Board of Directors Meeting
08.30am – 1.00pm, Wednesday 30 January 2019
Seminar Room, Children's Centre, Dorset County Hospital

AGENDA

PART 1 (PUBLIC SESSION)

			Approx. timings	
1	**Service Story – Ophthalmology**		**8.30**	Sophie Jordan
2	**Welcome and Apologies for Absence:** Paul Goddard, Sue Atkinson		**9.00**	Chair
3	**Declarations of Interest**			All
4	**Chairman's Remarks**	Oral		Chair
5	**Minutes of Board of Directors 28 November 2018** To approve	Enclosure	**9.00**	Chair
6	**Matters Arising from those Minutes and Actions List** To receive	Enclosure	**9.10**	Chair
	QUALITY AND PERFORMANCE ITEMS			
7	**Chief Executive's Report** To receive	Enclosure	**9.20**	Patricia Miller
8	**Integrated Performance Report** To receive and agree any necessary action **a. Quality** **b. Performance** **c. Finance** **d. Workforce** **e. ICS update**	Enclosure	**9.35**	 Nicky Lucey Inese Robotham Rebecca King Mark Warner Nick Johnson
	BREAK		***10.15***	
	GOVERNANCE ITEMS			

9	**Risk Register and Board Assurance Framework** To approve	Enclosure	**11.45**	Nicky Lucey/Paul Goddard
10	**Mortality Report** To approve. To delegate authority to the Quality Committee to approve the Mortality Report for Q4 in April for noting by the Trust Board in May and to approve the Q2 Mortality Report in October for noting by the Trust Board in November.	Enclosure	**12.00**	Alastair Hutchison
11	**Medical Re-validation** To approve.	Enclosure	**12.15**	Alastair Hutchison
12	**Guardian of Safe Working Report** To discuss	Enclosure	**12.20**	Alastair Hutchison

CONSENT SECTION

The following items are to be taken without discussion unless any Committee Member requests prior to the meeting that any be removed from the consent section for further discussion.

13	**Workforce Committee Terms of Reference** To approve	Enclosure		Mark Warner
14	**7 Day Hospital Services Self-Assessment – Autumn 2018** To approve	Enclosure		Alastair Hutchison
15	**Quarterly Activity Report Communications** To note	Enclosure		Nick Johnson
16	**Any Other Business**		**12.40**	Chair

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

Questions from the Council of Governors and Members of the Public – 12.45pm to 1.00pm. Fifteen minutes will be allowed for questions, with priority being given to Governor questions submitted in advance of the meeting.

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

BOARD OF DIRECTORS
PART 1 (PUBLIC SESSION)

Minutes of the Meeting of Wednesday 28 November 2018
Seminar Room, Children's Centre, Dorset County Hospital

Present:

Mark Addison (Chair)
Sue Atkinson (Non-Executive Director)
Judy Gillow (Non-Executive Director)
Paul Goddard (Director of Finance)
Peter Greensmith (Non-Executive Director)
Alastair Hutchison (Medical Director)
Victoria Hodges (Non-Executive Director)
Richard Jee (Divisional Director)
Nick Johnson (Director of Strategy and Business Development)
Nicky Lucey (Director of Nursing and Quality)
Ian Metcalfe (Non-Executive Director)
Linda Power (Interim Chief Operating Officer)
Inese Robotham (Chief Operating Officer)
Matthew Rose (Non-Executive Director)
Mark Warner (Director of Organisational Development and Workforce)

In Attendance:

Rebekah Ley (Trust Board Secretary)
Fiona Richey (Divisional Lead Nurse)

Apologies:

There were no apologies.

Observers:

Members of the public: Mr Philip Jordan.

BoD18/121 Patient Story

Fiona Richey introduced Brenda's story. Brenda had undergone a traumatic colonoscopy. She subsequently attended the Day Surgery Unit of the Trust and her experience had been positive. She complained to the Trust about her care and treatment when undergoing her colonoscopy via the PALS team. Her complaint was resolved with a meeting with the Consultant and a member of the PALS team. The experience illustrates the wider learning, for all staff, that can come from informal PALS matters. In this case the key learning point being the importance of listening to patients.

The Chairman asked Fiona to pass on the Board's thanks to Brenda for her story.

BoD18/122 Welcome and Apologies for Absence

None were received.

BoD18/123 Declarations of Interest

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

BoD18/124 Chairman's Opening Remarks

The Chair welcomed Inese Robotham (Chief Operating Officer) to the meeting and thanked Linda Power for her contribution to the Trust during her tenure as Interim Chief Operating Officer.

The Chair thanked everyone for achieving the recent Good rating from the CQC.

The Chair noted that the Charity Team would be joining the Board for lunch to celebrate their achievement in reaching the Cancer Appeal target.

The Chair said that the papers for the meeting were too long. He reminded the Board of the commitment it had made that Board papers should have a one page summary sheet (front sheet) describing the contents of the paper. There should then be a main paper of no longer than four sides of A4. All additional information should be included in appendices.

BoD18/125 Minutes of the Previous Meeting held on 26 September 2018

There were minor typographical errors that the Chair had noted (for correction outside of the meeting). Apart from these, no other changes were proposed and the minutes were approved as a true and accurate record of the meeting.

BoD18/126 Matters Arising and Action Tracker

BoD18/102: To agree extended terms of reference with Internal and Externa Auditors regarding review of the EPRR statement. Ian Metcalfe, Chair of the Risk and Audit Committee had taken this forward with the Interim Chief Operating Officer. He confirmed that internal audit will be reviewing EPRR evidence and business continuity in due course. The Chief Executive said that if Parliament rejects the Brexit proposals on the 11th December then there will be an immediate response from the Centre that will be issued to all Trusts. Item to be closed on the action tracker.

BoD18/073.1: DPR presentation in February. This is on the forward work plan for the Board and will include a live demonstration. Item to be closed on the action tracker.

BoD18/073.2: The Winter Plan: noted that this is an agenda item. Item to be closed on the action tracker.

BoD18/056: Strategic Plan Update Report: noted that this will be an item for every other Board Meeting and is on the Board's Forward Work plan. Item to be closed on the action tracker.

BoD18/008: Ophthalmology department presentation: noted that this is an agenda item for January. The Chair stressed that the Board wanted to hear from front line staff as part of the presentation. Item to be closed on the action tracker.

BoD18/028: Research Strategy: noted that this is an agenda item for the January Board meeting. Item to be closed on the action tracker.

BoD17/105: Well-led Action Plan Update: noted that this is an agenda item for Part 2 of the meeting. The Board will receive regular updates on the Well-Led Action Plan. Item to be closed on the action tracker.

The Chair noted that the changes to the Governance Code were mentioned in the Board Minutes. The Trust Secretary confirmed that she had prepared a paper and this had been submitted to the Chief Executive. The changes would be applicable for the financial year 2019/20 and this would be an agenda item for the Board in March.

There were no further matters arising or items from the action tracker.

QUALITY AND PERFORMANCE ITEMS

BoD18/127 Chief Executive's Report

The Chief Executive, taking the paper as read, highlighted the following:

Sir David Behan has been appointed chair of Health Education England (HEE). The Department of Health and Social Care has confirmed Sir David will chair HEE for three years from 1 December 2018. Sir David announced he was stepping down as Chief Executive of Care Quality Commission earlier this year after six years leading the regulator.

Public Health England was being restructured and there will be seven regional directors. The revised structure for the organisation had been published. She said this represented a risk going into winter with a new Regional Director.

Professor Theresa Marteau, Head of the Behaviour and Health Research Unit at the University of Cambridge, has warned that government plans to target individuals with health advice tailored to their lifestyle and even genetic make-up may prove ineffective. The Secretary of State for Health and Social Care, Matt Hancock, launched an initiative on preventing ill health, saying public health bodies should use personal data to target advice on alcohol, diet and exercise. Dame Theresa said that the key to improving behaviours was to change the physical, economic and digital environments that shape our behaviour.

The Royal College of Physicians (RCP) has launched a new code of conduct, encouraging doctors to be the best they can be by being more aware of their behaviour on others. The code contains a simple 10-point plan. The code is set to be written into the RCP byelaws and reflects the values launched by the College. The standards compliment guidance provided by the General Medical Council and other guidance in addition to the Nolan principles of public life.

In terms of local matters, the Chief Executive said that the Trust faced a number of operational challenges:

Temporary staffing: although overall workforce costs decreased in month, temporary staffing usage is still placing pressure on pay budgets and the spend remains above the NHSI cap.

Performance against the 62 day cancer referral to treatment standard continues below target. An external review by NHS Improvement identified a small number of improvements. She said that as the Trust has committed to two key operational standards namely four hour emergency access and the 62 day referral to treatment target, it is imperative the Trust sees significant improvement.

The SHiMi rates for the Trust continue to track above levels expected. A detailed action plan is in place to improve the depth of clinical coding but its full execution will require further investment. The Board can take some assurance from the report developed by the Medical Director outlining a number of safety indicators which the Board should focus on alongside mortality data to indicate whether or not safe care is being provided.

The Trust continues to find its financial plan challenging to achieve. A recovery plan has been signed off by the Finance and Performance Committee and Trust Board. However the Trust has not seen the improvements expected in October. Further financial controls have been implemented. The present position presents a significant risk to the long term sustainability of the Trust.

The Dorset ICS will meet with NHSE and NHSI on the 4th December as part of the national assurance process. She had attended a meeting of the CCG Governing Body and will provide feedback in Part 2 of the meeting.

Board members commented on the RCP code of conduct and said that it was helpful and relevant especially when viewed in conjunction with the patient story they had heard at the beginning of the meeting. The Medical Director confirmed that the code had been circulated to the Clinical Directors to share within Care Groups and with Consultants.

The Chair thanked the Chief Executive for her report and noted that it was helpful to have both the national and local perspectives in her report.

BoD18/128 Integrated Performance Report

The Chair said that in future the report will include information from the Workforce and Risk and Audit Committees.

Quality Report

The Director of Nursing and Quality introduced the report. The key areas of concern are:

- There was 1 Never Event reported during this month.
- Dementia screening and onward referral remains below the standard required.
- There has been no improvement noted within the timeliness of complaint responses.
- There has been deterioration in the standards for sepsis screening and antibiotic administration within 1 hour.

There are positive things for the Board to note:

- Infection prevention and control indicators have been sustained.
- Falls risk assessments, pressure ulcer assessments and VTE risk assessments have been consistently achieved.
- There were no falls resulting in severe harm during this reporting period.
- Inpatient, Emergency department and Outpatient recommendation rates for the Friends and Family test have been achieved.
- The home birth rate has consistently delivered well above the national average at 8.5% for October.

The Chair of the Quality Committee, Judy Gillow said that she agreed with the summary provided. She said that in some areas the Trust performs well and consistently and this illustrates that improvement can be sustained. She said that the focus of the Committee is on complaints and dementia screening, she said that her view is that sepsis figures will improve. She said that the Committee cannot provide assurance to the Board around complaints and dementia screening but confirmed that the Committee continues its relentless, forensic focus on these matters. She said that there were issues around clinical engagement in respect of both complaints and dementia screening that needed to be addressed. The Quality Committee is ensuring that the complaints team follows national guidance is followed in respect of complaint responses. The target is for a response in 25 days but this can be extended with the agreement of the complainant. This has not always been consistently recorded however, the move to the Datix system should help with this.

The Medical Director agreed that clinical engagement was necessary to improve many areas of quality performance and that improved engagement was what would take the Trust from Good to Outstanding at its next QCQ inspection. The Chief Executive said that there was a broader point to be considered by the Board at a future meeting and that was performance management and treating clinicians in the same way as all other staff.

Board members asked about the never event and whether the Director of Nursing and Quality can give the Board any assurance around the WHO checklist. Board members expressed concern that the checklist provides people with a false sense of security. The Director of Nursing and Quality explained that the item in question, that had been retained, was a sleeve that does not come within the scope of the WHO checklist. This had been escalated at a national level.

The Chair noted that the issues identified were complex to tackle. He asked his Executive colleagues to think about culture, governance and effectiveness and the tools the Trust might want to employ as part of this. The Chief Executive said that the Clinical Leadership Development Programme that will commence in April 2019 will help inform this.

Action: Trust Board Secretary to plan the Development Session for the Trust Board in August next year with a focus on Clinical Governance.

Performance Report

The Interim Chief Operating Officer introduced the report. She said that October was a busy month for operational teams with additional focus on finalising the business continuity plans for the winter period. In month, there was a reduction in non-elective emergency activity and an increase in elective referrals. Performance against the 4 hour standard in ED was achieved and the Trust was noted on the BBC Hospital tracker as being the joint-second best performing Trust nationally in month. This is attributed in part to a reduction in the number of attendances with a return to the normal sessional levels of 120-135 attendances per day. The RTT constitutional standard was not achieved; however, performance against the revised trajectory of 79.8% was achieved. The reduction in performance is hampered by increased demand; consultant vacancies and an increase in fact track referrals with the biggest impact on ophthalmology, T&O and Oral Surgery. There were no 52 week breaches. There has been a notable improvement in the performance against the cancer standards despite the stepped increase in fact track referrals. The exception is the 62 day standard with the main concern being the prostate pathway and access to tertiary services. The Trust has not achieved, but has improved performance against the diagnostic standard. This performance is being driven by cancer referrals. The growing waiting list for routine endoscopy is a concern and could affect JAG accreditation. The Chief Operating Officer said that in respect of endoscopy, the Trust has six months to recover its position. If it does not achieve JAG accreditation it has financial implications for the Trust.

Matthew Rose, Chair of the Finance and Performance Committee said that there were three main points he wanted to highlight, ED performance and the improvement must be recognised. He said that the Trust had made a conscious decision around RTT but that there are over 6,000 follow-up appointments to be booked and FPC is unsighted on the impact on those patients waiting. He said he was working closely with the Quality Committee in this regard. He said that it might be the case that as many as half of those patients do not need to be waiting. He said that closely interlinked with the demand and capacity piece; demand is out-stripping capacity in most areas and, at the present time, the Trust is dealing with this. However, there is a point at which a line needs to be drawn because services cannot be sustained at this level.

