture Web model is however useful to ensure we focus on a "cultural" shift, rather than just a identifying a list of actions.

Most importantly, the development of the strategy should feel an engaging process with our community; recognising that it needs to be led by the Board.

3. Scope

The Equality, Diversity & Inclusion agenda is wide ranging and is based around the nine Protected Characteristics identified in the Equality Act 2010**:** age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

In order to make appropriate progress in relation to the various characteristics we may wish to consider a phased approach to the programme. Given the current focus on ethnicity and the disparities that exist between different ethnic group, it is recommended that the first phase of the work focuses on ethnicity.

Later stages of the programme will then look at all other protected characteristics.

4. Discovery phase

The initial phase of the project will bring together information to inform the current status or culture within the Trust. This will include metrics and data as well as observations, interviews and output from group discussions. Much of this information is already available through he staff survey and work undertake through the Board development programme, however things have changed since that time and it is important that we ensure the input is comprehensive, representative and current.

5. Strategy development

Following the discovery phase, we will develop the vision for the future and identify areas for development.

Reference will also be made to the national work on this agenda and ensure our strategy supports the national objectives. The headings for this work have been identified as:

a) **Protection of staff** - to ensure that risks to individuals are prioritised and managed effectively, and that all staff feel able and empowered to raise concerns safely.

b) **Engagement with staff** - to enable us to hear and learn from your lived experience, share guidance and hear from you what actions we need to take and what support we can provide

c) **Representation in decision making** - to ensure that BAME staff have influence over decisions that affect them.

d) **Rehabilitation and Recovery** - to ensure there is tailored and ongoing health and wellbeing support during and after the crisis for BAME colleagues.

e) **Communications and Media** - to ensure that all public health communications are tailored to reach different communities, and that the contribution of our BAME colleagues is better represented in our internal and external communications and media.

There is a risk that waiting to align with national initiatives will delay our own planning and implementation and it is likely that will need to progress elements concurrently to national initiatives.

6. Implementation

Implementation will be against an agreed action plan and progress reviewed through the Workforce Committee and Board. The role of the ED&I steering group will be confirmed and any other governance and oversight.

As mentioned above, it is important we are not delayed in our implementation and it will be important to keep momentum and respond to the issues already raised. One issue that has come up in terms of engagement is a lack of confidence that things will change and to build on the engagement we have started, it will be important we are seen as responsive and moving at pace.

7. Resources

It is anticipated that this will require dedicated resource to take forward and considered against any wider culture review programme. There is a risk this will lose focus if this is part of a wider programme, although this is clearly fundamentally part of culture. The proposal is to focus on this programme in its own right and defer any wider culture review programme.

We currently have one Band 7 member of staff (Bernie Pritchard) covering Diversity & Inclusion as well as Health & Wellbeing. Since the Covid outbreak the focus has been on Health & Wellbeing and there will be a continued need to prioritise this important agenda.

We are also in the process of recruiting a 0.8 FTE Head of OD. It is envisaged that this appointee will play a key role in this strategy development and implementation; however they will also have responsibility for Leadership Development, Health & Wellbeing, Staff Survey and other tactical OD interventions.

There is the possibility of using an external consultant, Eden Charles, to provide guidance in terms of strategy development, which I believe would be very helpful. We are also aware that Yvonne Coghill has offered some assistance with the implementation of the strategy once it is agreed. The Director of Workforce and OD and the Chief Executive will also play a key role in the strategy development and implementation.

Looking at the resources overall, I believe we should consider having a dedicated resource covering ED&I and the FTSUG role, and recruit a dedicated resource to manage the Health and Wellbeing agenda (Band 6/7) and a more junior role to support from an operational perspective (Band 4/5) which could flex between both portfolios.

8. Time line

The Black Lives Matter movement presents a great opportunity to gather learnings and material and also to capitalise on the heightened awareness and national focus on equality, diversity and inclusion. There has never felt a better or more important time to launch this work.

From an operational perspective we are also heavily engaged in the next phase of the Covid recover work and organisational resources are clearly stretched. As mentioned, the need to continue to focus on the health and wellbeing of our staff is also paramount. Finally, we are interviewing for the OD Lead role on the 17th June and may not have that person in role for a number of months.

It is proposed that we mobilise and set up the programme during July, run the “discovery” phase of the project from August to October. We would then move to “development” phase from November – January, with implementation from February 2021. There will however be the opportunity to progress tactical initiatives ahead of this time scale and we will identify these opportunities as they emerge. These timescales will should align to the availability of Yvonne Coghill and benefit from the learnings form her work in London.

Dorset County Hospital
NHS Foundation Trust

Title of Meeting	**Board of Directors**
Date of Meeting	**29 July 2020**
Report Title	**Board Assurance Framework**
Author	Paul Lewis, Head of Transformation
Responsible Executive	Nick Johnson, Director Strategy, Transformation & Partnerships

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 Outstanding Services and Sustainable 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. All Executives were asked to review and provide updates where appropriate to the relevant BAF items.

6. The following section outlines the substantial changes made to the BAF since the last period:

    - Updates to the control mechanisms for objective 3 – Collaborative.
        - The SW region has just prioritised the expansion of ED as their top priority.
        - CEO is the SRO for the Dorset maternity transformation programme which is a national priority in the LTP.
        - CEO Poole/RBCH and DCH have agreed that when appointments are reviewed for clinical leads at a specialty level to lead the transformation work, there needs to be balance between the East and West.
    - A reduction in to overall risk score for Sustainability

○ The Trust is on plan to meet its financial targets this year although the revision to the financial regime from August has not been formally published so there is a degree of uncertainty. ○ Similarly the financial planning parameters for next year are not known and without a significant increase in income is likely to mean the trust will continue with a sizeable underlying deficit. • Changes to the control and reporting mechanisms for objective 4 Enabling & Empowering staff. ○ Ongoing recruitment of Head of OD to focus on the delivery of an Organisational Culture review programme ○ Diversity and Inclusion/ Wellbeing Manager appointed to provide a dedicated resource to this agenda. ○ Health and Wellbeing champions have been identified to ensure local action plans developed and discussed. ○ BAME staff network launched
Paper Previously Reviewed By Executive Management Team Risk and Audit Committee, 21 July 2020
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 is requested to: • review the Board Assurance Framework; and • note the high risk areas

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: MARCH 2020

Summary Narrative

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

We may not have the appropriate workforce in place to deliver our patient needs. We continue to experience increasing dependancy on the use of temporary clinical staff and the failure to maintain spend within the regulator ceiling for agency staff. The current COVID-19 Pandemic is putting severe strain on the Trust in the short term which may have consequences for the longer term achievement of the Strategic Objectives. However, it is too early to determine this.
There is also a high risk in ensuring we are SUSTAINABLE. The Trust is on plan to meet its financial targets this year although the revision to the financial regime from August has not been formally published so there is a degree of uncertainty. Similary the financial planning parameters for next year are not known and without a significant increase in income is likely to mean the trust will continue with a sizeable underlying deficit. The strength of control and assurance however remains the same.

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

Objective	Range of Risk Scores	Strength of Controls	Strength of assurance
1. Outstanding: Delivering outstanding services every day. We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	**6-20**	**A**	**G**
2. Integrated: Joining up our Services. We will drive forward more joined up patient pathways, particularly working more closely with and supporting GP's.	**2-20**	**A**	**G**
3. Collaborative: Working with our patients and partners. We will work with all of our partners across Dorset to co-design and deliver efficient and sustainable patient-centred, outcome focussed services.	**6-12**	**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.	**5-16**	**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	4	**12**	6
R3	Not achieving national and constitutional performance and access standards	IR	4	4	**16**	12
R4	Not having effective Emergency Preparedness, Resilience and business continuity plans	IR	3	2	**6**	6
R5	Not having the appropriate workforce in place to deliver our patient needs	MW	4	5	**20**	12
R6	Failing to improve the Trust SHMI index	AH	4	4	**16**	9

B) We will CONTROL these risks by...		**Strength**	**C) The REPORTING MECHANISM...**	**Strength of Delivery**
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits). ICS quality surveillance Group monitors and scrutinises safety and quality with the system and the regulator. (R1)	G	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 remain in 'Routine Surveillance' with acknowledgement to planned waiting list RTT risk.	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 . Select number of KPIs not at standard being managed as Quality Improvement programmes (MUST/VTE) with investment required for Dementia team to address Dementia. Reductions seen in Patient experience relating to planned admission and cancelled operations - related to access constitutional standards - gap in assurance and reduced strength in delivery	A
C3	Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement (R3)	G	Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee	G
C4	Performance Framework - triggers for intervention/support (R3)	A	Performance monitoring via weekly PTL meetings and monthly Divisional Performance Meetings (through to Sub-Board and Board). Divisional Performance Framework presented at July 2019 Trust Board.	G
C5	Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE (R4)	G	Reporting from EPRR Committee to Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership.	G
C6	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 joint working to mitigate and collectively tackle Dorset workforce issues	A
C7	Scrutinising other care quality indicators to assure standards of care (R6)	A	Regular reports to Hospital Mortality group , Quality Committee and Board	G
C8	Poor data capture drives patient coding which effects SHMI (R2)	A	Internal audit of sample of 1000 patient notes and national benchmarking undertaken by PWC	A
Overall Strength		A		G

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

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	November 2018 CQC rating as 'Good', remain on Routine Surveillance at system and regulator level through Quality Surveillance Group (QSG). Quarterly review with Regulators review of KPIs (CQC; NHSI/E).	CQC report. QSG notes. Other benchmark datasets via internal KPIs. National patient surveys
C2	National benchmarked datasets such as RCEM, ICNARC, HQIP, Surveys	Quality Committee and Divisional Reports
C3	CCG assurance visits and contract monitoring	CCG assurance reports
C4	Internal performance reports	Board and FPC reports
C2	External auditors - Quality Account (transparency and accuracy of reporting)	Board and QC reports
C5	Internal Audit of systems and processes; and CCG assurance of the EPRR standards	Audit Committee and Board
C1	External review of Divisional Governance Structures and the PWC Well Led Review	Quality Committee and Board
C6	Monthly workforce reports detailing vacancies and trajectories.	Strategic Resourcing Group, Workforce Committee
C8	NHSE/I regular scrutiny and support (R6)	Ongoing NHSi/E reviews

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

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		**ACTION**
C1	CQC inspection process being redefined as it progresses, 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**
C2	Significant resource constraints to deal with increased demand for both Elective and Emergency services.	System wide working on changes to care models and capacity and demand analysis to identify areas for additional investment. Escalation via Elective Care Board, Urgent Emergency Care Board, OFRG and SLT.
ISSUE 3		**ACTION**
	Uncertainty over no deal Brexit and associated impact on procurement, staffing and charging of overseas patients.	Receiving regular briefings from regional team, participation in national data submissions, task and finish group reporting to Audit Committee.
C5	COVID-19 new virus that requires responsiveness to new guidance and ERPP planning	COVID-19 Incident Management Team in place with a steering group overseeing all actions and planning. Responsiveness to changes in national guidance daily with assurance reports on actions in place.
ISSUE 4		**ACTION**
C4	Inconsistent application of the Performance framework within the Divisions leading to failure to pick up early warnings of deteriorating performance	
ISSUE 5		**ACTION**
C6	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) The SW region has just prioritised the expansion of ED as their top priority. CEO is the SRO for the Dorset maternity transformation programme which is a national priority in the LTP. CEO Poole/RBCH and DCH have agreed that when appointments are reviewed for clinical leads at a specialty level to lead the transformation work, there needs to be balance between the East and West.	A	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	A
C3	All improvement programmes (Elective Care Recovery and Sustainability Programme) (R2)	G	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	G
C4	Divisions supported by the Transformation Team (DCH) integral part of Locality and service redesign meetings (R3)	G	SMT Meeting updates and escalation to Execs and Board where applicable	G
C5	Investment in DCH workforce planning team. 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		G		G

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

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

REF	ASSURANCE	EVIDENCE
C1	Learning Disabilities engagement system wide (R1)	Safeguarding Adults work plan
C2	CSR collaboration of engagement with CCG (R2)	CSR outcome publication
C3	Leadership of Project 3 (Elective Care) and Project 4 (Urgent and Emergency Care) (R2)	Minutes, exception reports
C4	Primary Care collaboration in locality projects and DHC/Primary Care collaboration in frailty pathway. (R3)	Mid-Dorset Hub/ICS Minutes

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

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		ACTION
C1	Public engagement in all elements of developments is not embedded and requires strengthening strategies to deliver this	Communication Team, Head of PALS/Complaints and Transformation team to build and embed processes to deliver patient and public engagement
ISSUE 2		**ACTION**
C2	No independent assurance on controls in place for the Dorset Care Record (R5)	Progress reported through the Dorset Informatics Group. DCH input is progressing well but other partners are behind their milestones.
ISSUE 3		**ACTION**

BOARD ASSURANCE FRAMEWORK - REVIEW OF STRATEGIC RISKS WE ARE SEEKING TO CONTROL

REF	STRATEGIC OBJECTIVE	Risk		Rating
4	**Enabling. Empowering Staff.** We will engage with our staff to ensure our workforce is empowered and fit for the future			
		Strength of controls		G
		Strength of assurance		A

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not achieving a staff engagement score in the top 20% nationally	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 Head of OD to focus on the delivery of an Organisational Culture review programme (Second Round of Interviews July 2020). Diversity and Inclusion/ Wellbeing Manager appointed to provide a dedicated resource to this agenda. Health and Wellbeing champions have been identifed to ensure local action plans developed and discussed. BAME staff network launched. (R1)	A	Staff survey results reported to the Workforce Committee and Board. Review of Equality & Diversity and Health and Wellbeing associated issues at respective Steering Boards and regular review at Workforce COmmittee.	A
C2	People Strategy approved at May 2018 Trust Board. (R2)	G	Workforce committee established to consider and report progress against People Strategy. Workforce Committee workplan tabled at Boad in Jan 2020.	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 Workforce Committee 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	3	5	15	12
R2	Failing to be efficient as outlined in the Model Hospital	PG	2	3	6	9
R3	Not generating 25% more commercial income with an average gross profit of 20%	NJ	1	5	5	5
R4	Not using our estate efficiently and flexibly to deliver safe services	PG	4	3	12	12
R5	Failure to secure sufficient funding to ensure financial sustainability	PG	4	4	16	12

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	The Board approved a financial sustainability strategy in Sept 17. The Director of Finance and Resources is leading on the implementation of the strategy. The Transformation Team is supporting the delivering of key work streams in the strategy. (R1)	R	The Better Value Better Care Group oversee the implementation of the financial savings. The Senior Management Team receive regular updates on the Transformation Programme. Regular reports received by the Finance and Performance Committee and the Board.	R
C2	Model hospital metrics accessible to service areas. Regular reports and opportunities identified by the Better Value Better Care Group (R2)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	G
C4	Commercial Board reviews income against metrics, overseen by Better Value Better Care Group (R3)	G	Financial reporting mechanisms at commercial board and the Better Value Better Care Group	A
C3	Model hospital will provide information on the efficient use of our estate. (R4)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	A
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	A	The Authorising Engineers which the Trust appoint, are independent and ensure that safe systems of work and inspection regimes are in place and carried out in accordance with the legislative requirements	G
C6	Six facet survey undertaken in Q2 of 19/20 to identify backlog maintenance levels and investment requirements. (R4)	A	Capital Planning Group review the 6 facet survey and capital investment required. This is reported to the Senior Management Team, Finance and Performance Committee and Board of Directors for approval.	A
C7	The Trust is part of the Dorset Finance 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.	G
Overall Strength		A		R

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

Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.

CONTROL	ASSURANCE	EVIDENCE
C1	Internal audit reports on financial controls. (R1) and (R2).	BDO audit reports
C2	Model hospital information provides the information on our level of efficiency. (R2)	Model Hospital
C3	Estates Benchmarking (ERIC) return confirms efficient use of estate with opportunities in waste management (R2)	Estates Benchmarking (Eric) Return

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

E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.

ISSUE 1		ACTION
C1	(R1) No formal report discussed at the Better Value Better Care Group on the financial sustainability strategy or reported up to the Senior Management Team and Finance and Performance Committee.	(R1) Regular reports to the Senior Management Team and Finance and Performance Committee to be provided on implementation of the Financial Sustainability Strategy.
ISSUE 2		**ACTION**
C5	(R4) No independent assurance on compliance with statutory estates legislation	(R4) This was considered within the 2019/20 Internal Audit plan but not prioritised.
ISSUE 3		**ACTION**
C1	(R1) There is a risk we do not have the resource to make all of the transformation change happen timely.	An internal audit of the transformation programme was undertaken and reported to the November 2018 Audit and Risk Committee

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 4	Very low risk
5 - 9	Low risk
10 -14	Moderate risk
15 – 19	High risk
20 - 25	Extreme risk

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

A frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur 1 in 3 years	Do not expect it to happen/recur but it is possible it may do so 1 every year	Might happen or recur occasionally 1 every six months	Will probably happen/recur but it is not a persisting issue 1 every month	Will undoubtedly happen/recur,possibly frequently 1 every few days

Identifying Risks

The key steps necessary to effective identify risks from across the organisation are:

a) Focus on a particular topic, service area or infrastructure
b) Gather information from different sources (eg complaints, claims, incidents, surveys, audits, focus groups)
c) Apply risk calculation tools
d) Document the identified risks
e) Regularly review the risk to ensure that the information is up to date

Scoring & Grading
A standardised approach to the scoring and grading risks provides consistency when comparing and prioritising issues.
To calculate the Risk Grading, a calculation of **Consequence (C)** x **Likelihood (L)** is made with the result mapped against a standard matrix.

Consequence score (C)
For each of the five main domains, consider the issues relevant to the risk identified and select the most appropriate severity scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. This provides five domain scores.

DOMAIN C1: SAFETY, QUALITY & WELFARE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) 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/poor 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	**29 July 2020**
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 with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.

Risk Ref	Description	Current Risk Score (with mitigations in place)	Affecting BAF Objective	Movement
919	Covid- 19	Extreme (25)	BAF Objective 1: Outstanding BAF Objective 2: Integrated BAF Objective 3: Collaborative BAF objective 4: Enabling BAF Objective 5: Sustainable	
	TARGET DATE: 31.07.2020 **TARGET SCORE**: LOW (9)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 31.07.2020	
468	Recruitment and retention of Medical staff across specialities	Extreme (20)	BAF Objective 1: Outstanding BAF Objective 2: Integrated BAF Objective 3: Collaborative BAF objective 4: Enabling BAF Objective 5: Sustainable	
	TARGET DATE: 31.03.2023 **TARGET SCORE**: Moderate (12)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 31.07.2020	
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	Extreme Extreme (20)	BAF Objective 1: Outstanding BAF Objective 3: Collaborative BAF Objective 5: Sustainable	
	TARGET DATE: 31.03.2025 **TARGET SCORE**: Low (9)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 31.07.2020 *NOTE: Due to Covid 19 all monitoring of standards has ceased.*	

710	Follow up waiting list backlog Failure to ensure that patients are followed up according to their clinical needs and presentation.	Extreme (20)	BAF Objective 1: Outstanding BAF Objective 3: Collaborative	
	TARGET DATE: 31.03.2023 **TARGET SCORE**: Moderate (12)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 31.07.2020 *NOTE: During Covid 19 – Access team have been contacting patients on the waiting lists and some clinics are being held in different formats.*	
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)	High (15)	BAF Objective 1: Outstanding BAF Objective 5: Sustainable	
	TARGET DATE: 31.03.2021 **TARGET SCORE**: Low (6)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 30.09.2020	
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	High (15)	BAF Objective 1: Outstanding BAF objective 4: Enabling	
	TARGET DATE: 31.03.2025 **TARGET SCORE**: Moderate (12)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 30.09.2020	
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.	High (16)	BAF Objective 5: Sustainable	
	TARGET DATE: 31.03.2020 **TARGET SCORE**: Low (12)		Last reviewed: 25.06.2020 NEXT REVIEW DUE: 30.11.2020	
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.	Moderate (12)	BAF Objective 1: Outstanding	
	TARGET DATE: 31.03.2021 **TARGET SCORE**: Low (9)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 30.09.2020	
450	Emergency Department Target, Delays to Care & Patient Flow Inconsistent achievement of the	Moderate (12)	BAF Objective 1: Outstanding BAF Objective 5: Sustainable	

	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.			
	TARGET DATE: 31.03.2021 **TARGET SCORE**: Moderate (12)		Last reviewed: 30.06.2020 NEXT REVIEW DUE: 30.09.2020 NOTE: *Due to Covid 19 all monitoring of standards has ceased.*	
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.	Low (9)	BAF Objective 1: Outstanding BAF Objective 2: Integrated BAF Objective 3: Collaborative BAF objective 4: Enabling BAF Objective 5: Sustainable	
	TARGET DATE: 31.03.2020 **TARGET SCORE**: Low (6)		Last reviewed: 08.07.2020 NEXT REVIEW DUE: 31.08.2020	

No new risks have been added to the Corporate Risk Register for this reporting period.

UPDATE ON DIVISIONAL LEVEL EXTREME RISKS

Urgent and Integrated Care Division

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

This still remains on the Divisional Risk Register however as part of the Covid-19 preparation, ED's foot print has been temporarily enlarged.

- Resilience of Mosaiq (SACT electronic Prescribing System) (Currently rated as 20 (EXTREME) on the Divisional risk register and unlikely to be managed at Divisional Level).

How the risk has been scored:
Consequence: Major
Impact on patient safety - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects
Quality/complaints/audit - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating
Statutory duty - multiple breeches in statutory duty, low performance rating
Adverse publicity - National media coverage <3 day service well below reasonable public expectation
Business objectives - Key objectives not met.
Finance including claims - Claims between £100k and £1m
Likelihood: Certain

34 Incidents have been linked to this risk, reporting failures of IT system and the impact on patient care. The system is used to support the prescribing of chemotherapy medications. The system is frequently crashing and the system capability is day dependent.

In order to mitigate this risk and maintain patient safety, staff are creating paper records of the prescriptions and then when they have access the paper records will be added electronically later (this is a risk in itself).

Additional licences have been provided and a review of the licences in use being undertaken.

Family Services and Surgical Division

- Lack of Ophthalmology Service Capacity to meet service demand (Currently rated as 20 (EXTREME) on the Divisional risk register and unlikely to be managed at Divisional Level).

How the risk has been scored:
Consequence: Major
Impact on patient safety - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects
Quality/complaints/audit - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating
Statutory duty - multiple breeches in statutory duty, low performance rating
Adverse publicity - National media coverage <3 day service well below reasonable public expectation
Business objectives - Key objectives not met.
Finance including claims - Claims between £100k and £1m
Likelihood: Certain

Mitigations in Progress:
Risk stratification review, macular receive advice following intraocular injection with advice leaflet and direct contact numbers for clinical concerns and clear guidance and contact numbers for follow-up appointments.

- Ophthalmology weekday out of hours' service now delivered by Bournemouth Hospital.
- Follow up waiting list reviewed by consultants for glaucoma and macular patients.
- Roll out of risk stratification actions to glaucoma pathway
- Review follow up clinical priority pathway for macular and glaucoma patients.
- Implemented dedicated phone line for macular follow up manned by the "fail safe officer" run by the ophthalmology department. Phone lines to be given at 1st OPA
- Funding agreed to support reduction in 52 week wait risk
- Pan-Dorset External review of services undertaken. Dorset Eyecare Board established to take recommendations forward.

- Community Paediatric Long Waits for ASD Patients Currently rated as 20 (EXTREME) on the Divisional risk register and unlikely to be managed at Divisional Level).

How the risk has been scored:
Consequence: Major
Impact on patient safety - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects
Quality/complaints/audit - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating
Statutory duty - multiple breeches in statutory duty, low performance rating
Adverse publicity - National media coverage <3 day service well below reasonable public expectation
Business objectives - Key objectives not met.
Finance including claims - Claims between £100k and £1m
Likelihood: Certain

Actions in progress:

- Maximise capacity by reducing DNAs with significant effect
- Keeping patients informed and signposting for support and information
- Holding letters
- Pan Dorset pathway redesign
- Proposal to be discussed with Fiona Richey by end June 2020. Agreement to fund training for 8 staff in 3Di, which will release Consultant and Administrative capacity.
- Triage introduced in May which will also release capacity over time.