He said that the Trust will need to decide what it can and cannot deliver. Until now, the Trust has absorbed numbers but he said that serious consideration should be given to the Trust escalating concerns that it has about the system and where the Trust has serious safety concerns about services it will need to stop those services. There needed to be discussions with Commissioners because currently the risks are borne by the Trust.

In response to a question, the Interim Chief Operating Officer confirmed that there were ongoing talks in respect of the Weymouth Urgent Care Centre and the request for Dorset Healthcare to increase the opening hours to 10pm. Dorset Healthcare is considering this. The plan is to take this matter to OFRG for a decision. She said that this is an illustration of the issues that the Trust is facing working with system partners who unilaterally make decisions that have a knock-on effect with Dorset County Hospital. The Chair noted the role of the CCG and their responsibilities in instances such as this. The Chief Executive agreed and said that despite the tensions and difficulties for the CCG they have legal, statutory responsibilities and these should be not underestimated.

The Trust Board supported the decision to negotiate with Dorset Healthcare in respect of the Weymouth Urgent Care.

Finance

The Finance Director introduced this aspect of the report. He said that in month (October) the Trust was just about on plan. However, the Trust had not achieved the expected improvement trajectory and in particular this was in Division B. He said that some time had been spent discussing this at the Finance and Performance Committee. There would be tighter central controls. There had also been pressures in respect of drug costs and theatre consumables which reflect the demand pressures. Agency spend did fall in the month in respect of medical rather than nursing staff. He said there are still big risks around the Trust hitting its control total and he will discuss this further in Part 2 of the meeting. The Chair of the Finance and Performance Committee expressed the Committee's disappointment that there had not been the necessary behavioural changes which mean the Trust's position is worse than planned.

Workforce Report

The Director for Organisational Development and Workforce introduced this aspect of the report. There had been an overall increase in workforce capacity in the month. He said that this reflects the Trust's successful recruitment initiatives. He said that this is the first month where the Trust is below NHSI agency cap. Projecting these figures forward, he said that it is unlikely the Trust will retrieve the position and may be over the Trust's cap at year end.

His team has had a busy period with the international nurses starting at the Trust. He said that five of the international recruits, two have taken their OSCE exams and passed first time which is a real achievement and reflects the support that they have received from across the Trust to achieve this. He said the Trust will continue to recruit from overseas but will look at other offerings apart from working with Yeovil.

He said that sickness figures are flat and turnover is similarly so although he said that this can mask particular pressure points. His team is currently working with Pharmacy to understand their staff turnover and what is driving this. Appraisal rates continue to be below target. He said that as part of its Forward Work plan, the Workforce Committee is planning a deep dive for January on appraisal rates. He drew the Board's attention to the second six monthly leadership event that had been held on Monday 26th November. This time the event had been a half-day session focussing on health and well-being which is one of the Trust's three priorities as part of the People Strategy.

Victoria Hodges, Chair of the Workforce Committee added that the last two meetings of the newly formed Committee had looked at the Terms of Reference and Work Plan. She said that one of the challenges is that "people" covers almost everything that is Trust related and the Committee is working out just how broad the agenda should be and what the Committee should focus on to provide assurance. The Committee will be broadening the membership of the Committee and engaging the Divisions and other

departments as part of this. At the last meeting the Committee looked at the People Strategy roadmap and as part of the Work plan review the Committee will ensure deep dives in particular areas to ensure the Trust is making progress on these. She wants to see a change in focus that means the meeting is less about reporting but supporting a shift in culture and responsibility to focus on actions.

The Chair thanked the Executives for their reports. He said that at the next Board meeting there would be a focus on performance across the system.

The Board took a short break at 10:30

STRATEGIC ITEMS

BoD18/129 Winter Plan

The Chair noted that the Plan had been approved by the Finance and Performance Committee but that the Trust Board is required to formally "sign-off". The Interim Chief Operating Officer introduced the report. She said that the Finance and Performance Committee had requested that information about staff support be included in the plan and this had been added to the papers before the Board.

The Board supported the plan but suggested that there were monitoring systems in place as far as was practicable to ensure that if community and system partners are not working to the agreed plans, that the Trust has clear trigger points for closing beds and/or robust decision making and escalation processes. The Board would like to see a level of system monitoring against the Plan.

The Interim Chief Operating Officer said that there are safety checks four times a day at the bed meetings to risk assess what is feasible in terms of patient capacity set against the staffing resource. The Chief Executive said that at the bed meetings there is often a focus is on trying to open additional capacity, she said that the Trust does not want to put staff at risk. She said that when considering staffing the availability of junior doctors should also be part of that. If additional capacity for patients is created this has an extra burden on junior doctors. She said the issue of escalation would benefit from a discussion outside of the meeting with her Executive colleagues.

The Director of Nursing and Quality said that it was important that she flagged to the Board her concerns about the wider system issues. She said that the Trust has patients whose discharge is delayed because of staffing issues and constraints outside of the Trust. She said that mental health provision was also an area of concern. There were often delays in the appropriate placement of patients with the Trust using Police and security at its own cost to safely manage them. She said that the council had shared its winter plans with the Trust but the Trust has concerns about their staffing resources to be able to manage their additional capacity in particular to provide care at night.

The Chair thanked the Interim Chief Operating Officer for the work undertaken to develop the Plan. The Board approved the plan but noted the need for clarity on process for assessing risk and in particular for closing beds. He said the wider points about the system raised by the Director of Nursing and Quality were noted as were the points about junior doctors.

Action: Executive Directors to discuss the Trust's escalation process regarding the Winter Plan.

GOVERNANCE ITEMS

BoD18/130 The Corporate Risk Register and Board Assurance Framework

Corporate Risk Register
The Director of Nursing and Quality introduced the Corporate Risk Register.

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 corporate risks are effectively being managed and that controls are in place to monitor these. All care group risk registers have been reviewed.

The most significant 5 risks which could prevent the Trust from achieving its strategic objectives are:

1059: Recruitment and retention of medical staff across specialties.
1058: Volume of appointments on gastroenterology out-patients waiting list causing negative outcomes for patients.
1045: Ophthalmology service capacity.
1011: Access to care in the community.
1049: Financial sustainability

An emerging risk to flag to the Board is the issue relating to the management of Co-Tags, the system whereby staff access the hospital site. She said that consideration is being given to putting Electronic Discharge Summaries on to the Register. She said that all risks continue to be transitioned to the Risk Register Module in Datix.

There was a broad discussion around risk levels and scoring and subjectivity rather than objectivity and the same debate had taken place at the Risk and Audit Committee. In general the Board felt that better narrative was required to understand the extent of mitigations in place. A summary of risks should include pre and post mitigation scores. The Board also felt that the Winter Plan and/or elements of it should be on the Register or more narrative detail added to risk 1011.

The Board also noted confusion around the risks related to fire and fire doors (different figures for the number of doors that are a concern) and suggested that this was another area on the register that would benefit from better narrative detail.

There was also concern that financial sustainability was rated as amber (moderate). The Board noted that this would be discussed by the Risk and Audit Committee in January and then again that the Trust Board. If adjustment was required it would be discussed then. The Board also said consideration should be given to adding Clinical Coding to the Register.

The Board Assurance Framework (BAF)

The Director of Finance introduced the report. He said that the BAF had been discussed at the Risk and Audit Committee meeting on the 20th November. In summary he said that the BAF is about the Trust's strategic objectives and the risks inherent with achieving those objectives. He said that the highest risk is financial sustainability. He had adjusted the objective of achieving an Outstanding CQC rating slightly on the basis of recent CQC report and refreshed the other pages and reflected changes of Executive Directors. He said the biggest areas of debate had been around the strength of assurance and controls.

A key point he wanted to highlight to the Board is the pace of change (or lack of it) and how this can be accurately reflected in the BAF. For example, the Trust has a Masterplan but if it doesn't do Part A it will not be able to do Part D etc. and how that is reflected in the BAF is a challenge. He said that capturing mitigations accurately is also complex. He wants to ensure that the BAF accurately captures actions and mitigations and ensures that the narrative is sharp. This is particularly complex when

looking at strategic aims that are inherently dependent on the system and system working.
The Chair noted the comments in respect of the pace of change and said that this is a concern around the system and in particular the impact on DCH. He noted that the Risk and Audit Committee and Board would be reviewing again in January.

The Chair thanked the Executives for their reports.

BoD18/131 Mortality Report

The Medical Director introduced the report. He noted that the report had been reviewed by the Quality Committee and published on the Trust's website. He said that the latest SHiMi score for the rolling year to March 2018 has risen to 118 which means at face value 18% more people have died at the Trust than would be expected. Having reviewed a number of cases and working closely with the Hospital Mortality Group, he did not believe that this was the case. His view is that coding is the issue. The plan is to recruit experienced coders which should improve the depth of coding overall at the Trust and this will also be relevant to the Trust's income.

He said that the next report the Board will see, will provide a broader dashboard for consideration and this will be developed in conjunction with NHSI locally. It will include ICNARC data (intensive care information and the Trust performs highly in this). He is anxious that the information available to the public is accessible and intelligible. He said that it will take a minimum of 12 months for the SHiMi score to improve.

The Chair of the Quality Committee said that the report is much more helpful than previously. She noted that this is a work in progress but said that it would be helpful to see themes from SJRs and also a Trust set trajectory to measure progress and improvement. The Medical Director said that he would consider a trajectory. In terms of SJRs he said that his view was that the Trust had been undertaking too many but that looking at themes would be helpful.

The Director of Nursing and Quality said that there is a link between the End of Life Group and Hospital Mortality Group with a nurse specialist sitting on both groups. She said that the CQC report had also provided assurance around End of Life Care issues.

In terms of the report, Board members felt that it would be helpful to have information that was less technical and more patient/family focussed as this was the likely audience for the information published on the website. The Medical Director said that there was a tension between what had to be published for regulatory purposes and what would be helpful for patients.

The Medical Director extended his thanks to Deputy Medical Director Julie Doherty for the work she had undertaken before he commenced at the Trust.

The Chair thanked the Medical Director for his report and noted that the work to improve the Trust's SHiMi would take a considerable period of time. He said that the Board was pleased the Trust was working with NHSI on this important issue.

Action: The Medical Director to consider the development of a trajectory for SHiMi improvement, themes from SJRs to be included in the quarterly mortality reports and the need for more patient and family focussed accounts on the Trust's website.

BoD18/132 Charity Annual Report and Accounts 2017/2018

The Director of Finance introduced the paper to the Board. He said that the Annual Report and Accounts had previously been approved by the Charity Committee and the

Auditors. He explained that the governance arrangements for the Charity, requires the Corporate Trustee to formally sign them off. If approved they will be submitted to the Charity Commission. He recommended them to the Board and said that it had been a successful year for the Charity.

Peter Greensmith, Non-Executive Director and Chair of the Charity Committee said that he was happy to endorse the Accounts. He said that overall the performance of the Charity was good having grown from @£500k of income to £1m. He would like the Charity to aim to achieve £2m of income. This might mean the need for additional staff in the team, consideration of which, he recognised, needs to take place as part of the Trust's Business Planning for the Charity.

Board members noted that there were a number of events that had taken place that would be included in the Annual Report and Accounts for 2018/2019. Members suggested that the Annual Report and Accounts should be reviewed by the Board earlier in the financial year.

Action: Director of Strategy and Business Development and Trust Board Secretary to look at timing of the submission to the Trust Board of the Annual Report and Accounts.

BoD18/133 CQC Report

The Director of Nursing and Quality said that the report in the papers provided the Board with an overall summary of the key issues from the recent inspection. She said that the activity poster on the CQC's website was incorrect and she confirmed that the Trust had achieved a Good rating and not Requires Improvement. The Chair noted the scores that had been carried forward from the previous inspection in 2016 because these services had not been re-inspected.

The Chair reiterated his thanks, on behalf of the Trust Board, to all staff regarding the result.

BoD18/134 Workforce Race Equality Standard

The Director of Organisational Development and Workforce explained that this issue was linked to the recent CQC inspection. The CQC had identified that the Trust had not correctly publicised the results of this standard. This information had been published on the intranet but not the extranet and so not available to the general public. The results had been discussed at the Workforce Committee. In the longer term, the Workforce Committee will bring together information regarding the Gender Pay Gap and Equality and Diversity for onward reporting to the Trust Board twice a year.

The Chief Executive said that the information indicated that the Trust's BAME staff do not feel they have same opportunities for career progression and that on occasion they feel bullied by other staff. She said that looking at the WRES results, this is a deteriorating position and that this also reflects information from the staff survey results. She will be holding listening events with BAME staff to look at the underlying issues.

CONSENT ITEMS

BoD18/135 Safeguarding Children Annual Report
The report was approved by the Trust Board.

BoD18/136 Board Forward Work Plan (including Development Sessions)
The Board received the Work Plan. The Chair said the Plan would be an agenda item for the Consent Section at each meeting.

BoD18/137 Any Other Business

No other business.

BoD18/138 **Questions from the Public**

Mr Jordan was pleased to have a printed agenda but requested a hard copy set of papers. He noted the comments in respect of fire risk and access and explained the need for regular safety inspections. He commented on the issues in respect of the Weymouth Urgent Care Centre and said that this matter was of concern to the public.

Post meeting note: the Trust Board Secretary explained to Mr Jordan that the Trust was no longer printing off copies of the papers for the meeting in line with its sustainability goals. There is a notice to this effect on the Trust's public website. Papers are available online in advance of the meeting.

BoD18/139 **Date of Next Meeting (open to the public): Wednesday 30 January,** 8.30am Seminar Room, Children's Centre, Dorset County Hospital, 8.

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

ACTIONS LIST – BOARD OF DIRECTORS PART ONE 28 NOVEMBER 2018

Minute	Action	Owner	Timescale	Outcome
BoD18/128	Development Session in August 2019 regarding Clinical Governance.	RL	ASAP	*Added to the Board Forward Work Plan in November 2018 for August 2019.*
BoD18/131	Development of trajectory for SHiMi improvement and themes from SJRs to be included in the quarterly mortality reports.	AH	January 2019	
BoD18/132	Timing of submission of the Charity's Annual Report and Accounts to be reviewed and brought to Board as soon as practicable after year end.	NJ/RL	ASAP	*Added to the Board Forward Work Plan in November 2018 for July 2019 Board meeting.*

Title of Meeting	**Board of Directors**
Date of Meeting	**30 January 2019**
Report Title	**Chief Executive's Report**
Author	**Chief Executive**
Responsible Executive	**Chief Executive**

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

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

Key developments nationally are as follows:

Brexit
NHS England director of Acute Care, Keith Willett, has been seconded to jointly lead a 200 strong team preparing the NHS for a 'no-deal' Brexit. The news follows indications in December that system leaders were building a Brexit readiness team as "anxiety about the potential consequences of the UK leaving the EU continued to grow among the NHS' national leadership.

National Patient Safety Strategy
NHS Improvement has opened a consultation on the development of a national patient safety strategy. The aim of the strategy is for the NHS to be the safest healthcare system in the world. The strategy is being developed alongside the NHS Long Term Plan and will be relevant to all parts of the NHS, be that physical or mental health care, in or out of hospital and primary care. The consultation closes on 15 February 2019 and the Trust Secretary is collating comments for a corporate response.

NHS Long Term Plan
The NHS Long Term Plan was published this month following the announcement last year of a £20.5bn annual real terms uplift for the NHS by 2023/24. The plan sets out ambitions for ensuring the NHS is fit for the future and covers a ten year window. A consultation and engagement period will now begin on the Plan, running until the summer.

Key local developments are as follows:

DCH performance.

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

- Growing elective waiting list

- 62 day referral to treatment cancer standard
- Staffing, in particular the use of temporary staff
- Finances
- Mortality

Plans are in place to mitigate these. But progress may need to be made at a faster pace to avoid the escalation of risk.

From a strategic perspective it is important that the Trust continues to make progress with the delivery of its Transformation Programme, the development of the Damers site and the wider Estates Strategy as these programmes will play a key role in securing the Trust's long term future. Further work is required on the key programmes of work identified in the Trust's Finance Strategy and the Dorset ICS Transformation to ensure the Trust feels the full benefit of these programmes within the timescale required. Now that the Trust is in possession of its proposed control total for 2019/20, clarity on next year's financial settlement in light of the additional funding coming into the NHS will also play a key role.

Paper Previously Reviewed By
Chief Executive.

Strategic Impact
In order for the Board to operate successfully, it has to understand the wider strategic and political context.

Risk Evaluation
Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation.

The Board also needs to seek assurance that credible plans are developed to ensure any significant operational risks are addressed.

Impact on Care Quality Commission Registration and/or Clinical Quality
An understanding of the strategic context is a key feature in strategy development and the Well Led domain.

Failure to address significant operational risks could place the Trust under increased scrutiny from the regulators.

Governance Implications (legal, clinical, equality and diversity or other):
Failure to address significant strategic and operational risks could lead to regulatory action.

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

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

Chief Executive's Report

Strategic Update

National Perspective

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

National Context

Unacceptable Waiting Times
A recent public accounts committee (PAC) report into the provision of mental health services for children and young adults criticised "unacceptably long" waiting times in the treatment of children and young people with mental health issues and the NHS' efforts for failing to deliver the required provision of care. It states that just three in ten children and young people with a diagnosable mental health condition able to access NHS-funded treatment in the last financial year.

NHS performance target review process
Concerns have been raised by senior doctors over the consultation process and the timetable set out for a major review of NHS performance targets. Much of the review's early focus has been around the four-hour accident and emergency access standard, which has not been achieved since July 2015, but it had also discussed the 18-week elective treatment standard. Leading emergency medicine professionals said they had not been formally consulted on proposed changes since 2017, while other senior clinical and management figures privately raised similar concerns. The Royal College of Emergency Medicine also said it was "surprised and seriously concerned" it had not been formally consulted by the review team. Professor Stephen Powis, leading the review has said that no decisions had yet been taken by the review.

Brexit
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Local Relevance

National Patient Safety Strategy
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NHS Long Term Plan
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Chapter 1: A New service model for the 21st century.

The Plan includes a guarantee that over the next five years investment in primary medical and community services will grow faster than the overall NHS budget, creating a ring-fenced local fund worth at least an additional £4.5bn a year in real terms by 2023/24. It summarises a series of improvements to be delivered in the following five key areas:

- Improving out-of-hospital care (primary and community services)
- Reducing pressure on emergency hospital services
- Delivering person-centred care
- Digitally enabled primary and outpatient care (this is considered by Chapter 5)
- A focus on population health and local partnerships through ICSs

Chapter 2: More NHS action on prevention and health inequalities.

To address the growing demand for healthcare created by a growing and ageing population, the Plan sets out an aim to target the top five causes of premature death in England.

- Smoking
- Alcohol
- Obesity
- Antimicrobial resistance
- Air pollution
- Strong action on health inequalities

Chapter 3: Further Progress on Care Quality and Outcomes.

For all major conditions, the quality of care and the outcomes for patients are now measurably better than a decade ago. However, the Plan looks at both physical and mental health and outlines a range of condition specific proposals focussing on children and young people, autism and learning disability and children's cancers.

The Plan also focuses on tackling the top five causes of early death for the people of England: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm.

Chapter 4: NHS staff will get the backing they need

The Plan does not obscure the scale of the challenges facing NHS trusts and staff with NHSE acknowledging that workforce growth "has not kept up with need" while staff have been inadequately supported to meet the changing requirements of patients over the past decade. However while some tangible goals and new programmes have been outlined in the Plan, most of the requisite detail has been delayed until the publication of "the comprehensive workforce implementation plan", due to be published later in 2019. We expect this replaces the long awaited national workforce strategy.

Chapter 5: Digitally-enabled care will go mainstream across the NHS

The Plan commits the NHS to be "digital first" in ten year's time. Particular attention has been given to digitally-enabled primary and outpatient care, primarily via a digital NHS front door in the form of the NHS app.

Chapter 6: Taxpayers' investment will be used to maximum effect

The Plan outlines how the NHS will continue to become more efficient over the coming decade. It restates the five tests set out by the government in the 2018 budget, and sets out how the NHS will meet them.

A longer term vision for the NHS is welcomed and it is pleasing to see the direction of travel mirroring that outlined in the Dorset STP. However, the following should be noted:

The NHS does not currently have a plan for a sustainable workforce. There are currently 108,000 vacancies across the NHS, 40,000 of which are in nursing. Without a workforce plan that is deliverable the ambitions set out in this plan will be challenging to deliver. It should also be noted that as many of the posts needed will require education programmes to support qualification, many will not come on line until towards to end of the initial five year period.

The Plan is not accompanied by a strategy to ensure the sustainability of social care. We are now expecting a paper later this year but that will be a Green Paper for consultation not a White Paper ready for implementation

Budgets for staff training and public health have been consistently reduced during the last few years. Further thought will need to be given to how ambitions in terms of prevention and the development of the workforce will be funded going forward.

Of more specific relevance in Dorset are some important proposals around the continued development Integrated Care Systems and what this may mean for providers and their regulation. These changes are outlined below:

There will be an increased focus on population health via ICSs. Integrated Care Systems (ICSs) are central to the delivery of the Long Term Plan, with ICSs and expected to cover the country by April 2021. ICSs will therefore have a key role in working with Local Authorities at place level

Commissioners will also make shared decisions with providers on how to use resources, design services and improve population health but CCGs will continue to make some decisions independently, for example in relation to procurement and contract award.

There will be a single, leaner more strategic CCG for each ICS area and every ICS will have:

- A partnership board drawn from Commissioners, Trusts, Primary Care Networks, Local Authorities, voluntary and community sector and others
- A non-executive chair locally appointed and approved by NHSE and NHSI
- Full engagement with primary care through a named accountable Clinical Director of each primary care network

All providers with an ICS will be required to contribute to ICS performance, underpinned by:

- Potential new licence conditions supporting providers to take responsibility with system partners, for wider objectives on resource use and population health
- Longer-term NHS contracts with all providers including care requirements to collaborate to achieve system objectives

- Changes to align clinical leadership with ICSs including ensuring Cancer Alliances and Clinical Senates align with one or more ICS

- NHSI will take a more proactive role in supporting collaborative approaches between Trusts, including supporting Trusts to explore formal mergers

- A new Integrated Care Provider contract will be made available for use from 2019 to be held by public statutory providers

A new ICS accountability and performance framework will provide a consistent and comparable set of performance measures, including a new 'integration index'

ICSs will agree system wide objectives with the relevant NHSE/I Regional Director and be accountable for their performance against these objectives

NHSE/I will support CCGs and local authorities to blend health and social care budgets.

As always the devil will be in the detail. The implementation plan will be an important next step in providing clarity on how these ambitions will be realised.

Operational Planning and Contracting Guidance 2019/20
The Planning Guidance has also been published this month, with a stated ambition of moving all providers to a position out of deficit within the coming two years. Further detail will be provided by the Director of Finance. Again the devil will be in the detail, in terms of what savings will be required at an organisational level once sustainability and recovery funds have been made available from NHSI and contracts with CCGs and NHSE have been agreed.

Experience of BAME staff
The NHS Workforce Race Equality Standard. The report shows that 19.1% of staff working for NHS trusts in England are from a BAME background, an increase year on year. However, BAME staff are still underrepresented in senior roles. Leaders from BAME backgrounds bring a wealth of experience to leadership roles as well as frontline roles. It is important that NHS has a leadership which reflects the growing diversity of its workforce. 15% of BAME staff also report being bullied and harassed.

Land Sales
NHS providers will no longer be able to meet financial targets through land sales. The change is outlined in letters to providers from NHS Improvement which stated that the treatment of gains on disposal of assets has been amended in 2019-20. Providers will not be able to use any of these gains to deliver their original 2019-20 control total. Any gains will instead result in a revised control total, which should disincentivise the accounting measure. In 2017-18, £206m of land sale proceeds boosted the national revenue account, compared to £131m boosting capital budgets.

Local Perspective

DCH Performance
The Trust continues to face challenges with operational performance due to demand in many areas outstripping capacity. That said a number of targets were achieved at the end of 2018, although those relating to elective care, diagnostics and 62 days for cancer patients continue to underperform against the national standard.

From a quality perspective good performance has been maintained against most standards. Although mortality rates, particularly SHiMi remain a concern. Further detail has been provided on the main agenda. However, it is essential that the Trust makes progress with two key actions. Firstly, to make

improvements in the depth of clinical coding and secondly, to progress the appointment and implementation of medical examiners in line with national policy. A recent review by the Medical Director of fifty cases that had been subject to a structured judgement review, will provide assurance to the Board that the SJRs being completed are comprehensive and have not identified any cause for concern in terms of the quality of care provided at the Trust.

In summary, a number of operational risks now require attention if the Trust is to retain the confidence of the regulator:

- A development of a plan to reduce the elective waiting list
- Achievement of the 62 day referral to treatment standard for cancer
- Development of a comprehensive workforce plan
- Further work on the Trust long term finance plan
- Improvements in the depth of clinical coding that will in turn show an improvement in the Trust performance against the national mortality metrics

Dorset Integrated Care System
The Clinical Networks Programme is now beginning to make reasonable progress in a number of areas:

- The system wide maternity transformation has been successful in bidding for a new system. This will move DCH away from paper records and support the development of personalised care plans
- A full business case for Pathology has been discussed and will be discussed on the Board agenda today. This will develop a more sustainable and efficient service across Dorset in the long term
- Rheumatology, Urology and Haematology Services are working on the development of networks across Dorset.

At our next meeting we will be reviewing priority areas for 2019/20.

The Somerset clinical services review is now picking up pace and we should shortly know what this will mean in terms of the impact of any decisions on DCH.

Some Good News……
The Trust received some very good news this month with regards to regional and national awards. The Research Service has been shortlisted in four categories in the Wessex Clinical Research Awards:

Outstanding research professional - Cecilia Priestley,
Excellence in patient and public involvement and engagement - DCH research ambassadors
Rising Star - Emily Beaves
Outstanding clinical trial support - Heather Sellers

This is the second consecutive year the research team has reached the Wessex finals and is acknowledgement of their commitment to this important agenda and the positive difference it makes to our patients.

Ali Fuszard and her team have been shortlisted for the Team of the Year Award in the Royal College of Midwives Annual Awards. Again, this is recognition of the care and compassion Ali and her team show to mums and babies in their care.

Both Award Ceremonies take place in March. Well done to these members of staff and our fingers will be crossed in March!

Patricia Miller, Chief Executive
January 2019

Balanced-Score Card Performance Report

Report to Board: 30 January 2019

Performance Summary:

December was a challenging month with increased ED attendances and ambulance conveyances resulting in increased number of ambulance handover delays and decreased ED performance. In December the Trust's performance was just below the 95% standard at 94.97%. The Trust did achieve the 4 hour standard for Q3 in aggregate. A number of winter schemes continue to be implemented to deal with seasonal pressures, namely Enhanced Domiciliary Care Service (Agincare), patient tracking pilot on elderly care wards, length of stay panels with local health economy partners and discharge follow-up telephone service. There has been a significant reduction in the number of super stranded patients (patients with length of stay of 21 days or more – average number of patients per day in December 2018 was 38 compared to 52 in December 2017. The RTT constitutional standard was not achieved; however, performance against the revised trajectory of 77.70% was exceeded at 79.00% and for fourth consecutive month there were no 52+ week breaches. The overall waiting list has reduced by 164 patients from November 2018 to December 2018, however the 18+ backlog has increased by 110. The most challenged specialties remain Ophthalmology, Trauma and Orthopaedics, Oral Surgery and Dermatology. There was a notable improvement in performance against 2ww (all) cancer standard at 94.9% which meant that the Trust achieved aggregate performance for Quarter 3 for this standard. Equally performance against 62 day referral to treatment standard is improving; the forecast December position is around 82% (compared to 77.6% in October and 75.2% in November). Performance against 6 week diagnostic standard declined in month (82.79% compared to 86.31% in November 2018); significant capacity shortfall for endoscopic procedures remains the main driver for this underperformance, in addition there was an urodynamic equipment failure and reduction in capacity in audiology and neurophysiology over the festive period.