FOR NOTE:

This is the first review of this paper.	
Paper Previously Reviewed By Risk and Audit Committee, 21 July 2020	
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 is requested to: • review the current Corporate Risk Register ; and • note the Extreme and 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.

Ref:	Risk Statement	CURRENT RISK RATING	Extreme (25) Consequence: Catastrophic Likelihood: Certain Reviewed: 30.06.2020
919	Covid- 19	Previous Rating	Extreme (25)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
This will impact on all of our strategic objectives. **How this risk has been scored:** **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Tony James
Current position/Progress/ Mitigation		POST MITIGATION RATING	Low (9) Consequence: Moderate Likelihood: Possible
• All areas have undertaken a risk assessment to ensure both clinical and non clinical areas are Covid secure. This has meant a reconfiguration of beds, recommissioning of office areas to ensure that the hospital is able to meet demand and prepare for winter pressures or a second wave. Fit mask testing continues as different PPE is delivered. Continue to monitor situation and Government guidance • Services are beginning to restart activities. • Introduction of the use of masks for all when entering the hospital • Reinforcing IPC guidance		Next review date	31/07/2020

Ref:	Risk Statement	CURRENT RISK RATING	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 30.06.2020
468	Recruitment and retention of Medical staff across specialities	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Mark Warner
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 **How this risk has been scored:** **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Catherine Youers Emma Hallett
Current position/Progress/Mitigation		POST MITIGATION RATING	Moderate (12) Consequence: Moderate Likelihood: Likely
We are reviewing the medical model within acute medicine to respond to areas of known skill shortages. We continue to look at joint consultant posts with partner organisations, and are currently recruiting for a joint post in Rheumatology. Within business planning we have identified additional recruitment needs, which will need to be prioritised. This also gives an opportunity to consider alternative staffing models in areas of skill shortage. This work is being co-ordinated by the newly created workforce planning team. We are keen to develop an SAS academy to support specialty doctors in their development and also position the Trust as an attractive proposition for employment.		Next review date	30.09.2020

Ref: 	Risk Statement	CURRENT RISK RATING	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 30.06.2020
709	Failure to achieve constitutional standards (elective Care)	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : **Outstanding:** Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards Strategic Objective 3 Not achieving a 96% score on our friends and family test, Not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities **Strategic Objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Inese Robotham
Current position/Progress/Mitigation		POST MITIGATION RATING	Low (9) Consequence: Moderate Likelihood: Possible
• RTT - 50/50 risk share agreement in place with the commissioners to treat patients over 40 weeks in order to avoid as many 52 week breaches as possible. Additional independent sector capacity secure for ophthalmology, endoscopy and dermatology. Alternative NHS provider capacity agreed with Yeovil hospital for Orthopaedics. Further exploration of capacity for other specialities. • *Due to Covid 19 all monitoring of standards had ceased.* • Activity is being reintroduced using the Winterbourne and other options to undertake clinics, such as telephone reviews or Skype.		Next review date	31.07.2020

Ref:	Risk Statement	CURRENT RISK RATING	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 30.06.2020
710	Follow up waiting list backlog	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain **7 service related risk register records. Other linked reports on cancer incidents**		Local Manager	Adam Savin
Current position/Progress/Mitigation		POST MITIGATION RATING	Low (9) Consequence: Moderate Likelihood: Possible
• Robust reporting arrangements are in place to allow the services to oversee and manage all of the patients on their waiting lists. • Follow up waiting list numbers and profile of the waiting list is routinely reported to FPC. • Demand management tools such as attend anywhere and consultant connect being trialled in the Trust. • Due to Covid 19 a number of services were ceased, these are now starting to be reintroduced • Access team have been contacting patients on the waiting lists and prioritising on clinical need, or changing presentation. System wide a Pan Dorset view is being undertake to ascertain the level of harm caused to patients by the delay in being seen, where harm is deemed to have been caused and incident will be reported.		Next review date	31.07.2020

Ref: 	Risk Statement	CURRENT RISK RATING	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 30.06.2020
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Sue Eve-Jones
Current position/Progress/Mitigation		POST MITIGATION RATING	Low (6) Consequence: Minor Likelihood: Possible
Recruitment of new coders has taken place and they are currently receiving their training which is due to be completed by September 2020. The longer term plan is for coders to sit with clinicians to complete the coding to ensure that the coding is correct and that we can maximise legitimate income to assist with the financial sustainability. Trends and problem areas are regularly reviewed at the Hospital Mortality Group where the Dr Foster information is reviewed and discussed.		Next review date	30.09.2020

Ref:	Risk Statement	CURRENT RISK RATING	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 30.06.2020
463	**Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff**	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	Mark Warner
Strategic objective 1 : Outstanding Not having the appropriate workforce in place to deliver our patient needs **Strategic objective 4: Enabling** Failure to deliver flexible and appropriate service models Loss of training status for junior doctors Not benefitting from the successful delivery of the People Strategy **How this risk has been scored:** **Consequence: Moderate** **Patient safety** – event that impacts on a small number of patients, increase length of stay by 4-16 days **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Likelihood:** Certain 109 linked incident records re staffing.		Local Manager	Catherine Youers Emma Hallett Hilary Harold
Current position/Progress/Mitigation		POST MITIGATION RATING	Moderate (12) Consequence: Moderate Likelihood: Likely
• 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. • Risk Register to be discussed at Workforce Committee moving forward		Next review date	30.09.2020

Ref: 	Risk Statement	CURRENT RISK RATING	High (16) Consequence: Major Likelihood: Likely Reviewed: 25.06.2020
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 5: **Sustainable** Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** Discussion at SMT 15.01.2020 Electrical work is now underway Data is back and work will commence on this before financial year end Tender will be out shortly for new installation work - this will fall in to the new financial year. **UPDATED PROGRESS:** Electrical installation 30% complete. Data out to tender. To be complete by 31MAR20. New system install specification nearing completion. Roll out anticipated end Q1 FY20/21 **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain 10 LINKED INCIDENTS		Local Manager	Andy Morris
Current position/Progress/Mitigation		POST MITIGATION RATING	Very Low (2) Consequence: Negligible Likelihood: Unlikely
Discussion at SMT 15.01.2020 Electrical work is underway Data is back and work will commence on this before financial year end Tender will be out shortly for new installation work - this will fall in to the new financial year. Electrical installation 30% complete. Data out to tender. To be complete by 31MAR20. New system install specification nearing completion. Roll out anticipated end Q1 FY20/21 UPDATE: Significant delay to programme due to COVID. System failures continue to be experienced. Project expected to go live again Q3/Q4		Next review date	30.11.2020

Ref: 	Risk Statement	CURRENT RISK RATING	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:30.06.2020
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective 1: Outstanding : Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit -** non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity -** National media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position/Progress/Mitigation		POST MITIGATION RATING	Low (9) Consequence: Moderate Likelihood: Possible
The SHMI is not a measure of quality of care. A higher than expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. The Trust continues to investigate reasons behind the higher than expected SHMI on a regular basis. Processes are overseen by the Learning from Deaths Hospital Mortality Group, which reports to the Quality Committee. Medical Examiners scrutinise all deaths of in-patients at DCH and recommend which cases require further investigation by RCA, SJR or review at an M&M meeting. The Group also reviews audit data gathered both locally and nationally to search for any evidence of unnecessary deaths. Additional monthly information on deaths, care quality and safety is provided by the Dr Foster team. **UPDATE: 10.07.2020** Mortality rates are now within the expected range – this will need to be maintained and then the risk will be reviewed.		Next review date	30.09.2020

Ref: 	Risk Statement	CURRENT RISK RATING	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 07.01.2020
450		Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible** Linked to Risk Ref 709 – Failure to achieve constitutional standards.		Local Manager	Samantha Hartley
Current position/Progress/Mitigation		POST MITIGATION RATING	Moderate (12) Consequence: Major Likelihood: Possible
Mitigation: **NOTE:** ***Due to Covid 19 all monitoring of standards has ceased.*** *Due to Covid 19 ED attendances have dropped and bed capacity has increased. There were still potential issues with mental health patients in the department with a change in the delivery of psychiatric liaison service now offering telephone assessments and face to face assessments at Maiden Castle Road. It is likely that this risk will increase again following the Covid 19 issue resolving or restrictions being lifted.* Update: Liaison Service now back on site. ED service activity is starting to rise again.		Next review date	31.07.2020

Ref: 	Risk Statement	CURRENT RISK RATING	Low (8) Consequence: Major Likelihood: Unlikely Reviewed: 08.07.2020
449	**Financial Sustainability**	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Paul Goddard
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 **Target met and at the start of a new financial year. Additional monies are available due to Covid 19**		Local Manager	Rebecca King
Current position/Progress/Mitigation		POST MITIGATION RATING	Low (6) Consequence: Moderate Likelihood: Unlikely
There are a number of uncertainties that are present after the 1st August that may increase this risk so we will have to keep this under review.		Next review date	31.08.2020

Title of Meeting	**Board of Directors**
Date of Meeting	**29 July 2020**
Report Title	**Infection Prevention and Control Annual Report 2019/2020**
Author	Nicola Lucey / Emma Hoyle / Dr Paul Flanagan
Responsible Executive	Nicola Lucey, Director of Nursing and Quality

Purpose of Report (e.g. for decision, information) To provide the Board of Directors with information and assurance of the management of Infection Prevention and Control at DCHFT	
Summary Annual report covering 2019-2020	
Paper Previously Reviewed By Quality Committee, 21 July 2020	
Strategic Impact No exceptions identified	
Risk Evaluation No risk exceptions identified	
Impact on Care Quality Commission Registration and/or Clinical Quality High standard of Infection Prevention and Control at DCHFT – no impact likely	
Governance Implications (legal, clinical, equality and diversity or other): High standard of Infection Prevention and Control at DCHFT – no governance implications likely	
Financial Implications No financial implications	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	To note the report.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2019-20

Infection Control Week 2019- Heroes and Villains Theme winners

Ilchester Ward

Nicola Lucey - Director of Nursing and Quality/ Director of Infection Prevention and Control

Emma Hoyle - Associate Director Infection Prevention and Control

Dr Paul Flanagan – Infection Control Doctor

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EXECUTIVE SUMMARY

The annual report provides a summary of the Infection prevention and control activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust.

The Director of Nursing and Quality is the accountable board member responsible for infection prevention and control and undertakes the role of the Director of Infection Prevention and Control.

The Infection Prevention and Control Group function in order to fulfil the requirements of the statutory Infection Prevention and Control committee. It formally reports to the sub-board Quality Committee, providing assurance and progress exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – part 3 Code of Practice for the Prevention and Control of HCAIs), which was reviewed and updated in 2015.

The workplan, led and supported by the Infection Prevention and Control team (IPCT), sets clear objectives for the organisation to achieve with clear strategies in place to meet the overall Trust strategy of Outstanding.

Overall 2019-2020 was a successful year, meeting key standards and regulatory requirements for infection prevention and control. Below is the highlight of those:-

- The Trust met the trajectories set for MRSA bacteraemia and *Clostridium difficile* infections for 2019-2020
- The Trust has successfully reduced healthcare acquired infections year on year
- The Trust developed and adjusted in the global pandemic of COVID-19
- Hand hygiene compliance has remained high and sustained at 97%
- Only two outbreaks of Norovirus which were well contained and occurred for a short period only
- The Trust achieved above the national average for several elements of the PLACE assessments for the year.
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to control pseudomonas and legionella in tap water in high risk areas
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNet).

1. INTRODUCTION

This is my fourth year as Director of Nursing and Quality, with the responsibility of Director for Infection Prevention and Control (DIPC) and this report summarises the work undertaken in the Trust for the period 1st April 2019– 31st March 2020. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

I am pleased to report good progress against the trajectory for HCAIs. The Trust met the target for zero cases of MRSA bacteraemia and reported 6 trajectory cases of *Clostridium difficile* against a target of 16 cases. In addition, the Trust has been very proactive in reviewing trends and improvements in Gram-negative blood stream infections (BSIs) with sharing across system partners as part of the Dorset Integrated Care System (ICS). The Infection Prevention and Control Team has seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

These low rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases. I am incredibly proud of the teamwork that has enabled this positive track record of patient safety.