Main Performance Risks facing the Trust in 2018/19

Quality and Access risks:

- Underperformance against Diagnostic standard remains a significant concern, in particular for endoscopic procedures
- 62 day cancer standard remains a challenge
- RTT backlog continues to grow and there is a risk of 52 week breaches in 2019/20 in Ophthalmology and Trauma and Orthopaedics
- Increased demand and capacity gaps continue to impact overall delivery of the performance standards
- Sepsis screening antibiotics within one hour has not been achieved
- VTE assessment remains unachieved
- Dementia assessment – slight improvement, however remains unachieved
- Slight improvement in complaint responses; still below the standard required

Financial risks:

- The Trust has declared to the regulator that it expects to fall short of the financial control total at the end of the year by £5.1m given the shortfalls on in year CIP delivery and run rate pressures.
- It is highly likely that the Dorset wide financial position will not deliver the system wide control total. This will mean the Q4 PSF funding will not be earned by each organisation. This equates to £2.1m for the trust.
- Agency spend is currently significantly above the target set by the regulator and it is unlikely to recover by year end.

Quality and FPC Recommendations

Escalation from Quality Committee in January:

- Recognition and praise of staff for sustained improvement in many quality indicators despite increased activity and demand
- Acknowledgement of increased activity and effects of this on areas such as the Stroke Unit and ability to admit directly
- Supportive of draft 2019/2020 Quality Account Priorities with further suggestions on unwarranted variation to be incorporated
- Following a full deep dive of Sepsis and Antibiotic administration, the committee were able to acknowledge the governance and improvement work on sepsis, the Committee was also able to gain assurance that any death of a patient with sepsis is reviewed and if clinical indicated goes through a full SJR, with learning feeding into mortality review process and governance.
- Electronic Discharge Summaries performance remains a concern

Escalation from Finance and Performance Committee in January:

- One Dorset Pathology FBC
- Performance update and positive points to note and share
- Endoscopy investment
- Ophthalmology
- Financial performance against the control total
- Cardiac catheter laboratory proposed investment
- Patient flow and deep dive for May QC and FPC

Are we on track to deliver the 9 Must Dos?

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

Key Performance Metrics Summary

	Metric	Standard	Nov-18	Dec-18
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	2 (0.2)	2 (0.3)
	C-Diff hospital acquired cases post 72 hours due to lapses in care (Rate per 1000 bed days)	13	0 (0.0)	0 (0.0)
	Never Events	0	0	0
	Serious Incidents declared on STEIS (under investigation)	51 (4 per month)	1	0
	SHMI - Rolling 12 months, 6 months in arrears (Jun-17 to Jul-18)	<1.12	1.18	
	Mortality Indicator HSMR from CHKS - 2 months in arrears (October-17 to September-18)	100	120.6	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	92%	80.0%	79.0%
	RTT Incomplete Pathway Waiting List size	11,991	13,971	13,807
	All cancers maximum 62 day wait for first treatment from urgent GP referral	85%	78.9%	86.3%
	Maximum 6 week wait for diagnostic tests	99%	86.3%	82.8%
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	95%	96.2%	94.8%
Finance	Elective levels of contracted activity (£)	2018/19 = £2,439,542/month	2,324,905	2,097,777
	Surplus/(deficit) (year to date)	2018/19 = (1,283) YTD M9 = (6,670)	(5,295)	(5,679)
	CIP - year to date (aggressive cost reduction plans)	2018/19 = 7,882 YTD M9 = 3,157	2,364	2,677
	Agency spend YTD	2018/19 = 2,929 YTD M9 = 1,934	2,377	2,733

Rating Key
Achieving Standard
Not Achieving Standard

** Never Events – Although this is highlighted as Green and achieving the standard of 0 for the timescales shown, it should be noted that the standard for the year has not been achieved. There have been a total of 3 Never Events identified, with 1 being de-escalated by the CCG panel. Likely year end position will be reporting 2 Never Events.

INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain
Safe

- Never events: Likely x2 never events will be de-escalated by CCG panel in January ACTION: CCG panel end of January to de-escalate events
- MRSA non-elective screen: no infection harm occurred. ACTION: reviewed in Infection prevention and Control Committee
- VTE assessment: remain not achieved as just under threshold. ACTION: Divisional reviews of cases
- WHO Checklist: Percentage not achieved: ACTION: Theatre improvement review includes culture and processes review
- Sepsis: Sepsis screening antibiotics within one hour has been not been achieved. In ED there were 26 patients screened as triggering sepsis of which 21 received antibiotics within an hour. In Inpatients there were 43 triggering on assessment for sepsis, of which 30 received antibiotics within the hour. Deeper dive presented to Quality Committee.

Effective

- Mortality: SHMI remains as expected with no change. ACTION: New invested Coder posts advertised. NHS Improvement review anticipated March 2019.
- Stroke: Improvements in TIA and imaging. Overall Stroke at SSNAP score level B. ACTION: Ongoing management with Divisional team
- Dementia: Slight improvement in assessments but overall below expected requirement. ACTION: ongoing medical engagement and focus upon delirium with Medical Director support.
- EDS: remain below expected standard with no improvement noted. ACTION: Medical Director leading with Divisional leadership team to address locally with plan to validate data.

Caring

- Mixed sex breaches: All cases relate to delays in discharge from Critical Care for patients who were deemed fit for discharge with no inpatient bed capacity available

- Friends and Family Test: Improved position in Maternity, just below standard. ACTION: continue to monitor if any theme or trend.

- Complaints: There has been a very slight improvement in complaint responses within agreed time frame. Family and Surgical Services Division has achieved 100% (8/8); Urgent and Integrated Services Division have deteriorated to 60% (3/5); There was 1 joint divisional complaint which was responded to on time (1/1). Therefore of 14 complaints requiring responses, 12 were within timescales. ACTION: Deputy Director of Nursing is directly leading improvement plan with Divisions

Responsive

The access standards for December remain challenging with increased emergency activity including trauma and growth in elective referrals and fast track referrals in particular. Despite the demand challenges there has been significant improvement against 2ww and 62 day cancer standards, however, the need to prioritise patients on cancer pathways impacts on routine elective performance.

The following standards were met:

- Cancer 31 days (all)
- Cancer 2 week wait
- Zero 52 week waits

Standards not met:

- ED – 4 hour standard combined with MIU
  - Increase in emergency activity including trauma were the main contributors to non-achievement of the standard.
  - Increased incidences of ambulance batching, particularly during the festive period when access to primary care was limited
- Cancer 62 days referral to treatment
  - Urology , Lung and Colorectal remain the main underperforming specialties
  - Weekly tracking meeting has been established and is chaired by the COO, looking at patient pathways on a patient by patient basis
  - Inaugural Cancer Steering Group meeting scheduled for 29th of January 2019
- Cancer breast symptomatic 2 week wait
  - A significant peak in referral numbers at the beginning of November impacted performance in both November and December. Additional capacity has been identified and it is forecast that the standard will be met from January onwards.
- RTT
  - Overall waiting list reduced by 164 patients, however the backlog of 18+ week waiters increased by 110 patients
  - Future risk of 52 week waiters in Ophthalmology and Trauma and Orthopaedics due to the size of existing backlog
  - Oral surgery and Dermatology continue to have capacity gaps and increased cancer demand
- Diagnostic 6 week wait
  - Deterioration in performance compared to November 2018 (82.79% versus 86.31%)
  - Significant underlying capacity shortfall for endoscopic procedures
  - Reduced capacity in audiology and neurophysiology over the festive period
  - Failure of Urodynamic equipment (now resolved).

Well Led

Whilst the Trust has performed slightly better than the plan to date, CIP identification and delivery remains a concern and remain as the key drivers to the predicted year end pressure. Pay costs in month are higher than the year to date average although very similar to last month. Agency spend has increased compared to last month and exceeds the year to date average. The biggest increase has been seen in junior medical spend where there has been a need to cover gaps due to sickness. Nursing agency however has reduced compared to the levels seen in November.

Total workforce capacity increased by 26.9 FTE in Month 9 and was 264 FTE above prior year: substantive workforce capacity increased by 19.6 FTE. Total workforce costs (substantive, bank and agency combined) increased by £10.3k in Month 9. Agency staffing costs increased (+ £25.7k) in Month 9. The sickness absence rate for Month 8 (November) increased by 0.44% to 3.89%, and was 0.46% above the corresponding figure for Month 8 of the previous financial year.

The annual appraisal rate increased (+2%) to 82%, which is below the Trust target of 90%: both Divisions have presented plans committing to achieve the 90% target by March 2019.

As of 10 January 2018, 77.7% of staff have been vaccinated against Flu: for patient facing staff this figure was 81.2% which represented a positive increase on last year's campaign.

Metric	Threshold/ Standard	Type of Standard	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Q1	Q2	Q3	YTD	Movement on Previous period	12 Month Trend
Safe																	
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff hospital acquired post 72 hours - Due to lapses in care (Rate per 1000 bed days)	**13**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.0)	0 (0.0)	1 (0.0)	↔	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	96.8%	97.3%	96.5%	96.1%	**94.1%**	95.1%	95.4%	97.4%	95.7%	96.7%	**94.8%**	96.2%	95.9%	↓	
Never Events	**0**	Contractual (National Requirement)	0	0	0	**1**	0	**1**	**1**	0	0	0	**2**	**1**	**3**	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	0	0	1	1	1	1	0	1	0	3	2	5	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	2	2	1	2	1	0	2	1	1	5	3	4	12	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	0	0	0	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**	1	1	**5**	1	**5**	**3**	**4**	**2**	4	**11**	**9**	**24**	↑	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	**2 (0.2)**	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	**1 (0.1)**	0 (0.0)	**2 (0.3)**	0 (0.0)	2 (0.1)	1 (0.0)	2 (0.1)	5 (0.1)	↑	
Pressure Ulcers - Hospital acquired (grade 2) confirmed avoidable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	1 (0.1)	0 (0.0)	1 (0.1)	1 (0.1)	0 (0.0)	2 (0.1)	2 (0.1)	4 (0.1)	↔	
Pressure Ulcers - Hospital acquired (grade 3) confirmed avoidable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	1 (0.0)	0 (0.0)	1 (0.0)	2 (0.0)	↑	
Emergency caesarean section rate			20.6%	8.3%	18.5%	19.4%	17.6%	15.8%	17.7%	13.2%	13.8%	15.7%	17.6%	14.9%	16.0%	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	CQUIN target	**69.7%**	**78.7%**	96.8%	90.0%	**86.4%**	100.0%	94.6%	**84.3%**	92.7%	**78.5%**	91.4%	90.2%	**86.5%**	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	CQUIN target	**81.0%**	92.2%	100.0%	97.4%	100.0%	92.3%	**88.5%**	92.9%	90.9%	90.9%	96.7%	90.8%	92.8%	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	CQUIN target	**73.9%**	92.2%	100.0%	93.9%	**88.9%**	100.0%	**77.8%**	90.0%	**80.8%**	**89.8%**	94.3%	**82.8%**	**89.4%**	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	CQUIN target	**84.8%**	**69.8%**	**81.8%**	**68.2%**	**73.8%**	**85.7%**	**77.1%**	**77.3%**	**73.7%**	**77.1%**	**74.1%**	**76.1%**	**75.8%**	↓	
Effective																	
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD] **- 6 months in arrears (Jun-17 to Jul-18)**	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**1**	**1**	**1**	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD] **- 6 months in arrears (Jun-17 to Jul-18)**	**<1.12 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**1.14**	**1.17**	**1.18**	N/A	↓	**N/A**
Mortality Indicator **HSMR** from CHKS - 2 months in arrears **(October-17 to September-18)**	**100**	Contractual (Local Quality Requirement)	**117.25**	**119.76**	**118.73**	**118.03**	**119.36**	**120.33**	**120.58**	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Mortality Indicator **Weekend Non-Elective HSMR** from CHKS - 2 months in arrears **(October-17 to September-18)**	**100**	Contractual (Local Quality Requirement)	**126.50**	**125.75**	**129.30**	**126.12**	**129.22**	**127.66**	**122.90**	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score (latest national published data = Sept-18). Subsequent results calculated using local predictor tool	**C or above**	Contractual (Local Quality Requirement)	B			C			N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	**46.9%**	**55.4%**	**68.5%**	**82.3%**	**54.2%**	**78.3%**	**58.8%**	**62.7%**	**70.8%**	**56.4%**	**71.6%**	**64.4%**	**64.0%**	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	98.9%	99.6%	↓	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	Contractual (Local Quality Requirement)	**73.7%**	**62.5%**	**73.9%**	**76.7%**	**68.4%**	**45.0%**	**51.7%**	**64.0%**	**48.0%**	**69.7%**	**65.2%**	**54.4%**	**62.6%**	↓	
Caring																	
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	20	28	17	21	28	24	21	18	22	65	73	61	199	↓	
Complaints - Percentage response timescale met (1 month in arrears)	**TBC**	Local Trajectory	75%	70%	79%	81%	64%	64%	85%	78%	N/A	N/A	N/A	N/A	N/A	↓	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	98.5%	98.8%	98.4%	98.6%	99.2%	99.0%	99.4%	99.0%	99.7%	98.6%	98.9%	99.4%	98.9%	↑	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	89.3%	87.9%	85.1%	**83.0%**	85.2%	88.5%	88.8%	**83.7%**	86.5%	87.3%	85.4%	86.5%	86.4%	↑	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**93.2%**	**93.7%**	94.9%	94.4%	**92.9%**	**93.4%**	94.1%	94.0%	94.5%	**93.9%**	**93.6%**	94.2%	**93.9%**	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**40**	**23**	**20**	**19**	**31**	**21**	**19**	**23**	**15**	**83**	**71**	**57**	**211**	↓	

Metric	Threshold/ Standard	Type of Standard	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Q1	Q2	Q3	YTD	Movement on Previous period	12 Month Trend
Responsive																	
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position)	**92%**	Contractual (National Operational Standard)	**87.7%**	**88.2%**	**85.9%**	**85.1%**	**82.6%**	**81.3%**	**80.2%**	**80.0%**	**79.0%**	**85.9%**	**81.3%**	**79.0%**	**79.0%**	↓	
RTT Incomplete Pathway Waiting List size	**11,991**		**12,226**	**12,595**	**12,594**	**13,058**	**13,513**	**13,532**	**14,292**	**13,971**	**13,807**	**12,594**	**13,513**	**13,807**	**13,807**	↑	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**74.9%**	**74.6%**	**70.6%**	**87.2%**	**90.8%**	**92.3%**	94.0%	**90.8%**	94.9%	**73.3%**	**90.0%**	93.2%	**85.7%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**78.6%**	**5.3%**	**7.7%**	93.8%	93.3%	100.0%	94.4%	**72.2%**	**79.3%**	**23.7%**	95.1%	**81.5%**	**64.2%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	97.4%	99.0%	99.0%	97.9%	97.9%	98.9%	100.0%	98.4%	98.2%	98.9%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	100.0%	-	-	100.0%	-	-	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**84.3%**	**71.6%**	**73.6%**	**73.8%**	**75.2%**	**76.52%**	**77.63%**	**78.87%**	86.32%	**75.6%**	**75.1%**	**80.5%**	**77.0%**	↑	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	100.0%	**88.2%**	100.0%	**83.3%**	**77.8%**	100.0%	100.0%	-	100.0%	95.3%	**86.4%**	100.0%	93.9%	↔	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**87.4%**	**85.6%**	**87.0%**	**91.2%**	**85.7%**	**84.0%**	**84.6%**	**86.3%**	**82.8%**	**86.7%**	**87.2%**	**84.5%**	**86.1%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	97.3%	**94.5%**	**92.7%**	**90.8%**	**87.1%**	**94.5%**	95.2%	**92.3%**	**89.6%**	**94.7%**	**90.6%**	**92.4%**	**92.5%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	Contractual (National Operational Standard)	98.7%	97.4%	96.6%	95.7%	**94.0%**	97.3%	97.6%	96.2%	**94.8%**	97.5%	95.6%	96.2%	96.4%	↓	
Well Led																	
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		44.00%	33.87%	48.39%	47.58%	53.23%	50.00%	44.83%	38.79%	54.31%	N/A	N/A	N/A	N/A		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	2.8%	2.6%	3.0%	3.3%	3.3%	**3.4%**	**3.6%**	3.9%	N/A	2.8%	3.3%	**3.7%**	3.2%	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	**76%**	**83%**	**84%**	**85%**	**84%**	**82%**	**81%**	**80%**	**82%**	81%	**84%**	**81%**	82%	↑	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	11.0%	11.6%	11.5%	10.5%	10.3%	10.2%	9.3%	9.1%	8.9%	11.4%	10.4%	9.2%	10.4%	**N/A**	
Total Workforce Capacity	**2,460.9**	Internal Standard reported to FPC	2,321.3	2,298.1	2,292.6	2,291.7	2,307.6	2,297.9	2,340.9	2,336.0	2,355.6	2,304.0	2,299.1	2,344.2	2,315.7	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**5.8%**	**6.6%**	**6.8%**	**6.9%**	**6.2%**	**6.6%**	4.4%	4.6%	**3.8%**	**6.4%**	**6.6%**	4.3%	**5.7%**	↑	
Total Pay Cost	**9,560.9**	Internal Standard reported to FPC	**9,797.9**	**9,515.8**	9,455.7	**9,653.8**	**10,134.2**	**9,756.5**	**9,732.5**	**9,822.6**	**9,832.9**	**9,589.8**	**9,848.2**	**9,796.0**	**9,744.7**	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	1	0	0	0	0	0	0	0	1	0	0	1	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**87%**	**89%**	**88%**	**84%**	**86%**	**85%**	**87%**	**86%**	**84%**	**88%**	**85%**	**86%**	**86%**	↓	
Elective levels of contracted activity (activity)	**2018/19 = 2342/month**		**2,155**	**2,283**	**2,352**	**2,188**	**2,159**	**2,039**	2,453	2,368	**2,046**	**6,790**	**6,386**	**6,867**	**20,043**	↓	
Elective levels of contracted activity (£) Including MFF	**2018/19 = £2,439,542/month**		**2,347,287**	2,456,219	2,379,317	**2,135,425**	**1,998,347**	**1,994,336**	**2,359,604**	**2,324,905**	**2,097,777**	**7,182,823**	**6,128,108**	**6,782,286**	**20,093,217**	↓	
Surplus/(deficit) (year to date)	**2018/19 = (1,283) YTD M9 = (6,670)**	Local Plan	(831)	(1,610)	(2,189)	(2,833)	(3,573)	(4,281)	(4,780)	(5,295)	(5,679)	(2,189)	(4,281)	(5,679)	(5,679)	**N/A**	**N/A**
Cash Balance	**2018/19 - 2568 M9 = 1669**		4,264	2,559	3,449	8,562	10,416	9,800	7,416	9,119	10,453	3,449	9,800	**2,677**	**2,677**	↑	
CIP - year to date (aggressive cost reduction plans)	**2018/19 = 7,882 YTD M9 = 3,157**	Local Plan	**200**	**385**	**731**	**1,052**	**1,345**	**1,765**	**2,072**	**2,364**	**2,677**	**731**	**1,765**	**2,677**	**2,677**	**N/A**	**N/A**
Agency spend YTD	**2018/19 = 2,929 YTD M9 = 1,934**		**328**	**666**	**912**	**1,198**	**1,494**	**1,808**	**2,047**	**2,377**	**2,733**	**912**	**1,808**	**2,733**	**2,733**	**N/A**	**N/A**
Agency % of pay expenditure	**2018/19 = 2.6%**		**3.3%**	**3.5%**	**3.2%**	**3.0%**	**2.9%**	**3.2%**	**2.4%**	**3.4%**	**3.6%**	**3.2%**	**3.1%**	**2.4%**	**3.1%**	↓	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Report Title	**Workforce Safeguards**
Author	**Nicky Lucey, Director of Nursing and Quality**

1.0 Introduction

NHS Improvement published new guidance in October 2018 regarding 'Developing Workforce Safeguards: supporting providers to deliver high quality care through safe and effective staffing. The guidance recognises the challenge facing NHS providers of increased demand for healthcare staff exceeding supply, alongside the financial challenging constraints. It aims to outline how Boards ensure these challenges do not have adverse impact on quality of care as well as patient/service and staff experience through effective use of best practice for staff deployment and workforce planning.

In addition, Sir Ian Dalton (Chief Executive NHS Improvement) have written to all NHS provider Chief Executives, Medical Directors and Directors of nursing on the 5th December (Appendix 1) outlining expectations Boards use of the guidance above and manage the increasing challenge of winter demands through staffed capacity and system working.

DCHFT has particular challenges in workforce planning with gaps in both capacity and capability to support the demand and capacity work in the Trust as well as transformation of services. This gap is picked up in a different paper for the committee and Boards consideration.

2.0 Summary highlights

2.1 NHSI Sir Ian Dalton expectations Winter letter
Sir Ian Dalton's letter (Appendix 1) outlines key winter preparation and safety learning aligned to supporting staff and patient care through the forthcoming expected very challenging winter. Key requirements outlined are:

- **Clinical decision making:** Expectation of wider system working and assessment of risk for workforce deployment of resources both from the internal organisational perspective and wider system working. The expectation is that the system works to the guidance on 'Developing Workforce safeguards'.
- **Capacity**: Expectation that additional emergency capacity is released and staffed to manage bed occupancy, with the expectations that financial considerations are not used as a barrier to opening bed capacity during busy periods and Trusts plan in advance as much as possible to be able to open capacity in a cost-effective way.
- **Ownership of emergency flow**: Expectation that all staff, not just those in emergency departments (ED), have a role in supporting emergency flow for patient care. It also outlines the expectations this is not only for acute ED providers but also for primary, community and social care.
- **Safety and Learning**: Expectation that patient safety is protected while an open culture of transparency of staff able to raise concerns, talk about problems with care delivery and risks exposed without fear of regulatory or internal blame or punishment.

For DCHFT the following table (table 1) outlines the controls and gaps against these expectations.

Table 1: Gap analysis NHSI Winter Expectations

Expectation	Control	Gap	Risk post control mitigation
1. Clinical decision making	1.1 Winter plan includes escalation process 1.2 Daily site/bed meetings review immediate staffing gaps 1.3 Weekly recruitment vetting panel 1.4 Ward safe staffing reported to Quality Committee monthly 1.5 Ongoing recruitment and retention strategies in place	1.1.1 System winter plan 'disjointed' with gaps already identified (e.g. SWAST, community staffing for beds and social care gaps and Continuing Healthcare Checks (CHC) CCG staffing issues creating delays in clinical decisions. 1.1.2 Gap in fill of staffing gaps internally in key shortage occupation roles and market supply (e.g.: medical and registered nursing staffing – on Corporate Risk Register – 1059/ 1045/ 1047/ 1055)	Consequence (C) = 3 Likelihood (L) = 5 3x5 = 15 Extreme Risk Risk narrative: • Internal staffing gaps not filled impact on quality and safety. See corporate risk register and Quality Committee safe staffing report 'red flags'. • External risk on gaps in staffing impacting on escalation capacity and provision of services already occurring (e.g.: Wareham community hospital closure due to staffing; SWAST reduction in GP OOH Mon-Fri 19.00-23.00 and Sat-Sun a.m.)
2. Capacity	2.1 Winter plan including bed capacity and flow capacity 2.2 Additional social care partnership for interim winter discharge capacity 2.3 Escalation process for additional staffing for opening of escalation beds internally in place with Executive Director authorisation, managed via site/bed meetings and on call Manager/ Executive OOH 2.4 Recruitment vetting panel weekly to ensure timely recruitment and	2.1.1 Gaps in temporary and short term staffing capacity internally and externally to meet need of additional capacity (see above) 2.1.2 Due to clinical decision-making externally on staffing of key capacity, without system oversight of QIA, impacts on capacity in place (see risk above)	Consequence (C) = 3 Likelihood (L) = 5 3x5 = 15 Extreme Risk See above Daily capacity pressures evident with increased duration of heighted OPEL level 3 position. Gaps in elective capacity due to emergency demand, results in cancellations of elective capacity to accommodate emergency (particularly

Expectation	Control	Gap	Risk post control mitigation
	authorisation for any additional staffing includes finance. 2.5 Operating escalation framework in place, includes system process and escalations via on call CCG/NHSE		evident in surgery)
3. Emergency flow	3.1 Assurance of DCHFT internal performance demonstrates whole site ownership of emergency flow, managed through site/bed meetings and escalation processes. 3.2 Escalation and prompt management of any speciality delay in support via divisional management team	3.1.1 System response can be slow due to capacity in CHC, social care and any decisions by local providers taken outside of partnership across system (see expectation 1.) 3.1.2 Occasional gap in speciality responsiveness in manging GP expected patients in ED, affecting emergency flow.	Consequence (C) = 3 Likelihood (L) = 3 3x3 = 9 High Risk
4. Safety and Learning	4.1 Risk management Policy in place 4.2 Freedom to Speak up Guardians in place 4.3 Chaplaincy support for staff 4.4 Staff Governors in place 4.5 Executive and Non-Executive 'back to the floor' time in place 4.6 Whistle blowing mechanisms in place 4.7 Learning from incidents – open, learning culture not punitive 4.8 Partnership working with CCG in reviewing all Serious Incidents in an open learning manner 4.9 System learning from incidents sharing in place	4.1.1 Staff survey raises some staff still feel uncomfortable in raising concerns 4.1.2 Relationship with regulators developing to foster open transparency, with recognised national behavioural stories can impact this (e.g.: resignation of senior leaders in provider organisations due to raised concerns on quality or incidents).	Consequence (C) = 3 Likelihood (L) = 3 3x3 = 9 High Risk

2.2 NHS Improvement Workforce Safeguards publication (Oct 2018)
NHS Improvement published guidance on Workforce Safeguards (Oct 2018) states that providers:

- Must deploy sufficient suitably qualified, competent, skilled and experiences staff to meet care and treatment needs safely and effectively
- Should have systematic approaches to determine numbers and ranges of skills needed to maintain safe care
- Must use an approach that reflects current legislation and guidance where available.

In addition, the guidance refers to the Care Quality Commission (CQC) fundamental standards for staffing linked to the Well-Led Domain and related legislative Regulated activity. There are 14 recommendations of the guidance, which providers are expected to follow. NHS Improvement workforce safeguards highlights are summarised in the Table 2 with a gap analysis against the guidance, excluding those already highlighted above from Sir Ian Dalton's letter.