It has been a particularly challenging year for the Trust and Infection Prevention and Control in the last quarter as the world-wide pandemic of COVID-19 evolved. The Infection prevention and Control team have been vital in developing and supporting the Trust during this period of time. They have provided expert counsel to others across the system and region, sharing best practice and challenge to ensure COVID-19 secure environments fort patients and staff.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team support epitomize this quality improvement ethos and they significantly contribute to achieving our strategic mission: "Outstanding care for people in ways which matter to them". Their support for training and engaging with the clinical teams has been at the highest standard, reflective of the care provided and experience by our visiting public.

Of course I am never complacent, with ongoing high ambitions for patient safety, as I look forward to another year ahead of delivering outstanding services every day through effective, efficient and joined up infection prevention and control.

Nicola Lucey
Director of Nursing and Quality
Director of Infection Prevention and Control

2. INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 5 times during 2019- 2020. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPCG is chaired by the Chief Executive Officer, Patricia Miller. Director of Nursing & Quality, Nicola Lucey, who also is the Director of Infection Prevention and Control (DIPC), is in attendance and acts as deputy Chair, with the responsibility for reporting to the sub-board Quality Committee for assurance.

2.2 DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2019-2020:

- Monthly MRSA Bacteraemia surveillance;
- Monthly *Clostridium difficile* surveillance;
- Monthly hand hygiene rates;
- Outbreak and incident reports;
- Antibiotic Stewardship Report;
- Progress with national ambition to reduce Gram Negative Blood Stream Infections by 50% by 2023

2.3 INFECTION PREVENTION and CONTROL TEAM

The IPCT has welcomed new members in the year and consists of:

- Patricia Miller, Chief Executive
- Nicola Lucey, Director of Nursing and Quality/ Director of Infection Prevention and Control
- Dr Paul Flanagan, Consultant Microbiologist and Infection Control Doctor
- Emma Hoyle, Associate Director Infection Prevention and Control
- Abigail Warne, Specialist Nurse-returned from maternity leave June 2019
- Julie Park, IPC Nurse – returned from maternity Leave January 2020
- Christopher Gover, Specialist Nurse – Seconded to team to cover Maternity Leave
- Debs Scott-Denness - Seconded to team to cover Maternity Leave until May 2019
- Helen Belmont – Bank Specialist Nurse
- Cheryl Heard, Administrator
- Rhian Pearce, Antimicrobial Pharmacist
- Emma Diaz, Lymphedema Specialist Nurse (supported the team and worked with us during COVID-19 peak period)
- Divisional Heads of Nursing/Quality

3. HEALTHCARE ASSOCIATED INFECTIONS

3.1 METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were no cases of MRSA bacteraemia in 2019-2020. The last case of MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA (blood samples taken ≥48hours post admission) have significantly reduced.

3.2 *STAPHYLOCOCCUS AUREUS* BACTERAEMIA (MSSA)

In 2019-2020 there were a total of 52 cases of MSSA bacteraemia, of these 44 cases were identified <48 hours of admission and 8 identified >48 hours after admission (Chart 1).

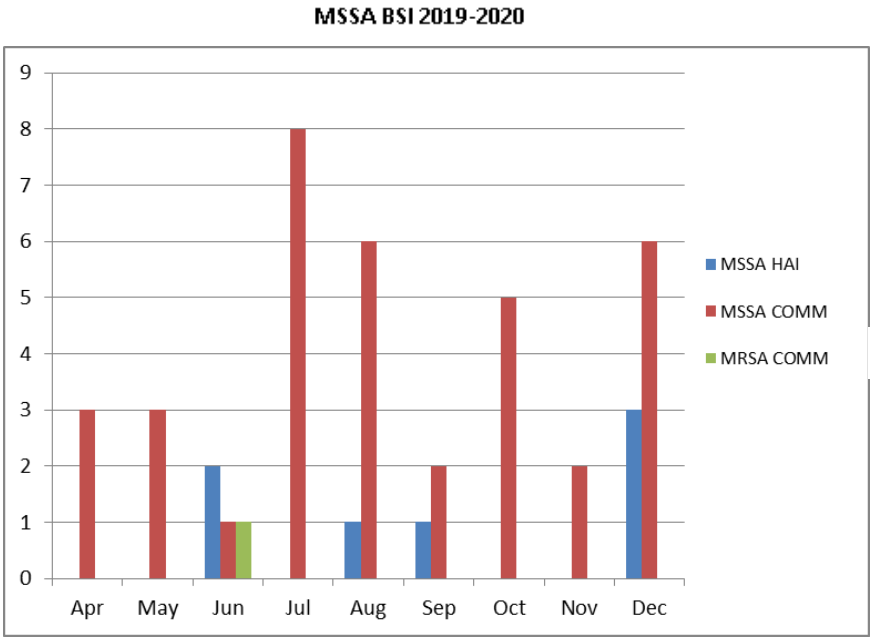


Chart 1

To achieve this reduction we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices. Analysis of cases in the >48 hour group has shown that there were no focus of infection related to hospital treatment. However, in two of the cases it was noted that there was poor documentation of indwelling devices. Despite this the rates of MSSA infections remains lower in comparison to the national picture.

3.3 GRAM NEGATIVE BLOOD STREAM INFECTIONS

3.3.1 Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017)

and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving this reduction has been changed to 2023. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.)*

3.3.2 Mandatory data collection has been in place for several years for E.coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella spp.and Pseudomonas *aeruginosa.*

3.3.3 In 2019-2020 there were a total of 162 positive BSI samples for E.coli. 11 of these cases were attributed to the Trust (Chart 2). This was a decrease by 9 cases from 2018-2019. All cases of E.coli that occur >48hrs after admission are reviewed by the Consultant Microbiologist and Infection Prevention & Control Team. A full data collection process is carried out in accordance with Public Health England guidance; this includes all mandatory and optional data. Full antibiotic review is carried out taking into account the preceding 28 days. In 2019-2020 DCHFT achieved a 45% reduction in cases from the previous year and a 35% reduction since 2016/2017 which brings the Trust back into trajectory for the 50% reduction by 2023.

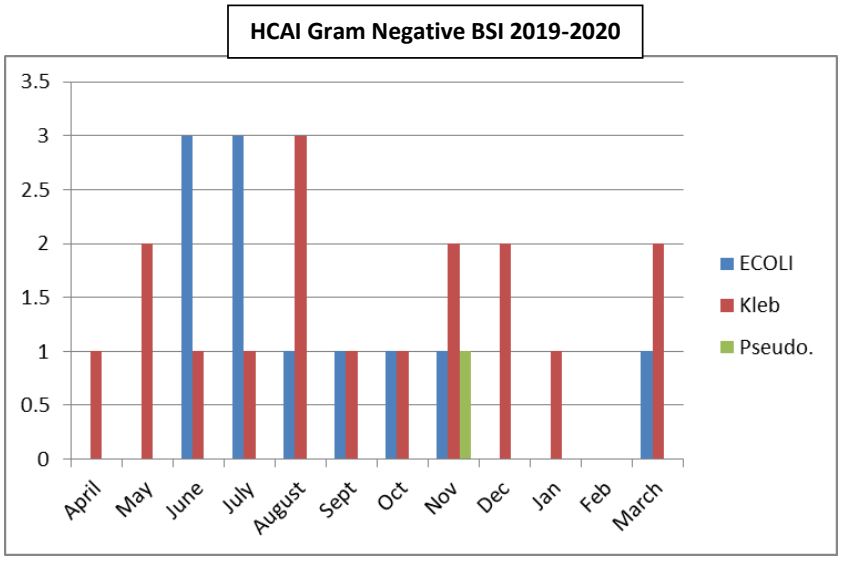


Chart 2

3.3.4 In 2019-2020 there were a total of 56 positive BSI samples for Klebsiella sps, 17 of these cases were attributed to the Trust (Chart 2). This was an increase by 7 cases from 2018-2019.

3.3.5 In 2019-2020 there were a total of 6 positive BSI samples for Pseudomonas *aeruginosa*, 1 of these cases were attributed to the Trust (Chart 2). This was a decrease by 1 case from 2018-2019.

It has been noted that there has been a rise in taking blood cultures for investigation over the past 3 years (Chart 3). This is in response to the action by the Trust to diagnosis and management of sepsis.

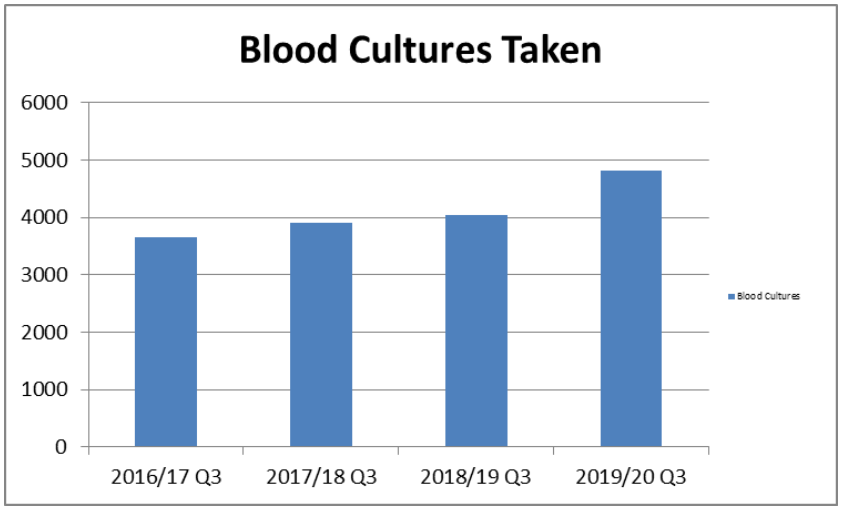


Chart 3

3.3.6 The IPCT continues to be involved in the nationally organised events and training via NHS Improvement (NHSI). Through these events it has been recognised and agreed that the reduction of gram negative BSIs is proving difficult to achieve and the target date for completion has been extended to 2023. At DCHFT the IPCT have been addressing the following to check current processes:

- Monthly audit of urinary catheter care including documentation and discharge
- Audit and subsequent actions into monitoring of indwelling devices e.g. Peripheral vascular cannula
- Participation in Hydration Projects Trust wide
- Supported the reduction in the use of urinary dipsticks

Within Dorset the four healthcare Trusts are working together on joint projects to seek solutions to this target as the majority of cases are community acquired and support is required to achieve resilience county wide. Nationally, the decrease in gram negative BSI has not been recognised and NHSE/i have agreed to stretch the target to 2023. This will enable further engagement with primary care – this remains the same since the last report.

3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

This year NHS England changed the reporting of C Difficile. This was from one definition of a case – sample taken over 72 hours after admission was deemed a HCAI requiring review. This year the definition is as follows:

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients has been an inpatient in the Trust reporting the case in the previous 4 weeks

- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks
- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust ion the previous 12 weeks

Bearing this in mind and the change in definition it has remained a successful year for reducing cases of CDI. The Trust trajectory for the year was 16 cases. In total the Trust reported 25 cases detected HOHA and COHA; of these cases 19 were appealed as non-preventable with no lapses in care; this resulted in 6 cases reported as hospital acquired (Chart 4).

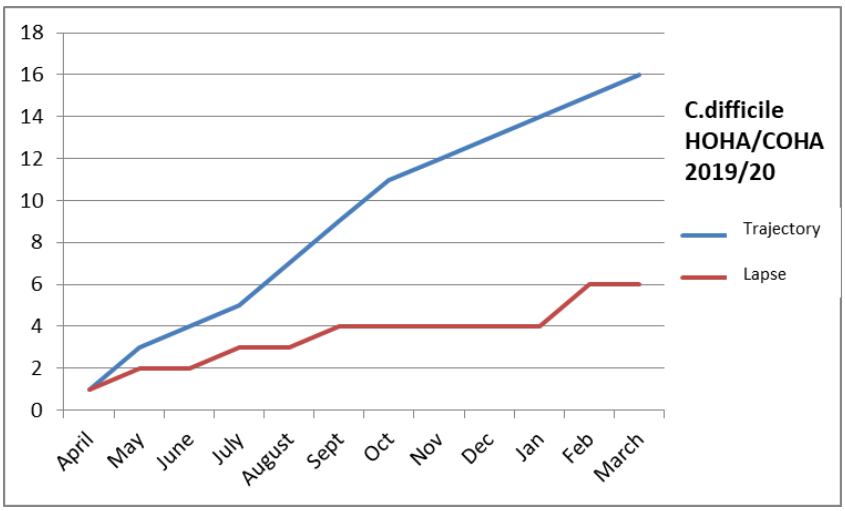


Chart 4

Over the course of the year we identified 6 different phage types. We can confidently say that we have not had any outbreaks or linked cases of CDI in the Trust 2019-2020.