Table 2: Workforce Safeguards guidance gap analysis

Guidance	Gap analysis	Recommendations
1. National Quality Board (NQB) guidance is embedded in safe staffing governance	1.1. In place for ward based nursing adult and paediatric 1.2. In place for Maternity 1.3. In progress for SCBU 1.4. Pathology as per shared service business care development 1.5. In place for emergency care 1.6. Demand and capacity includes review of medical capacity 1.7. Gap in AHPs (on risk register) 1.8. Gap in medical staffing reporting/ oversight	Overall consider revising Board reporting from Workforce Committee escalations including reporting on gaps below: - 1.7 Improve reporting on gaps in AHPs to Board - 1.8 Improve of reporting on medical safe staffing to Board
2. Trust ensure evidence based tools, professional judgement and outcomes are used when reviewing safe staffing	See above 2.1 Gap in workforce planning capacity and capability to assist in expertise in this.	See above Action to review workforce planning capacity and capability in the Trust and agree solutions to address gaps.
3. Annual Governance statement assessed by regulator includes staffing governance in place	See above 3.1 In place, signed off by Board 3.2 Gap in Workforce escalations, addressed by newly created Workforce Committee and developing Board reporting from this new assurance committee.	Board reporting and escalations from Workforce Committee to strengthen assurance related to this.
4. Regulatory arrangements in place to review quality, performance, finance and outcomes	4.1 In place	To continue as part of CEO update to Board
5. Yearly assessment through SOF to gain assurance on	5.1 In place	As above

Guidance	Gap analysis	Recommendations
provider performance		
6. As part of safe staffing review the Medical Director and Director of Nursing/Quality **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable	6.1 Partially in place. 6.2 Gap in no formal recording in Board of this 6.3 Current risk register and BAF position can only provide assurance that safe staffing is managed and mitigated.	Formalised Board recording of statement safe staffing assessment.
7. Trusts **must** have effective workforce planning, updated annually and signed off by CEO and executive leaders, with the Board discussion the plan in a public Board	7.1 Partial linked to business planning 7.2 GIRFT utilised as part of planning 7.3 Model Hospital is used 7.4 Significant gap in capacity and capability for effective workforce planning and annual review, linked to business planning and lack of NHSI toolkit used for workforce planning 7.5 Gap in E-Rostering is NOT used for all staff groups	See Workforce Planning paper and recommendations to address the gap and risks.
8. Agree and have in place a local dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics, such as Model Hospital, reported to the Board monthly.	8.1 Partial, as Model Hospital reviewed in Better Care Better Value meeting 8.2 Gap in not regular sharing at board in reporting this.	Review workforce report to Board to incorporate this.
9. Assessment and re-setting of nursing establishment using NQB guidance	9.1 In place and reported to Quality Committee	Consider reporting via new Workforce Committee
10. Ensure no 'local manipulation' of nursing resource from the evidence based figures derived from the above	10.1 in place as above	As above
11. As per CQC well-led framework and NQB guidance any service changes including skill-mix **must** have a full QIA	11.1 In pace for CIP plans or business planning/ business cases 11.2 Gap as QIAs have not been undertaken for workforce or service design unless associated with business cases, or CIP.	Revise processes internally
12. Any introduction of new roles are considered a service change and therefore a full QIA required	As above	As above
13. Day to day operational staffing challenges must use a dynamic and formal escalation process including risk assessed to safety, quality, finance, performance and staff experience, with description of these expected	13.1 in place via Site/bed meetings 13.2 Gap in no formal documentation of risks assessed on site/bed report or RAG on whole staffing position in Trust	Consider reviewing site/bed report to include risks assessment and RAG on staffing

Guidance	Gap analysis	Recommendations
14. Where any staffing risks continue or mitigations are insufficient trusts **must** escalate to the Board – with actions including full or part closure of a service or reduced provision.	14.1 Risks escalated via BAF and Risk register to Board 14.2 Gap in formalising decisions on capacity or service provision reductions	Improve escalations from Workforce Committee and documented actions/decisions from Board on service provision

3.0 Recommendation

The national context of workforce provision in NHS England is well documented and reported upon and is seen as a key risk going forward for the HS. This guidance is helpful to Boards and now places a higher responsibility in the Board having direct oversight and decision making in any workforce risk, changes or workforce planning. Therefore, it is key for the Workforce Committee to review this guidance and the expectations of providers set out by NHS Improvement and escalate to the Board the actions needed.

The Workforce Committee are asked to:

a) To note guidance
b) To discuss the guidance and agree any gaps in assurance or risks and next steps needed for managing these
c) To agree the key points, risks & concerns to be reported to the Board

Dorset ICS – Collaborative – Finance Report –November 2018

Our Dorset
Local NHS and Councils Working Together

10th January 2019

Contents

1. Executive Summary ICS (1)

Dorset Integrated Care System

Overall, the system is forecasting to be away from plan by **£(5.5)m** at year end. This is due to slippage in Social Care savings plans and cost pressures within Local Authorities **(£3.6)m**. Specialised commissioning is reported in shadow form for 2018/19, but is also forecasting an overspend against the Dorset contracts for high cost drugs **(£1.9)m**.

System Control Total / Dorset Health System

The Dorset Health System is reporting that it will **NOT** meet the **full system control total,** and currently has underlying distance from control total of **£11.1m forecast for 2018/19** at Q2, which will lead to a further in-year loss of Q4 PSF. This is partly related to unidentified cost improvement savings to find within the plan of £6.3m. Mitigations that were being pursued have been offered towards the NHS Improvement 2-4-1 incentive offer, which will benefit the system overall by £15m despite the loss of PSF in Q4.

Dorset Local Authorities

For Local Authorities, Dorset County Council expects the current balanced position to deteriorate to **£(3.6)m** adverse from plan by year end. This is due to potential slippage identified in the savings programme and emerging budget pressures within Adult and Children's Social Care. Bournemouth Borough Council and Borough of Poole position are currently reported as on plan. Joint work is continuing on Better Care Fund (BCF) projects although spend on Integrated Equipment (ICES) and placement costs are of concern. On 2nd October, the government announced additional funding for councils to spend on adult social care services in 2018/19. This is to help alleviate winter pressures on the NHS by getting patients home quicker and freeing up hospital beds, including expectations for weekend discharge arrangements.

South West Ambulance Service FT

Are expected to be breakeven because NHS Improvement have confirmed that the unplanned costs incurred supporting operational resilience activities will be funded.

Specialised Commissioning

The expectation nationally is that specialist commissioning commissioner spend will be incorporated into the health system control total from 2019/20, which if included for 2018/19 would add an additional **(£1.9)m** cost pressure to the control total to be managed.

1. Executive Summary (2)

Dorset system savings (£138.3m target)

The level of **savings** required by NHS providers for which there is **no identified solution** is **£6.2m**. This is known as unidentified cost improvement plans (CIP). The local authorities have not identified any savings gap in the plan, but there is slippage in the Adult & Children's Social Care plan at DCC. The CCG currently has £1.8m unidentified savings requirement (QIPP - Quality, Improvement, Productivity and Prevention) due to in-year STP and CHC cost pressures.

Dorset system risks

At this early point in the year, significant risks to delivery remain across the whole system, most notably:

- Non-delivery of individual or system control totals and Accident and Emergency targets leading to non-achievement of Provider Sustainability Funds (PSF)
- Non-delivery of demand management to previous year levels
- Non-delivery of current Savings (CIP and QIPP) schemes and failure to tackle unidentified savings.
- Other cost pressures arising in year remain unmanaged.
- Agency and Bank spend is ahead of plan by £9.3m, with total pay being £16.7m adverse variance at month 8.

2. Key Financial Duties – plan for 2018/19

This table summarises the ICS key duties and targets on a RAG rated basis (Red / Amber / Green).
Our financial plan as approved by the SLT allows for all key financial duties and targets to be met for 2018/19 if the plan is delivered.

	ICS	DCCG	DCH	DHC	PHT	RBCH
Key financial duties	**Plan for 2018/19**	**Plan for 2018/19**	**Plan for 2018/19**	**Plan for 2018/19**	**Plan for 2018/19**	**Plan for 2018/19**
Individual Organisations within the ICS deliver own financial position	✓	✓	✓	✓	✓	✓
Remain within the NHS ICS control total	✓					
Local Authorities achieve financial position	✓					
Achieve the A&E target to receive PSF Funding	✓		✓		✓	✓
Remain within the cash limit	✓		✓	✓	✓	✓
Full utilisation of allocated capital resources	✓	✓	✓	✓	✓	✓
Agency spend within ceiling target	✓		✓	✓	✓	✓
Increase investment in Mental Health (Parity of Esteem)	✓	✓		✓		

3. System Position Overview – as at end November 2018

Finance Sector Overview

Organisation Name	Pre PSF Control Total YTD			Pre PSF Annual Control Total			Forecast	Key Issues
	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	1819 Plan £'000	1819 Forecast £'000	1819 Variance £'000	1819 PSF £'000	
Dorset NHS Providers	-25,468	-24,707	761	-20,812	-20,727	85	47,286	Savings Gap £6.2m. Trauma pressure. ED recovery plan. £959k Lost PSF
Dorset Clinical Commissioning Group	1,156	1,156	-	1,734	1,734	-	-	Pressures in outside STP providers, CHC and funding out of hospital.
CCG Carried Forward Surplus	-	-	-	33,585	33,585	-	-	Retained by NHS England
DORSET NHS ICS CT SURPLUS / (DEFICIT)	**-24,312**	**-23,551**	**761**	**14,507**	**14,592**	**85**	**47,286**	
Dorset Local Authorities	Not Reported			-	- 3,649	- 3,649	-	Budget pressures within Adult & Children's Care Services.
South West Ambulance Service FT - Dorset	-	- 144	- 144	-	-	-	-	SWAST - Dorset c16% of costs. Breakeven - resilience costs funded.
Specialised (Wessex) - Dorset Providers	-	- 1,076	- 1,076	-	- 1,927	- 1,927	-	Higher excluded drugs spend with Dorset providers. (Shadow report).
DORSET ICS SURPLUS / (DEFICIT)	**-24,312**	**-24,771**	**- 459**	**14,507**	**9,016**	**- 5,491**	**47,286**	Dorset System Surplus/ (Deficit)

Finance By Organisation

Organisation Name	Position YTD			Annual Position			Forecast
	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	1819 Plan £'000	1819 Forecast £'000	1819 Variance £'000	1819 PSF £'000
Dorset County Hospital NHS FT	- 9,280	- 8,753	527	- 7,198	- 7,198	-	5,873
Dorset Healthcare University NHS FT	995	1,114	119	1,622	1,622	-	6,230
Poole Hospital NHS FT	- 11,391	- 11,281	110	- 12,855	- 12,855	-	8,183
Royal Bournemouth & Christchurch Hospitals NHS FT	- 5,792	- 5,787	5	- 2,381	- 2,296	85	27,000
PROVIDERS CT PRE-PSF SURPLUS / (DEFICIT)	- 25,468	- 24,707	761	- 20,812	- 20,727	85	47,286
Dorset Clinical Commissioning Group	1,156	1,156	-	1,734	1,734	-	
CCG Carried Forward Surplus			-	33,585	33,585	-	
NHS SYSTEM CT PRE-PSF SURPLUS / (DEFICIT)	- 24,312	- 23,551	761	14,507	14,592	85	47,286
South West Ambulance Service FT - Dorset	-	- 144	- 144	-	-	-	-
Specialised (Wessex) - Dorset Providers	-	- 1,076	- 1,076	-	- 1,927	- 1,927	
DORSET NHS ADJUSTED SURPLUS / (DEFICIT)	- 24,312	- 24,771	- 459	14,507	12,665	- 1,842	47,286
DORSET LAs SURPLUS / (DEFICIT)	-	-	-	-	- 3,649	- 3,649	-
DORSET SYSTEM LAs & NHS SURPLUS / (DEFICIT)	- 24,312	- 24,771	- 459	14,507	9,016	- 5,491	47,286

System Performance

- ✓ 31 day (urgent) cancer waits for October
- ✓ 14 day (urgent) cancer waits for Octoer as a system against a 93% target
- ✓ Steps to wellbeing 6 weeks RTT and 50% recovery target
- ✓ Acute delayed transfers of care 3.4% bed days lost against 3.5% target (October)
- × A&E 4 hour wait position 92.6% against 95% target (November)
- × 62 day cancer wait for October, 77.3% for the Dorset System against 85% target
- × RTT confirmed October position 84.4% against 92% target.
- × October waiting list 7% above March baseline
- × Diagnostics is 7.8% against a 1% target (October), DCH, patients waiting over 6 weeks (536)
- × Community & mental health delayed transfers of care (MH 6.71%, CH 12%) of bed days lost against 7.5%

Activity –ICS Providers (Dorset patients) – (Year-to-Oct)

- ✓ Total Planed elective inpatients –8.3%
- ✓ Day case activity -1.3%
- ✓ First outpatients (all specialties) -2.5%
- ✓ Follow-up outpatients (all specialties) -1.6%
- ✓ GP Referrals (all specialties exc. T&O) -1.9%
- ✓ GP Referrals (9 specialties exc. T&O) -3.1%
- × Non-elective admissions +3.5%

3.1 System Underlying Position – Forecast Outturn as at end September 2018

Overview

		Assumes receipt of PSF				Ignores receipt of PSF/CSF			
	PSF/CSF Plan	Plan	Realistic	Best	Worst	Plan	Realistic	Best	Worst
Organisation Name	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Dorset County	5,873	(1,325)	(7,781)	(6,981)	(8,981)	(7,198)	(11,598)	(10,698)	(12,798)
Dorset Healthcare	6,230	7,852	7,852	7,852	7,852	1,622	1,622	1,622	1,622
Poole Hospital	9,142	(3,713)	(14,637)	(14,637)	(15,137)	(12,855)	(19,619)	(19,619)	(20,119)
Royal Bournemouth	27,000	24,619	24,619	24,619	24,619	(2,381)	(2,381)	(2,381)	(2,381)
DORSET NHS PROVIDERS SURPLUS / (DEFICIT)	**48,245**	**27,433**	**10,053**	**10,853**	**8,353**	**(20,812)**	**(31,976)**	**(31,076)**	**(33,676)**
Dorset CCG		1,734	1,734	1,734	1,734	1,734	1,734	1,734	1,734
DORSET NHS SYSTEM SURPLUS / (DEFICIT)	**48,245**	**29,167**	**11,787**	**12,587**	**10,087**	**(19,078)**	**(30,242)**	**(29,342)**	**(31,942)**
Movement from Plan			**(17,380)**	**(16,580)**	**(19,080)**		**(11,164)**	**(10,264)**	**(12,864)**

"Realistic" System Control Total Gap of £11.2m (Excluding Q4 PSF lost)

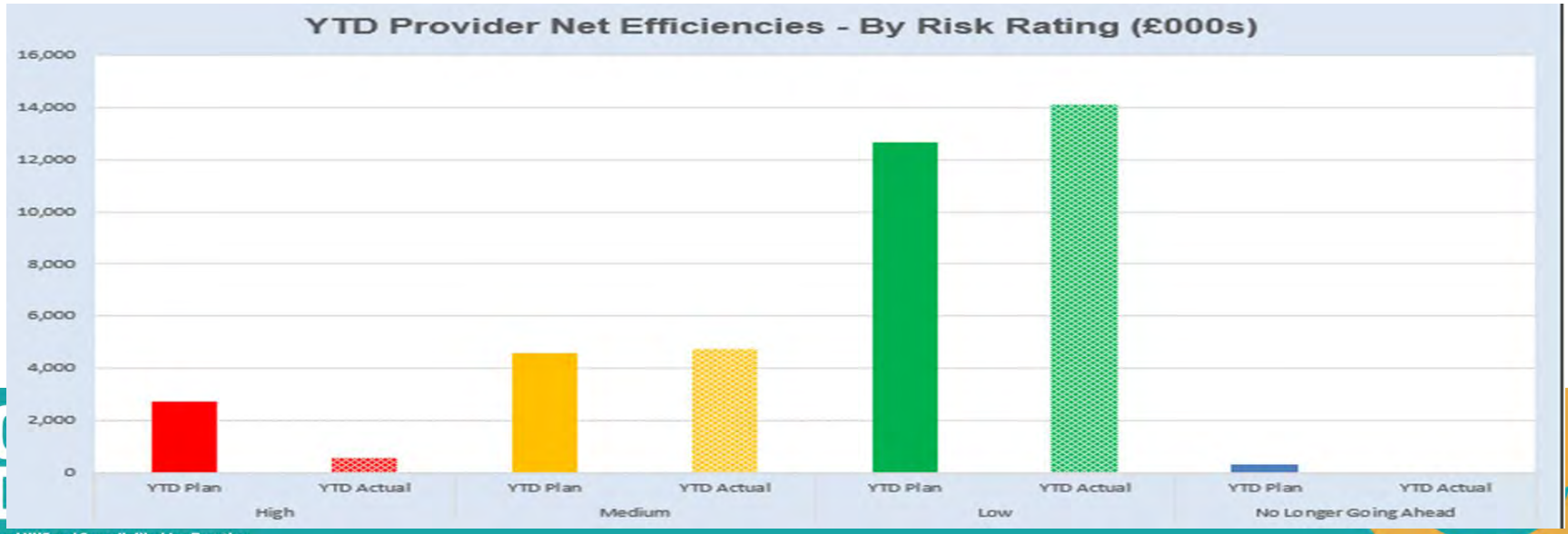
3.2 System Underlying Position – NHSI 2 for £1 proposal

	Realistic Case						
Description	**DCH**	**DHC**	**PHT**	**RBH**	**CCG**		**TOTAL**
Opening CT	(7,198)	(230)	(12,855)	(11,381)	1,234		**(30,430)**
Adjustment to CT		1,852		9,000	500		**11,352**
Revised CT	**(7,198)**	**1,622**	**(12,855)**	**(2,381)**	**1,734**		**(19,078)**
Forecast -							
Opening CIP gap not mitigated by system	(4,000)		(4,000)				(8,000)
Run-rate over-spend	(1,000)		(564)				(1,564)
Increased clinical revenue	600						**600**
Additional Winter Pressures			(1,000)				(1,000)
Robot debt			(900)				(900)
Interserve TUPE			(300)				(300)
Realistic case movements (before PSF)	**(11,598)**	**1,622**	**(19,619)**	**(2,381)**	**1,734**		**(30,242)**
Original PSF	**5,873**	**2,526**	**9,142**	**9,000**	**-**		**26,541**
Incentive PSF - £2:£1 NHS I incentive		**3,704**		**18,000**	**-**		**21,704**
Unachieved PSF - Missed Q4 CT & A&E	(2,056)		(4,160)				(6,216)
Realistic case movements (after PSF)	**(7,781)**	**7,852**	**(14,637)**	**24,619**	**1,734**		**11,787**
Original Control Total (inc PSF)	(1,325)	7,852	(3,713)	24,619	1,734		29,167
Variance to planned position	**(6,456)**	**-**	**(10,924)**		**-**		**(17,380)**
Incentive earned vs PSF lost	**(2,056)**	**3,704**	**(4,160)**	**18,000**			**15,488**

- **-£4.4m** Dorset County will move off forecast end of year control total although still planning to deliver quarterly performance for Q3
- **+£1.85m** Dorset Healthcare holding current over-delivery.
- **-£6.8m** Poole will move off forecast end of year control total, although still planning to deliver quarterly performance for Q3.
- **+£9m** - Bournemouth will over deliver by the original Nursing Home £3.5m, plus a further £5m charitable donation and £0.5m ICES stock.

4. Cost Improvement Forecast – as at end November 2018

Organisation	OrgCode	Plan	Actual	Variance	Plan	Forecast	Variance	Non-recurrent of Total		Variance	Unidentified of Total		Variance
Total Net Efficiencies		YTD M8 EFF1000	YTD M8 EFF1000	YTD M8 calc	FY EFF1000	FY EFF1000	FY calc	FY Plan EFF1002	FY Forecast EFF1002	FY calc	FY Plan EFF1003	FY Forecast EFF1003	FY calc
NHS Dorset CCG	11J	19,424	19,424	(0)	29,137	29,137	(0)	0	0	0	0	0	0
Dorset County Hospital NHS Foundation Trust	RBD	2,348	2,502	154	7,613	7,613	0	2,588	2,323	(265)	1,708	770	(938)
Dorset Healthcare University NHS Foundation Trust	RDY	5,147	5,669	522	8,354	8,077	(277)	3,085	3,372	287	579	421	(158)
Poole Hospital NHS Foundation Trust	RD3	4,242	4,191	(51)	10,934	11,006	72	4,114	4,471	357	2,652	2,705	53
Royal Bournemouth And Christchurch Hospitals NHS FT	RDZ	8,539	7,081	(1,458)	12,697	11,499	(1,198)	5,209	5,585	376	3,402	0	(3,402)
Total CCG Net Efficiencies		19,424	19,424	(0)	29,137	29,137	(0)	0	0	0	0	0	0
Total Provider Net Efficiencies		20,276	19,443	(833)	39,598	38,195	(1,403)	14,996	15,751	755	8,341	3,896	(4,445)
Total System Net Efficiencies		39,700	38,867	(833)	68,735	67,331	(1,404)	14,996	15,751	755	8,341	3,896	(4,445)



Local NHS and Councils Working Together

5. Workforce (WTEs & Expenditure)

Workforce And Expenditure Alignment

Substantive/Bank/Agency
All
Staff Group
All

		Workforce YTD Plan WTE	Workforce YTD Actual WTE	Workforce YTD Variance WTE	Expenditure YTD Plan £	Expenditure YTD Actual £	Expenditure YTD Variance £
Dorset County Hospital NHS Foundation Trust	RBD	2,597	2,579	(0.69)%	76,103	77,895	2.35%
Dorset Healthcare University NHS Foundation Trust	RDY	4,931	4,942	0.23%	123,760	127,673	3.16%
Poole Hospital NHS Foundation Trust	RD3	3,513	3,701	5.36%	109,513	114,989	5.00%
The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	RDZ	4,223	4,229	0.14%	122,665	128,167	4.49%
System total		15,263	15,451	1.23%	432,041	448,724	3.86%

Workforce And Expenditure Alignment

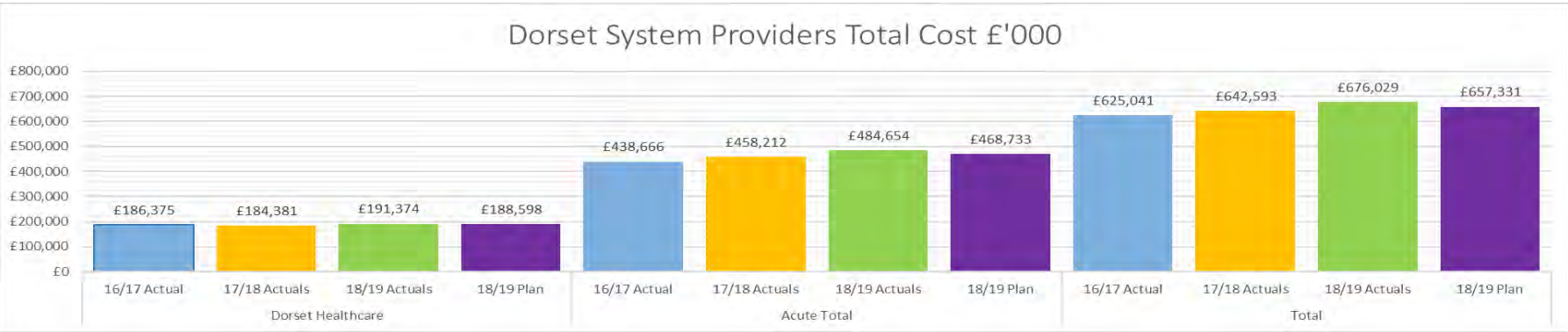
Substantive/Bank/Agency
All
Staff Group
All

		All Staff Groups						
		Total Bank YTD Plan £ WRK5001	Total Bank YTD Actual £ WRK5001	Total Bank YTD Variance £	Total Agency YTD Plan £ WRK5002	Total Agency YTD Actual £ WRK5002	Total Agency YTD Variance £	Agency Ceiling YTD Plan £ RR1011
Dorset County Hospital NHS Foundation Trust	RBD	2,328	4,499	2,171	1,697	2,377	680	1,697
Dorset Healthcare University NHS Foundation Trust	RDY	7,272	8,179	907	2,374	3,176	802	4,336
Poole Hospital NHS Foundation Trust	RD3	5,259	5,697	438	2,745	5,090	2,345	2,776
The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	RDZ	7,788	10,084	2,296	3,141	2,784	(357)	3,474
System total		22,647	28,459	5,812	9,957	13,427	3,470	12,283

5.1 Workforce (Costs)

This page summarises the overview of workforce for Dorset NHS Providers from the 2016/17 baseline period to date for costs

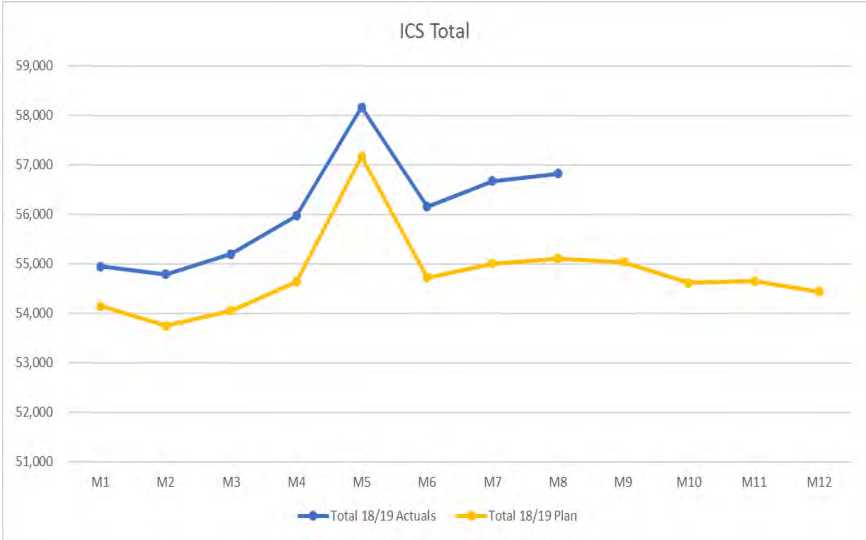
(note: 18/19 actual costs are estimates on a rolling average extrapolation – moving forward provider forecasts will be included).



	DCH	RBH	PHT	DHC	TOTAL
2016/17 Actuals	106,619	174,633	157,414	186,375	625,041
2017/18 Actuals	111,133	182,716	164,363	184,381	642,593
2018/19 Actuals	117,142	193,963	173,549	191,374	676,028
2018/19 Plan	114,374	187,323	167,036	188,598	657,331

2018/19 Actuals Reported	*77,894*	*128,167*	*114,989*	*127,674*	*448,724*
2018/19 Actual Estimate	*39,248*	*65,796*	*58,560*	*63,700*	*227,304*

Cost Increase / Movement £'000					
2016/17 to 2017/18	4,514	8,083	6,949	- 1,994	17,552
2017/18 to 2018/19	6,009	11,247	9,186	6,993	33,435

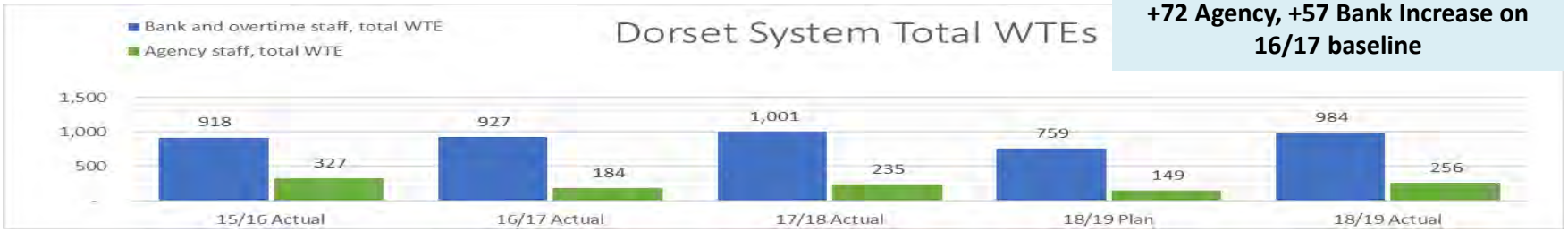


Costs are currently on trajectory to be above 2018/19 Plan by £18.7m, £15.9m of which relates to Acute Trusts

New Pay Awards are included and were paid from Month 4.