All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Patricia Miller, Chief Executive Officer and scrutinised to identify any relevant learning from the cases. The learning actions when completed are then presented and signed off by the Divisional Matron at the IPCG.

4. OUTBREAKS OF INFECTION

4.1 NOROVIRUS

Outbreaks of this viral illness have been identified at the Trust during this year in line with seasonal reporting. Individual cases have also been reported in very small numbers. There has been 2 outbreaks of Norovirus 2019-2020. This was identified quickly, patients sampled and isolated in line with Trust policy. In comparison with the national average the number of bed days lost due to outbreaks remains low.

4.2 INFLUENZA

A review of the Influenza Season (Summer 2019) in the Southern Hemisphere identified an early peak to the season which the Trust was prepared for.
There has been a national reduction in cases of Influenza A & B during the Winter 2019-2020 in comparison to the previous year. The Trust was able to demonstrate learning from the previous year and the impact at operational level for the Trust was minimal.
In preparation for 'Flu Season' all Trust staff were offered the annual flu vaccine. 89% of front line staff were immunised and 84% of all staff, an increase from 79% the previous year. The Trust were the top of the Southwest region for compliance with staff vaccination
The Trust did not have any outbreaks of influenza and all cases identified in the Trust were isolated and treated in a timely manner.

5 CLINICAL AUDIT

5.1 SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections that affect the superficial tissues (skin and subcutaneous layer) of the incision and those that affected the deeper tissues (deep incisional or organ space).

Preventing surgical site infections is an important component of Infection Prevention and Control programmes. There is a Mandatory requirement by the Department of Health for all Trusts' undertaking orthopaedic surgical procedures to undertake a minimum of three months' surveillance in each financial year.

SSI for all surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay
Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure
Stage 3- review of patients readmitted within 365 with SSI

During 2019-2020 the IPC team have supported 5 modules for surveillance. Surveillance. The IPCT are able to facilitate a less time consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

5.2 SURGICAL SITE SURVEILLANCE OF HIP REPLACEMENT

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for April- June 2019 (Table 1) and last 4 periods for which data was available.

The percentage of post discharge questionnaires returned by patients is significantly higher than the national data for all hospitals.

During this quarter the increased incidence of post-operative infections in orthopaedic cases were monitored and actions taken to investigate and seek the root cause.

Further to intensive investigation no source was found and no further infections identified.

Table 1 April – June 2019 Hip Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Apr-Jun 2019	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	59 59 81.4%	302 302 79.5%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0% (3.1 % Apr-June 2018)	3 1%
	No of post discharge confirmed % infected	0 0% (2.1% Apr-June 2018)	3 1.0%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	0 0% (5.1% Apr-June 2018)	6 2%

Result s of this quarter were significantly improved from the previous years audit.

5.3 SURGICAL SITE SURVEILLANCE OF KNEE REPLACEMENT

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for July - September 2019 (Table 2) and last 4 periods for which data was available.

The percentage of post discharge questionnaires returned by patients is significantly higher than the national data for all hospitals.

During this quarter the increased incidence of post-operative infections in orthopaedic cases were monitored and actions taken to investigate and seek the root cause.

Further to intensive investigation no source was found and no further infections identified.

Table 2 July – September 2019 Knee Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		July - Sept 2019	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	75 75 76.7%	294 292 79.1%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0%	0 0%
	No of post discharge confirmed % infected	1 1.3%	3 1.0%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	1 1.3%	3 1.0%

Results of this audit were the same as other hospitals in England.

Surgical Site Surveillance of Breast Surgery, Hips and Fractured Neck of Femur repair (Jan – March 2019 - data not available for 2019-2020 Annual report)

Data collection for this audit will be completed at the end of June 2019 the final report is not yet available from Public Health England.

5.4 GETTING IT RIGHT FIRST TIME (GIRFT)

Between May and October 2019 the Trust participated in the GIRFT surgical audit. Data was gathered for Orthopaedic and General Surgery. The COVID-19 pandemic has delayed formalisation of this audit and final results will be shared once available.

5.5 PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVC's are commonly used devices in acute hospitals, used for the administration of intravenous fluids and drugs. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular auditing to check that all PVCs are having visual infusion phlebitis (VIP) score checks completed has continued this year and remains ongoing. The annual average compliance for this year's audits has been 92% up from 90% last year.

Should compliance fall below 90% additional weekly/monthly audits are carried out. Divisional leads are invited to IPCG on a bi-monthly basis to discuss their areas results.

5.6 SHARPS AUDIT

The annual sharps bin audit by IPCT was completed in September 2019 with our main sharps box provider Daniels Healthcare Ltd completing their annual audit in November.

The audits seeks to gain insight into current practices with regard to the management of sharps in the clinical area with an aim to raise sharps awareness, assess current practice, discuss problems and advice on compliance to ensure that sharps are disposed of in a safe way to minimise the risk of injury.

Overall compliance was 95%.

These results were fed back to divisional nursing leads through the IPCG and sharps awareness continues to be a part of mandatory infection control training.

5.7 SLUICE AUDIT

Sluice areas across the trust must comply with a set range of standards and policies to ensure that infection control is optimised and ensure that sluices and commodes are fit for purpose.

This audit was conducted by external company Vernacare who supply the trust with pulp products and commodes. They looked at all sluice areas to assess the commodes and macerators in each sluice as well as looking at the overall cleanliness and storage of pulp products.

The IPCT fed back to all sisters and matrons any areas of concern to ensure that any non-compliance found was addressed; this was to be incorporated into divisional IPC plans. The biggest non-compliance was regarding the correct storage of pulp products and ongoing sluice and commode audits will continue as part of the trust environmental audit schedules.

5.8 ISOLATION AUDIT

This year's side room isolation audit took place in March and looked at all inpatient areas (excluding Kingfisher ward and ITU) with results as follows; Out of 35 side rooms in use for infection control purposes 71% had correct signage, 29% incorrect and a total of 92% overall side rooms in use across the trust. At the time of audit being carried out staff were educated on the importance of using correct signage to protect not only the patient but also themselves and visitors and thus reducing the transmission of infection.

5.9 COMPLIANCE WITH URINARY CATHETER POLICY

Over the past year the following audit has been carried out monthly in relation to Urinary Catheter Care;

- Indwelling Urinary Catheter Recording on Vital Pac

Compliance with the requirement to accurately document indwelling urinary catheter insertion on VitalPac has been good with an overall Trust compliance of 91% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 89% compliance and Urgent and Integrated Care 91% compliance.

Due to complications with methodology a decision was made to drop the previously audited Discharge from DCHFT with Urinary Catheter Pathway. This was agreed through IPCT.

6. EDUCATION

The Infection Prevention & Control Team provided formal education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and the team were involved in delivering formal sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Overseas Recruitment Training
- Intravenous Training
- Tissue Viability
- Volunteers Training

Mandatory Training for clinical and non-clinical staff has been offered via an online workbook. Overall compliance with mandatory IPC training over the year was 82% for clinical staff and 83% for non-clinical staff. IPCT recognised that additional support and training was required and so now provides monthly face to face formal mandatory training sessions for staff in addition to the online package. The drop in compliance may be attributed to the access opportunities in the last quarter due to the COVID-19 pandemic.

7 POLICY DEVELOPMENT/REVIEW

The following policies have been developed / reviewed during the year:

- Ward Closure Policy due to an outbreak of healthcare associated infections
- Policy for taking Blood Cultures
- Infection control of transmissible spongiform encephalopathies (cjd/vcjd)
- Guidelines for use of portable fans in the healthcare environment
- Isolation Policy including Isolation requirement for listed and infecting agents
- Isolation of Neutropenic patient son Fortuneswell Ward
- Pets for Therapy Policy
- ESBL/Gram Negative Policy
- Decontamination Procedures for Invasive Devices

- Policy for Venepuncture
- Clostridium difficile Policy
- Seasonal Influenza Policy
- Ice making Machine Standard Operating Procedure
- Wuhan Novel Coronavirus (WN0COV) Infection Prevention and Control Guidance

8. INFECTION CONTROL WEEK

The theme for this year's Infection Control Week was Superheroes Vs Supervillains and wards were asked to present a display showcasing their infection control superhero and supervillains focusing on an aspect of IPC relevant to their clinical area and how the hero can do 'battle' against the villain. Some of the displays included: Influenza Vs The Flu vaccine, Measles Vs Vaccination and MRSA Vs Decolonisation. The wards did not disappoint and there were some fantastic displays.

The annual judging of the displays was led by Patricia Miller and Nicky Lucey. Winners included:

- 1st place- Ilchester Ward
- 2nd place- Barnes Ward
- 3rd place- Medical Day Unit
- Highly Commended- Ridgeway Ward

1st place- Ilchester Ward

We were also supported by Reps from Schülke, Ecolab, Clinell, Vernacare, Daniels and GoJo who kindly donated prizes for the winners and some came in to promote IPC with stands in Damers restaurant.

9. COVID-19

In December 2019 an emerging virus was identified in Wuhan, China resulting in a global pandemic which remains ongoing.

This is the first pandemic that DCHFT has had to manage and preparedness for the evolving virus commenced in January 2020. Initially, this was lead via Infection Control and Emergency Planning but by February 2020 the international situation dictated a Trust wide response.

The Trust response was led by the Incident Management Team. Patient and staff safety was at the forefront of the pandemic.

The hospital environment has been adapted to suit the needs for this new virus and the complexities that it creates. Personal Protective Equipment (PPE) supplies remained good over the past six months and there has been no shortages. Staff support remains ongoing and at the time of writing the annual report routine patient services are re-starting.

A formal report will be provided to Quality Committee and Trust Board to provide further detail.

10. FACILITIES REPORT - CLEANING SERVICES (PAUL ANDREWS)

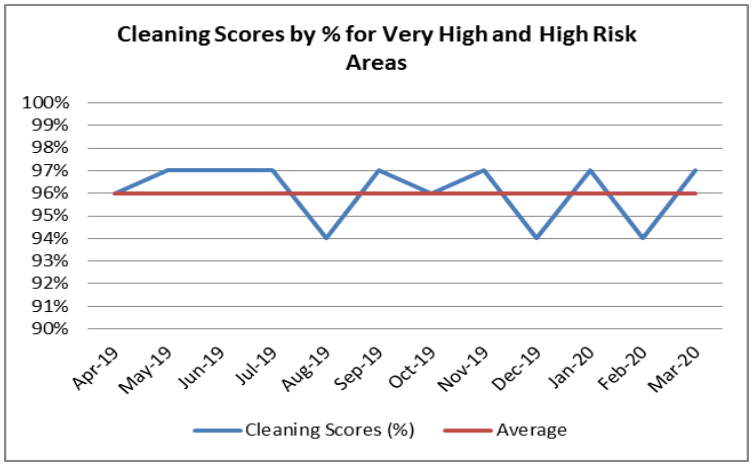
10.1 INFECTION PREVENTION & CONTROL & CLEANLINESS ANNUAL REPORT 2019/20

Provide and maintain a clean and appropriate environment

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes.

10.2 CLEANLINESS

Cleaning is provided by the Trust's in-house team of cleaners and deep cleaners; the internal team is supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the DomTime information system, with further input from local stakeholders, on a risk adjusted basis.
Outcomes for cleaning are monitored through several sources including internal monitoring, internal patient satisfaction surveys, the PLACE assessment and the CQC inpatient survey. We have continued to sustain a high standard of cleaning across all areas and continued to see low infection with improved patient feedback, which improves the overall patient experience and maintains patient safety.



10.3 CLEANLINESS – DEEP CLEANING

Whilst routine cleaning is completed in all areas on a daily basis, staff in very high and high risk areas are supported with extra staff to complete a full clean on a weekly basis. In the very high risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service, this is achieved with the assistance of the Estates team who undertake the high dusting of these areas.

In case of an outbreak or a high risk infection, the Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour (HPV) for the fogging of facilities and equipment.
The Trust has a working relationship with Glosair, whose services can be called upon as need requires it. We are currently looking to replace our 3 current HPV machines, as technology has vastly improved in this area, especially around the amount of time it takes to fog an area and the use of air scrubbers to remove any remaining hypochlorite solution from the environment. This will then enable a quicker turnaround of beds and cubicles, which is critical for any NHS Trust, without compromising patient safety.

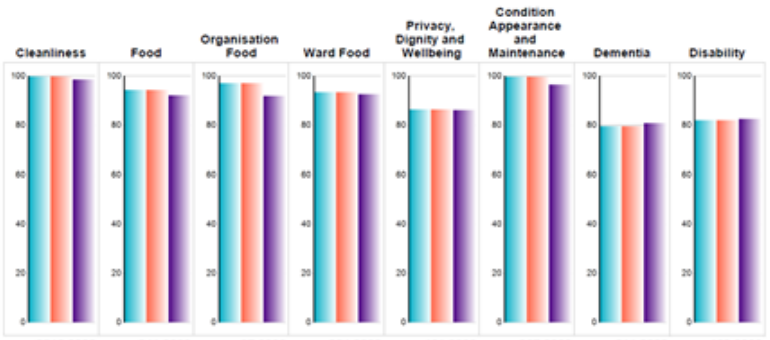
10.4 CLEANLINESS – INTERNAL MONITORING

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring.
Internal monitoring is carried out every day, visiting all areas on a weekly basis. Very high risk and high risk areas are monitored by an independent team made up from clinical, estates and facilities and supported by patient assessors who validate the ward audit scores, and check the patient experience to ensure the broadest picture is seen. All required improvements identified by the audits are acted upon by the internal team and the results, along with the patient survey, go to the Infection Prevention & Control Committee on a quarterly basis.

10.5 PLACE – PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT

The 2019 PLACE assessment identified many positives for the Trust and also areas to work upon. In relation to cleanliness and the environment; Cleanliness maintained its historical high score, in line with other internal and external audits; minor issues were identified and subsequently rectified immediately.
Condition, Appearance and Maintenance improved its score from the previous year, and was above the national average.
The areas that the Trust needs to focus upon are Dementia and Disability, as there was greater focus on these this year. The Trust did improve in these two areas, with Dementia and Disability scoring 79.56% and 81.91% respectively; these were still slightly below the national averages as shown in the graph below. The Trust has undertaken an audit across all of its premises, looking at compliance with new disability legislation, and planned works have already commenced in many areas to improve access and egress from these buildings and external areas.

DORSET COUNTY HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2516.0000	341.3333	87.3333	254.0000	461.3333	967.0000	611.0000	462.0000
Available Score (Actual)	2522.0000	362.0000	90.0000	272.0000	534.0000	970.0000	768.0000	564.0000
Site Score	99.76%	94.29%	97.04%	93.38%	86.39%	99.69%	79.56%	81.91%
Organisation Average	99.76%	94.29%	97.04%	93.38%	86.39%	99.69%	79.56%	81.91%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

11 ESTATES REPORT (ANDREW MORRIS – Head of Facilities and Estates)

11.1 WATER QUALITY

Throughout 2019, the Estates Team have maintained responsibility for the Trust's water services, reporting to the Water Quality Management Group (WQMG). Activities to maintain water quality continue to be supported and audited by independent experts in water hygiene management from Water Hygiene Centre with the WQMG sitting FOUR times per annum.

The Responsible Person, Andy Morris, and Authorising Engineer (Water), Paul Limbrick, were formally appointed in late 2019 and early 2020 respectively. Nicola Lucey, Director of Nursing/ Quality and DIPC is the Executive Director on Trust Board for Water Safety.

In March 2020 the 'Water Safety Policy' and accompanying 'Operational and Maintenance Procedures' were temporarily amended, in agreement with the WSMG, to take account of anticipated difficulties in routine surveillance monitoring due to COVID-19. This will be subject to continuous review and amended after consultation according to circumstances.

There has been continued progress in the remediation and closure of items identified in the 2016 L8 Risk Assessment throughout the period including;

- Installation of subordinate loop temperature monitoring system (ongoing)
- Purchase and ongoing installation of TWENTY RADA Sense 'auto-flushing' showers for Augmented Care areas prioritising those prone to raised Pseudomonas,
- Purchase of an HD Borescope to aid inspection of risk systems,
- Removal of dead legs and Little Used Outlets in Renal, Fortuneswell and Respiratory.
- Twenty one L8 Risk Assessments were carried out in the period along with Scald Risk Assessments. These will form the basis of ongoing works to maintain and improve system integrity alongside the continuing review and update of system schematics, asset registers and information on system use.

Pipework corrosion issues continue to occur resulting in leaks. These primarily present risks to continuity of supply rather than direct infection issues. Leaks are handled on an ad hoc basis with additional isolation valves put in place where possible to aid future maintenance and reduce the scope of necessary supply shut downs.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has continued according to previous schedules across the Trust. This work has been brought in-house to improve costs and control and a review of sampled outlets and scheduling undertaken.

Over the period covered by this report, MAR19 – MAR20, there were SIXTEEN instances of raised Pseudo. A. discovered during regular surveillance testing;

- POW – ONE instance
- Fortuneswell Ward - THIRTEEN instances
- SCBU – TWO instances

WSP procedures were followed in all cases and significant system or outlet changes made in order to mitigate further issues including the removal or little used outlets and the installation of self-flushing outlets. Further investigation of hot and cold water systems continues throughout the Trust property portfolio.

There have been THREE instances of raised Legionella counts in Renal Dialysis, Robert White Centre and Diagnostic Imaging. The Renal Dialysis issue is limited to a single outlet and under investigation. The Robert White Centre is more widespread and due to poor design, which remains unresolved and whose remediation is being planned. Despite a full system disinfection the issue remains and is expected to do so until the system is re-engineered to maintain control temperatures and fix inherent faults. Diagnostic Imaging remains under investigation, with remediation actions underway.

11.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME

A Deep Cleaning programme continues to be supported by the Estates Team when requested.

11.3 REPLACEMENT FLOOR COVERINGS

During 2018/19 the Estates delivery team and contractors have completed more than 140 various flooring repairs and a number of necessary replacements in corridors, shower rooms, ward and non-clinical areas.

11.4 DECORATION AND ENVIRONMENT

The Estates team continue to respond to reactive requests for decoration identified by staff and through the environmental auditing process. We are also carrying out proactive, scheduled inspections of high use and public facing areas to maintain an acceptable standard.

11.5 VENTILATION

During 2019/20 Estates and Housekeeping have continued to carry out high level deep cleaning in critical areas. Any deficiencies are reported through the Decontamination Group.

The Estates team continue to carry out routine inspection and maintenance on all ventilation systems and formal validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B carrying out remedial works as required. TWO AP(V) under the auspices of an AE(V) maintain Permit to Work system and ensure all statutory and regulatory records are validated.

11.6 WARD AUDITS

The Estates Dept. continue to support weekly environmental audits in association with Infection Control, Pharmacy Housekeeping and Patient Representatives.

11.7 CAPITAL WORKS

11.7.1 CONTAINMENT LEVEL 3 FACILITY REFURBISHMENT - The existing lab facility was installed during phase 1 of the hospital build in excess of 30 years ago; as a result it was in urgent need of replacement. The facility has been identified on the capital programme over the last four years for upgrade & replacement, but has been unable to be prioritised due to other pressures within the Trust's capital programme.

The aged facility was removed and replaced in early 2020, providing the lab with an upgraded and safer facility in accordance with the HSE guidance, Health Building Notes and Health Technical Memoranda.

BEFORE

AFTER

11.7.2 ULTRASOUND ROOMS (WOMEN'S HEALTH) - Ultrasound Rooms A and B were updated for the first time since the original East Wing build in 1997. Hand washing facilities were replaced with new IPS units, compliant wash hand basins and WRAS approved taps. The air conditioning outlet was also redirected, flooring and worktops were replaced and power and data points were adjusted to enable staff to work efficiently within the space available.

11.7.3 NURSE BASE ON PURBECK WARD - The nurse base was removed, redesigned and replaced to improve both the use of the space and visibility for staff. Due to the works being in the middle of a live ward, careful measures were used to

minimise the risk of infection from construction dust. This worked successfully with no issues reported.

11.7.4 FACET PROPERTY APPRAISAL - A survey was undertaken to formally identify the condition of the site, its buildings and infrastructure, as well as highlight and record Backlog Maintenance. As part of the survey Statutory Compliance and the breakdown of Clinical/Non Clinical area usage was also assessed.

The appraisal was carried out addressing each of the 21 physical elements pertaining to NHS building stock, including items such as;

- Drainage, sewerage and water supply
- Ventilation systems
- Hot and cold water systems

As a result, the Trust now have a more detailed and formal way of identifying High and Significant Risks, and this information will be fed in to the development of the updated Estates Strategy and work package/budget planning going forward.

11.7.5 THEATRE OPERATING LIGHTS – The main operating theatre lights were replaced in Theatres 2 and 5 where the surface of the original lights had been flaking away in parts, which was a major concern. The successful replacements have now removed this significant risk.

The scheduled replacement of the lights in Theatres 3 and 4 has been delayed by COVID-19; however the lights have been purchased and are being stored on site, with the intention to fit them as soon as access can be gained.

11.7.6 ROBERT WHITE CENTRE SLUICE – The addition of a sluice to the first floor area of the recently constructed building was requested in April 2019 by the users of the first floor, to allow them to do some minor procedures. Work could not be carried out until June 2019 as the Trust were required to wait until defects period on the construction had expired.

A collaborative project with the IPC Team, the works involved converting one of the two staff only toilets. Air flow rates were increased and a new full stainless sluice hopper sink, cistern and taps were installed with IPC sign off before use.

11.7.7 OTHER CAPITAL WORKS

Carpet flooring was replaced with vinyl in Respiratory Medicine and Neurophysiology and other notable flooring works were completed in Diagnostic Imaging, Damers Restaurant and Kingfisher Ward, making cleaning easier and more effective.

Estates assisted Procurement with the installation of improved and fit for purpose storage in a number of wards.

Two additional birthing pools were installed in the Maternity Department as part of the formation of a new Midwife Led Unit. Technical challenges had to be overcome around the waste water in order to comply with water safety regulations.

12 DECONTAMINATION SERVICES REPORT (Kate Still, Decontamination Services Manager)

12.1 STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016. The department is also registered with the MHRA.

The Notified Body Intertek undertook an annual audit in May 2019 and no non-conformances were found. This Accreditation continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

The 3 day Re-certification Audit by the Notified Body Intertek scheduled for May 2020 cannot be undertaken on site due to travel restrictions. This will now be undertaken remotely via video link which is a new experience for the department and the auditor based in Poland.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset as well as a local GP practice. More recently the team have worked with the Dorset & Somerset Air Ambulance to help create bespoke surgical sets for their service which are now reprocessed in the unit. The accreditation maintained by the department gave the DSAA Consultants assurance of the consistent quality of the service. The team were presented with an Award Certificate from DSAA acknowledging the ‘can do’ attitude of the team.

Environmental Monitoring

The Clean Room Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on five washed but unsterile items – Quarterly
- Water Endotoxin - Annual

Latest testing of all areas occurred in February 2020 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are trended and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern at this time.

For compliance with HTM 01-01 ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfector is effective.

Tracking and Traceability
Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and one Outpatient Department at the moment.

Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf Life Testing
Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis and when a new wrap is introduced. All expired samples that were sent for testing still showed 100% sterility in the last round of testing which gives assurance that the decontamination process is effective.

Staff Training
All Managers and Supervisors have now attended the SSD Managers/Supervisors course at Eastwood Park. This City & Guild qualification gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day to day basis.

The service administrator and one Supervisor have achieved NVQ qualifications appropriate to their area of work. The service manager has taken on the role of Trust Decontamination Lead following completion of the C&G Decontamination Lead course at Eastwood Park and is now a Chartered Member of the IDSc (Institute of Decontamination Science).

All members of staff receive training appropriate to the area of production they are working in and are observation assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a Supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

12.2 ENDOSCOPY DECONTAMINATION UNIT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016 as an extension to scope of the existing certification in the Sterile Services Department.

This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customer.

Environmental Monitoring
Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Quarterly
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually

Latest testing of all areas occurred in February 2020.

All results are trended and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern at this time.

Weekly rinse water samples are taken from each washer chamber on a weekly basis to be tested for TVC and pseudomonas aeruginosa. There have been occasional raised results but no confirmed root cause has been established. Protocol has been followed on each occasion with the relevant chamber being placed on restricted use for low-risk scopes only with an internal Field Safety Notice being issued for any high-risk scopes processed in the affected chamber. Various corrective actions have been undertaken previously, on the advice of the Authorised Engineer (Decontamination), and further advice has been sought from Public Health England. As the results have returned to within specified limits on the week following the raised result and pseudomonas results have been negative on each occasion it is deemed that there is no immediate concern. Evidence from the Decontamination network indicates this is similar to other units.

Tracking and Traceability
Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and provides accurate traceability of all endoscopes used and significantly reduces the risk of an endoscope that has expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4723 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Hospital Technical Memorandum) 01-01:2016 that full traceability of reusable items can be evidenced. In relation to invasive probes, used in the Outpatient or Theatre setting, this requires the completion of the Tristel Wipe audit book and the insertion of the Tristel Wipe decontamination sticker being placed in the patient's health care record.

The only exception was in Ultrasound; the Radiology Patient System is audited for the same information as patient's health care records are not accessed during this diagnostic process.

This annual audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The 2019 audit showed that compliance with the use of the appropriate system is overall very good and has been sustained in those areas familiar with its use.

The only non-conformance related to appropriate record keeping in the patient's health care records in one area. That particular area was already under increased surveillance from the 2018 audit but despite being provided with additional training mid-year results still showed some non-compliance with appropriate record keeping although there were no concerns relating to the decontamination of the item. An action plan was approved at the Decontamination Group meeting and these actions proved to be effective as all records from that point were audited and found to be fully compliant.

Audit #4734 Decontamination and Single Use Instruments

This annual audit is used to measure compliance with requirements for the management of sterile instruments and single use instruments as per HTM 01-01:2016 and the sample involves each department that is supplied by Decontamination Services and/or uses single use surgical instruments.

This observation audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The outcome of the 2019/20 audit showed excellent and sustained compliance with the appropriate storage of sterile items and the transportation of contaminated items.

The only non-conformances related to the failure to display a ‘single use’ poster in some storage areas. This was rectified on the day the results were reviewed and new posters provided to those departments.

13 ANTIMICROBIAL REPORT - RHIAN PEARCE (Antimicrobial pharmacist) Antimicrobials: Summary report for financial year 2019/20

13.1 OVERVIEW

Antibiotic misuse is widespread and has profound adverse consequences, most notably the development of antimicrobial resistance. Judicious antimicrobial prescribing is recognised as a critical component in slowing the development of resistance.

Antimicrobial Stewardship (AMS) can both optimise the treatment of infections and reduce adverse events. AMS is now a prominent feature on the government's healthcare agenda, with numerous publications and directives issued to promote stewardship across all healthcare settings.

13.2 SUMMARY 2019/20

- The Antimicrobial Stewardship Committee (ASC) is now meeting regularly. In recent years the ASC has suffered from dwindling clinician engagement. Since clinical leadership is critical to the success of any antibiotic stewardship programme, we are pleased to welcome Alastair Hutchison (Medical director) as the new chair.

- EPMA reporting capacity has continued to improve. Several reports have been developed to allow targeted intervention and improve data capture to support a wide range of stewardship activities. We have also introduced a powerful reporting database (REFINE), which allows active surveillance of antibiotic prescribing across the Trust. It also allows comparison of prescribing trends against other hospitals.

  Effective antimicrobial oversight is the foundation of any stewardship program, but sustained progress in this area can only be delivered through continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship Team.

- Continued work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. We have also reconfigured our antibiotic guideline webpage, making our guidelines easier to navigate.

- Non-CQUIN related audits have been performed on an ad-hoc basis. Limited resource, coupled with competing demands from mandatory targets, has hampered a formal programme of sustained audit activity. Timely reporting with feedback to clinicians is recognised as a significant driver for changing behaviour and improving prescribing and this is something we are keen to renew.

- Participation in *Clostridium difficile* RCA meetings and identifying themes related to antimicrobial prescribing and pharmaceutical review of patients.
- Published a range Safe Medication Practice Bulletins; penicillin allergy, antibiotic oral switch review, fluoro adverse reaction awareness.
- Procalcitonin has been introduced to steward early discontinuation of antimicrobials in COVID patients. We also performed a gap-analysis of available fungal diagnostics locally. Improving the range of laboratory based diagnostic testing for infection is recognised an essential tool for tackling resistance and optimising patient outcomes.
- FY1 teaching sessions; principles of antimicrobial prescribing, diagnosis and treatment of urinary tract infections, Gentamycin/Teicoplanin/Vancomycin prescribing.

13.2.1 NATIONAL TARGETS

CQUIN CCG1a: Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

Data collection was not possible due to difficulties identifying patients. Data submission is no longer mandatory due to the COVID pandemic. Other trusts have reported similar difficulties, prompting a review of the CQUIN data collection methodology for next year.

CQUIN CCG1b: **Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.**

DCHFT met the target, achieving 98% compliance. This exceeds the national mean of 87% for Q3.

CQUIN PSS1: Trigger 5, Antifungal Stewardship:

Attainment criteria were met for Q1, Q2 and Q3. This included the development of a comprehensive set of local antifungal prescribing guidelines. Q4 data submission has been suspended by NHSE due to the COVID outbreak.

13.2 ANTIBIOTIC CONSUMPTION TRENDS

Total antibiotic consumption targets now form part of the standard NHS contract. Carbapenem and access target indicators have been removed, but are included below for local use.

13.2.1 TOTAL ANTIBIOTICS

Target: Reduce total antibiotic consumption by 1% from the calendar year 2018 baseline.

Total antibiotic consumption is down 0.46% on last year, but falls short of the 1% reduction required (Fig 1). However, it still represents a total reduction of 22% compared with the 2016 baseline year, with DCHFT achieving the greatest reduction regionally during this period (Fig 2).

*Date range excludes COVID period

Fig. 1

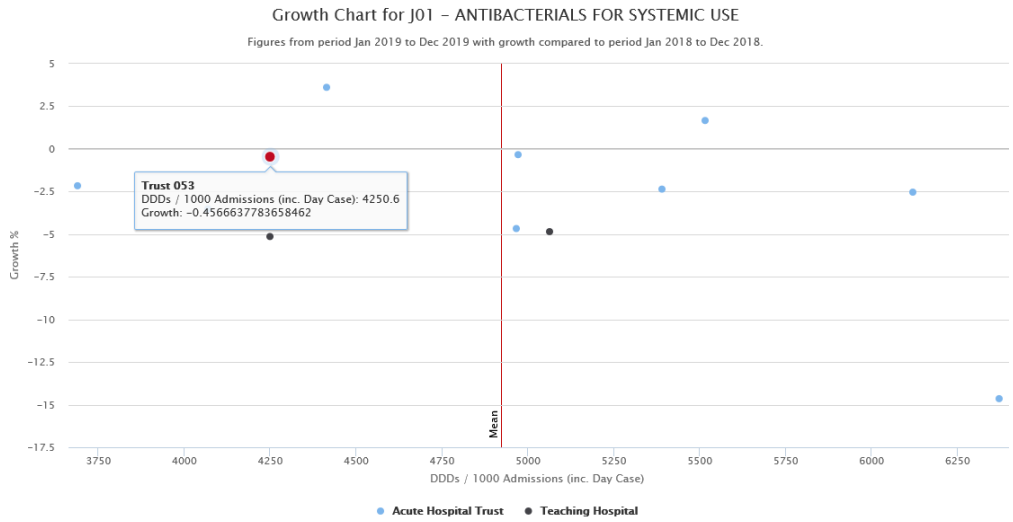
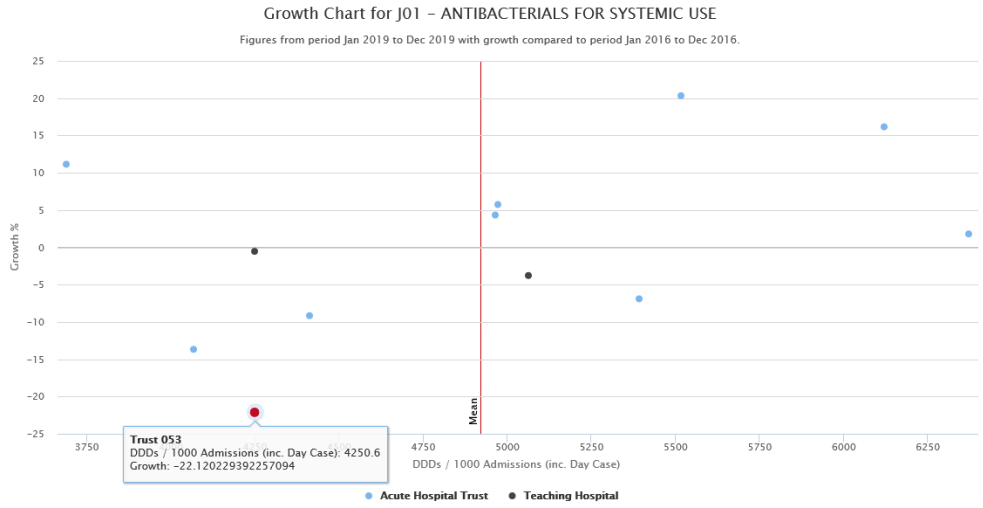


Fig 2.

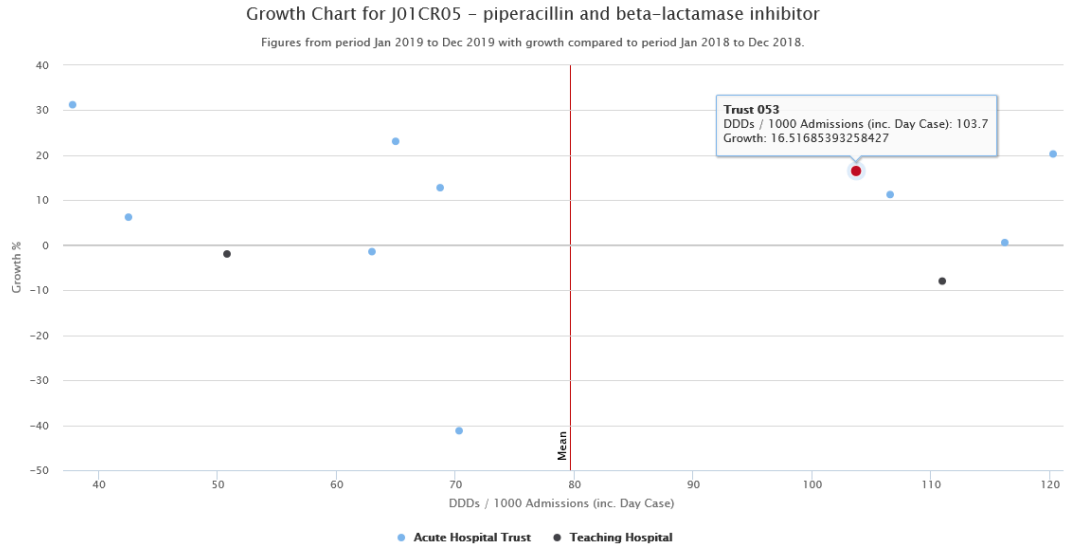


13.2.2. CARBAPENEMS AND PIPERACILLIN/TAZOBACTAM

Our standard reporting tool for monitoring carbapenem consumation indicates that usage for 2019/20 has approximately doubled compared to the previous financial year. Data validation is in progress to verify the figure. A separate report will be submitted to the next ASC and IPC.

Piperacillin/tazobactam consumption is up 16% on last year (Fig 3). The rise in consumption is currently being investigated. A separate report will be submitted to the next ASC and IPC.

Fig .3



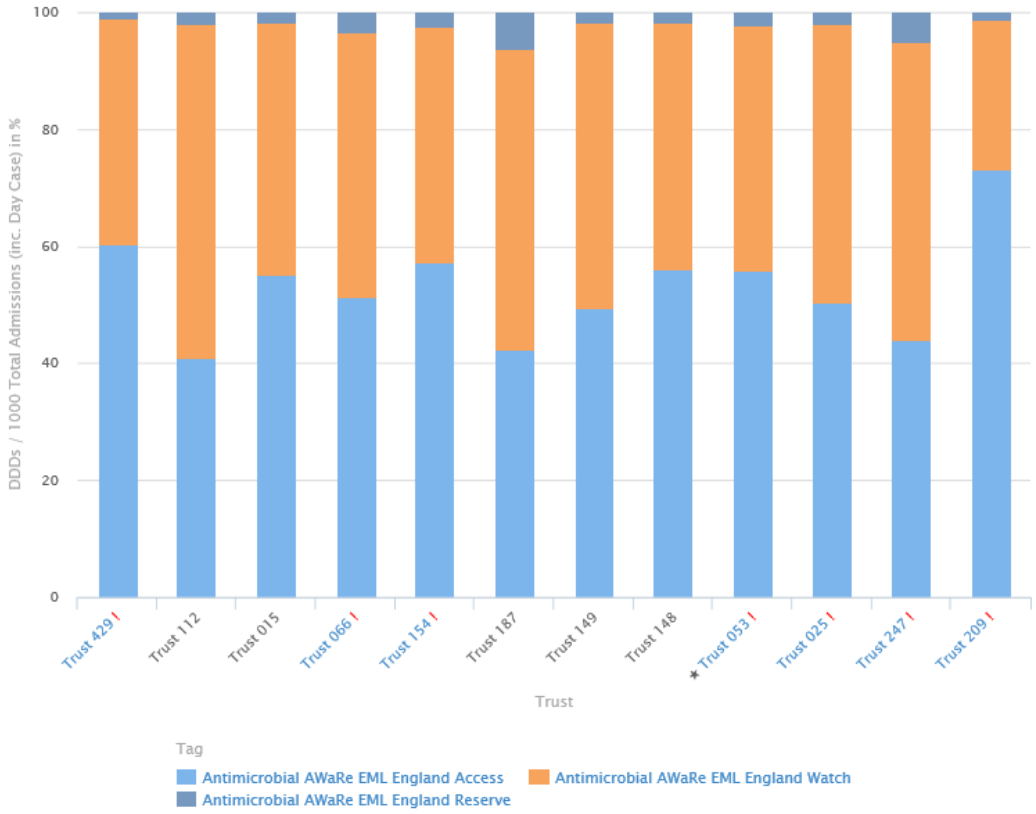
13.2.3. PROPORTION OF TOTAL ANTIBIOTICS BY AWARE CATEGORY

56% of DCHFT's total antibiotic consumption for 2019/20 were narrow spectrum agents (AWaRe access category), comparable to the previous year (57%). See Fig. 4.

Using consumption data alone, measured by DDDs, is a poor surrogate for overall antibiotic stewardship performance. In reality, a trust would meet the consumption targets by using a larger proportion of broad-spectrum antibiotics instead of narrow-spectrum agents. This is a known limitation of how antibiotic consumption figures are currently calculated, and using AWaRe categorisation alongside consumption helps mitigate this limitation.

Fig 4 AWaRe - Proportion of DDD per 1000 admissions by EML (England) category over last 12 months

(DCHFT =trust 053)



13.3 LIMITATIONS

Data are unadjusted for the confounding effects of case mix, age and sex. As such, direct comparison between DCHFT and the national or regional average is limited. In addition, CQUIN audit indicators are prone to inter-rater variability, which may in part explain the variability in performance across England.

Patient outcome data is not routinely collected or published alongside CQUIN and consumption data, raising concerns over the potential unintended consequences following their implementation.

13.4 SUMMARY OF FUTURE WORK

- To establish local AMR CQUIN groups to monitor progress against the 2020/21 AMR CQUINs and steer intervention. This group will report to the AMS committee.
- To ensure that AMR CQUINs are allocated to a suitable clinical lead, to encourage clinical engagement.
- Updating and streamlining the existing audit programme to incorporate CQUIN specific indicators for 2020/21. The CQUINs for 2020/21 focus on diagnosis and treatment of UTI and community acquired pneumonia.

  Next year's CQUIN has a demanding data collection element. NHS England has stipulated that stewardship teams should not collect data; instead, their time is better spent steering intervention and focussing on quality improvement. We would echo this recommendation and urge the Trust to recognise that the current data collection demands cannot be absorbed by the stewardship team, without displacing other core stewardship activities.
- To develop a systematic approach for reviewing local susceptibility patterns as part of the antibiotic guideline development process.
- To delineate channels within the organisation to disseminate audit results and garner support for AMS.
- Continued work on integrating the laboratory and stewardship programme to ensure rapid provision of test results and that clinicians understand their implications.
- We plan to introduce a comprehensive package of antimicrobial prescribing and stewardship training for doctors, nurse prescribers and pharmacists. This will be delivered via e-learning.
- Continued work on developing a set of metrics for monitoring stewardship activity; focusing on process and outcome measures to better illustrate the value and sustainability of our programme. This should also provide us with evidence for future investment and better resource allocation.
- As pharmacist recruitment and retention improves, we are keen to implement a framework for pharmacy-led interventions to optimise antimicrobial therapy, including dose optimisation and systematic conversion of intravenous to oral antimicrobial therapy.

It is essential that we continue to make progress, and as a team, we are pushing ourselves with a new set of challenging ambitions for next year. However, we are unlikely to meet these goals without increased engagement from the organisation, recognising that AMR is a threat to patient outcomes across all clinical divisions and is a shared responsibility. There is also a potential financial loss for the Trust if insufficient resources are allocated to meet the CQUIN targets for next year.

CONCLUSION

2019-2020 has been a very successful year with significant reductions in healthcare acquired infections reported i.e. Clostridium difficile, ECOLI and MSSA blood stream infections. Trajectories for both MRSA and Clostridium difficile were achieved demonstrating excellent practice and engagement with infection prevention and control by Trust staff.

This report demonstrates the continued commitment of the Trust and evidences successes and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all DCHFT staff dedicated in keeping IPC high on everyone's agenda.

The last quarter of the year was dominated by COVID-19 and the IPCT workload increased dramatically as a result. Keeping the Trust staff and patients safe was priority during this time and the working day of the IPCN was unpredictable and often very stressful. Throughout this time the team dedicated their time to the management of the pandemic and should be recognised for this hard work. I personally would like to thank my team for their dedication and maintenance of their positive spirit.

The annual work plan for 2020-2021 reflects a continuation of support and promotion of infection prevention & control. Looking forward to the year ahead the staff at DCHFT will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

2020-2021 will be a progressive year as DCHFT leads on the clinical element for the ICNet rollout Dorset-wide.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Hoyle

Associate Director Infection Prevention & Control

Appendix 1

Infection Prevention & Control Work Plan 2020-2021 V1

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Associate Director Infection Prevention & Control	Bi-Monthly	
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet. Support of the Dorset wide project to be clinically lead by DCHFT	Contract renewal	Associate Director Infection Prevention & Control	September 2020	
		The Trust will maintain a high standard of Infection Prevention & Control	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings IPC performance standard dashboard to be met Learning from performance data to be disseminated	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Heads of Nursing / Quality	March 2021	
2	Provide and maintain a clean	DCHFT will maintain a clean and safe	Dorset County Hospital to support PLACE	The environment is safe and clean	Infection Prevention & Control Team	Sept 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	and appropriate environment in managed premises that facilitates the prevention and control of infections	environment for patient care	assessment				
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	Facilities Manager	
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	IPC Team Facilities Manager Estates Manager Patient representatives Pharmacy	March 2021	
		All clinical equipment is clean and ready for use at point of care	Use of Clean/Dirty indication stickers implemented Trust wide 2018/19	All clinical equipment will be identified as clean or requiring cleaning	IPCT to implement review process via ward rounds Divisional Heads of Nursing / Matrons to monitor	August 2020	
		DCHFT will maintain a clean and safe water system	Policy to be updated and communicated and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy. Water Safety is a standing item at IPCG.	Head of Estates	March 2021	
3	Provide suitable accurate information on infections to service users and	Patients will be fully informed about their presenting infections. All new cases of *CDifficile,* MRSA and	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and	Positive patient feedback	IPCT	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	their visitors	ESBL will be counselled by an IPCN	contact details				
		The Trust will have up to date patient information relating to infection control	Review of all IPC patient information. Check meets standards and revise accordingly	Positive patient feedback	IPCT	March 2021	
4	Provide suitable accurate information on infections to any person concerned with providing further information support nursing/ medical care in a timely information	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and staff	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department, providing clinical support to staff and patients	Minimum cross infection, reduced prolonged outbreaks of infection, reduced HCAIs	IPCT	March 2021	
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other	Achieve trajectory for *Clostridium difficile* infection (CDI) TBC cases (does not include cases whereby no lapses of care were identified	Undertake Root Cause analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset- Healthcare Acquired and Community Onset Healthcare Acquired	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Divisional Head of Nursing / Matrons	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	people	Reduce rates of Gram-negative blood stream infections (BSI) by 50 % by 2023	Undertake IPC led Root Cause analysis of all hospital acquired cases of gram negative BSI – escalate to full RCA if lapses in care	All cases of Gram negative BSI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Associate Director Infection Prevention & Control	March 2021	
		Ensure the Trust is robustly prepared for Winter	Support staff vaccination programme for seasonal influenza Reinforce Seasonal Influenza Policy and Pandemic Influenza Policy Ensure staff are familiarised with the Outbreak/Noro policy	The Trust will be able to function effectively during the Winter months and Infection Control standards are maintained	Associate Director Infection Prevention & Control	October 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		Ensure Trust remains aligned to Public Health England COVID-19 Infection Control Guidance.	Maintain COVID-19 Board Assurance Framework and report bi-monthly to IPCG , Quality Committee and Trust Board	The Trust will be able to support the demands of the COVID-19 pandemic	Associate Director of Infection Prevention and Control Director Of Quality and Nursing	Ongoing	
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	High standards of hand hygiene practice throughout the Trust.	Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve<90% to present action plan to IPG.	Hand hygiene results >95% and sustained at this level for all wards/departments Departmental Managers to report to IPG with action plan when hand hygiene results <90%.	Divisional Head of Nursing / Matrons	Monthly	
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT	Bi-Monthly	
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2020	
		Education	Support DCHFT mandatory training programme	Education reflects national and local requirements for	IPCT	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Via e-learning and face to face training	mandatory IPC training.			
7	Provide or secure adequate isolation facilities	Ensure the risk of cross infection is reduced Trust wide	Undertake annual audit of isolation precautions to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation.	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2021	
8	Secure adequate access to laboratory support as appropriate	IPCT to support and be involved in the county wide pathology project ensuring delivery of safe patient care is not affected	IPCT to be involved in county wide meetings where appropriate and provide expert support for the project	Safe transition of service	Associate Director Infection Prevention & Control	March 2021	
			IPCT at DCHFT to take nursing lead on development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project to be implemented once funding released	One ICNet system across Dorset	Associate Director Infection Prevention & Control	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	Audit programme- to audit compliance with Key IPC policies	PVC audits undertaken to ensure compliance with observation standard	PVC observations will be observed every shift and recorded on Vital Pac	IPCT	Quarterly	
			Urinary catheter documentation audits undertaken to ensure compliance with observation standard	Urinary catheters will be reviewed on a daily basis and care documented on Vitalpac	IPCT	Monthly	
			Audit compliance with CPE screening recommendations. Divisional Matrons to review results with wards and develop action plans dependant on results of audits	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust	IPCT Divisional Matrons	Biannually	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan to be developed and implemented Results to be presented at Divisional Governance Meetings and IPCG	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads Divisional Matrons	March 2021	
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	Audit identifies compliance with safe management of storage and disposal of sharps	IPCT	Sept 2020 (IPCT) Oct 2020 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask testers in place to support evolving needs created continuous change of suppliers of masks influenced by COVID-19 pandemic	All clinical staff will have access to FFP3 training and able to care for patients using airborne precautions	Health & Safety Lead	Ongoing	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	provision of health and social care	Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious patients	Ensure all 'IPC Emergency Boxes' are maintained and in date Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	All clinical staff are aware and able to support the emergency preparedness of the trust for IPC issues	Associate Director Infection Prevention & Control / Lead Emergency Planner	October 2020	

There are 10 criteria set out by the *Health and Social Care Act 2012* which are used to judge how we comply with its requirements for cleanliness and infection control. This is reflected in the *Care Quality Commission Fundamental Standards Outcome 8* and detailed above in the annual work plan which is monitored by the Trust's Infection Prevention and Control Group.

Emma Hoyle – Associate Director Infection Prevention & Control June 2020

V1 June 2020