5.2 Workforce (Agency and Bank)

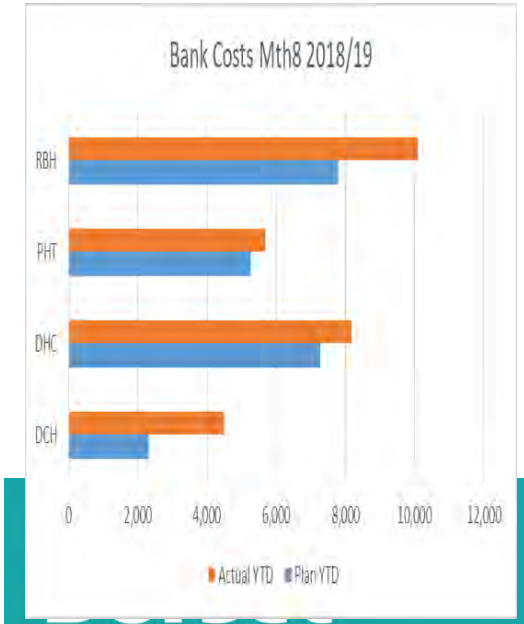
This page summarises the overview of Agency and Bank Costs

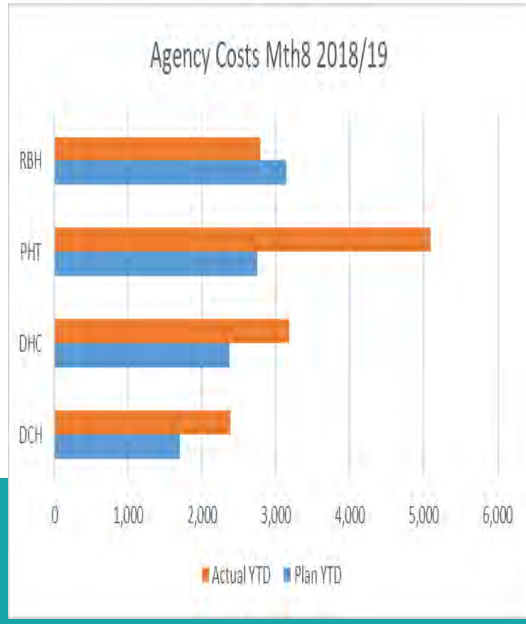


+72 Agency, +57 Bank Increase on 16/17 baseline

+225 above 18/19 plan for bank and overtime, +107 above 18/19 plan for Agency
Total substantive WTE is behind plan -192

Dorset providers have a planned outturn for 2018/19 on Agency of £15.8m, equivalent to 2.5% of total gross staff costs, however YTD is ahead of current plan, so will need careful management to deliver end of year position, especially noted for Poole Hospital. Bank costs are also ahead of plan for all providers.





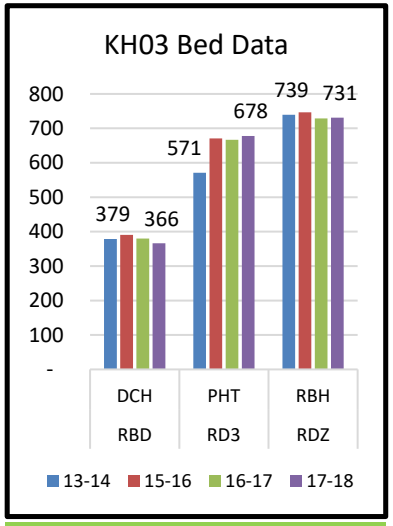
Actual Costs YTD				
Provider	Substantive	Agency	Bank	TOTAL
Dorset County	71,019	2,377	4,499	77,895
Dorset Healthcare	116,318	3,176	8,179	127,673
Poole Hospital	104,202	5,090	5,697	114,989
Royal Bournemouth	115,299	2,784	10,084	128,167
All Acute's	290,520	10,251	20,280	321,051
All Providers	406,838	13,427	28,459	448,724

STP Plan – What we said we would do

SOLUTIONS CATEGORIES	INTEGRATED COMMUNITY AND PRIMARY CARE SERVICES (ICPCS)	RIGHT REFERRAL RIGHT CARE	ACUTE RECONFIGURATION	PROVIDER COST IMPROVEMENT PLANS (2%)	SUSTAINABILITY AND TRANSFORMATION FUND	SPECIALIST COMMISSIONING	TOTAL
	£m	£m	£m	£m	£m	£m	£m
Managing demand together	35	28				20	**83**
Provider system efficiencies (2%)			19	81			**100**
Investment in community services	- 16						**- 16**
Draw-down from STF					55		**55**
Investment in nationally managed programmes					- 25		**- 25**
Health system stretch target	32						**32**
TOTAL SOLUTIONS							**229**

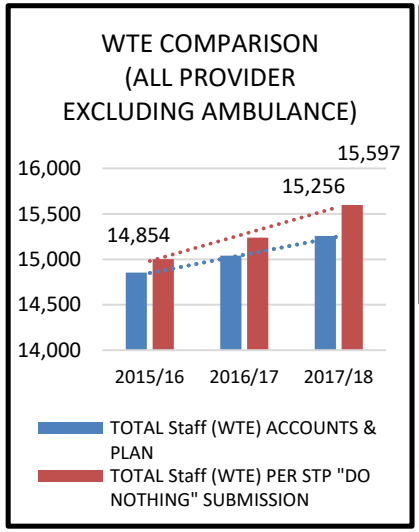
Hold Acute Activity FLAT | **Hold Workforce WTEs FLAT** | **Maintain Flat Cash** | **Maintain Performance** | **Maintain Quality**

Can we see any progress?



Beds fairly static over last 3 years

Note: beds for PHT in 13/14 were revised following McKinsey work to 654



WTEs needed to remain flat, however have impacted against "do nothing"

	Per STP Submission	Per 2017/18 Accounts	Movement
Provider Expenditure	1,020,123	966,142	-53,981
Provider Income	947,451	972,067	24,616
Surplus/(Deficit)	**-72,672**	**5,925**	**78,597**
CCG Expenditure	1,189,430	1,158,475	-30,955
CCG Allocations	1,151,165	1,164,849	13,684
Suplus/(Deficit)	**-38,265**	**6,374**	**44,639**
System Movement	**-110,937**	**12,299**	**123,236**

Provider
STF Income £32m
Pay avoided £19m
Drugs costs £9m
Other £20m

CCG
Bus Rules £12m
QIPP (inc.CHC) £18m
Other £15m

Provider Non-recurrent savings in 2017/18 **Local £17m (NHSI Reported £12m)**

Strong financial performance for 2017/18 against "do nothing" projection

- ✓ 14, 31 and 62 day cancer waits
- ✓ Steps to wellbeing RTT within 6 weeks
- × Delayed transfer acute target 3.5% - **4.3%**
- × 18 week RTT 92% target – **88.9%**
- × 6 weeks diagnostics 99% target – **85.4%**
- × A&E 95% target Jan 18 – **92.9%** DCH was the only provider to achieve target at 96.1%

Performance on cancer, IAPT, Delays and A&E either on target or marginally short

Significant challenges in RTT and Diagnostics

- × ED Attendances **1.7%**
- ✓ First and follow up Outpatients **-2.5%**
- ✓ Elective Inpatients **-5.8%**
- ✓ Day Case **-1.2%**
- × Unplanned admissions **0.4%**
- ✓ GP Referrals **-5.5%**

Elective demand has reduced

Non-Elective demand is increasing

Our Dorset
Local NHS and Councils Working Together

New Funding Settlement

- The NHS will receive increased funding of £20.5bn per year by the end of 5 years
- An average 3.4% a year real terms increase in funding
- £800m has been included in total NHS 18/19 for the pay deal costs

NHS England RDEL (excluding depreciation)	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
New nominal budget (£bn)	114.6	120.55	126.91	133.15	139.83	147.76
Cumulative real growth (18/19 prices) (£bn)		4.1	8.3	12.1	16.1	20.5
Real growth (%)		3.6%	3.6%	3.1%	3.1%	3.4%
Plus pensions funding (£bn nominal)		*1.25*	*1.25*	*1.25*	*1.25*	*1.25*
Revnised new nominal budget (£bn)	114.6	121.8	128.16	134.4	141.08	149.01
Dorset CCG (estimated possible)	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Resources	**1.147**	**1.187**	**1.229**	**1.267**	**1.306**	**1.350**
Dorset CCG% of national funding	1.0%	1.0%	1.0%	1.0%	0.9%	0.9%
Annual Growth £bn		0.041	0.042	0.038	0.039	0.044
Possible Dorset CCG Annual Growth £m		**40,675**	**42,139**	**37,593**	**38,758**	**43,827**

Note: Assumes total NHS uplift is applied to Dorset CCG core and Primary Care, excluding running cost allowance where no uplift is assumed

Current Progress

- 10 year plan for the NHS in England in development with various working groups.
- Tariff engagement delayed for 2019 and beyond.
- Expectation of a simplification of financial framework and levers, including PSF.

Department has set NHS 5 Tests

1. Improving productivity and efficiency
2. Eliminating provider deficits
3. Reducing unwarranted variation in the system
4. Much better at managing demand
5. Making better use of capital investment

6. Capital bids

This table summarises the ICS health overview of the capital bid position.
This incorporates wave 1 Acute and wave 4 bids on PDC and RHIC cases.

Scheme	CAPITAL						
	TOTAL	19/20	20/21	21/22	22/23	23/24	24+
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Wave 1 - Approved Capital							
East Acute Reconfiguration	£145,748	£7,415	£38,929	£61,374	£38,030		
TOTAL WAVE 1 (PDC)	**£145,748**	**£7,415**	**£38,929**	**£61,374**	**£38,030**	**£0**	**£0**
Wave 4 - PDC Capital bids							
DCH ED, ICU and Integrated Hub	£24,386		£24,386				
One Dorset Pathology	£5,099	£5,099					
Blandford Hub	£4,186	£1,340	£2,846				
Sherborne Hub	£18,166	£217	£4,531	£9,414	£4,004		
TOTAL WAVE 4 (PDC)	**£51,837**	**£6,656**	**£31,763**	**£9,414**	**£4,004**	**£0**	**£0**
TOTAL CAPITAL (PDC)	**£197,585**	**£14,071**	**£70,692**	**£70,788**	**£42,034**	**£0**	**£0**
Wave 4 - RHIC bids							
Alderney	£5,932	£1,977	£1,977	£1,978			
St Ann's	£15,956		£7,978	£7,978			
Wareham	£18,504		£9,252	£9,252			
TOTAL WAVE 4 (RHIC)	**£40,392**	**£1,977**	**£19,207**	**£19,208**	**£0**	**£0**	**£0**
TOTAL CAPITAL (PDC & RHIC)	**£237,977**	**£16,048**	**£89,899**	**£89,996**	**£42,034**	**£0**	**£0**

Wave 4 bid submitted on 13th July 2018 in accordance with the national process and having already been checked through the regional process. Awaiting feedback on the bids.
Dorset Healthcare are still exploring other options with NHS Improvement as alternatives to RHIC, which still appears to have a higher revenue charge per annum compared to PDC.

6.1. Capital – 2018/19 YTD and Forecast

Organisation Name	Org Code	Total Capital Expenditure	Total Capital Expenditure	Total Capital Expenditure	Total Capital Expenditure	Total Capital Expenditure	Total Capital Expenditure
Providers Only		2018/19 YTD Plan	2018/19 YTD Actual	2018/19 YTD Variance	2018/19 FY Plan	2018/19 FY Forecast	2018/19 FY Variance
Dorset County Hospital NHS Foundation Trust	RBD	2,892	2,960	68	8,535	8,491	(44)
Dorset Healthcare University NHS Foundation Trust	RDY	10,193	4,239	(5,954)	21,453	16,032	(5,421)
Poole Hospital NHS Foundation Trust	RD3	7,317	6,381	(936)	13,848	14,139	291
The Royal Bournemouth And Christchurch Hospitals NHS Foundation	RDZ	6,600	5,346	(1,254)	12,845	11,282	(1,563)
Total		**27,002**	**18,926**	**(8,076)**	**56,681**	**49,944**	**(6,737)**

Scheme Category	Total Capex	Total Capex	Total Capex	Total Capex	Total Capex	Total Capex
Providers Only	2018/19 YTD Plan	2018/19 YTD Actual	2018/19 YTD Variance	2018/19 FY Plan	2018/19 FY Forecast	2018/19 YTD Variance
	link	link	calc	link	link	calc
New Build - Land, buildings and dwellings	4,730	1,381	(3,349)	16,754	6,465	(10,289)
Routine Maintenance (non-backlog) - Land, buildings and dwellings	3,931	1,842	(2,089)	5,897	5,401	(496)
Backlog Maintenance - Land, buildings and dwellings	4,579	3,652	(927)	10,494	10,330	(164)
IT	3,373	2,753	(620)	5,550	9,348	3,798
Fire Safety	216	138	(78)	360	332	(28)
Plant and machinery/equipment/transport/fittings/other	9,978	8,532	(1,446)	16,735	16,501	(234)
Other - Intangible assets	131	199	68	433	433	-
Other - Investment property	-	-	-	-	-	-
Other	64	429	365	458	1,133	675
Total	**27,002**	**18,926**	**(8,076)**	**56,681**	**49,944**	**(6,737)**

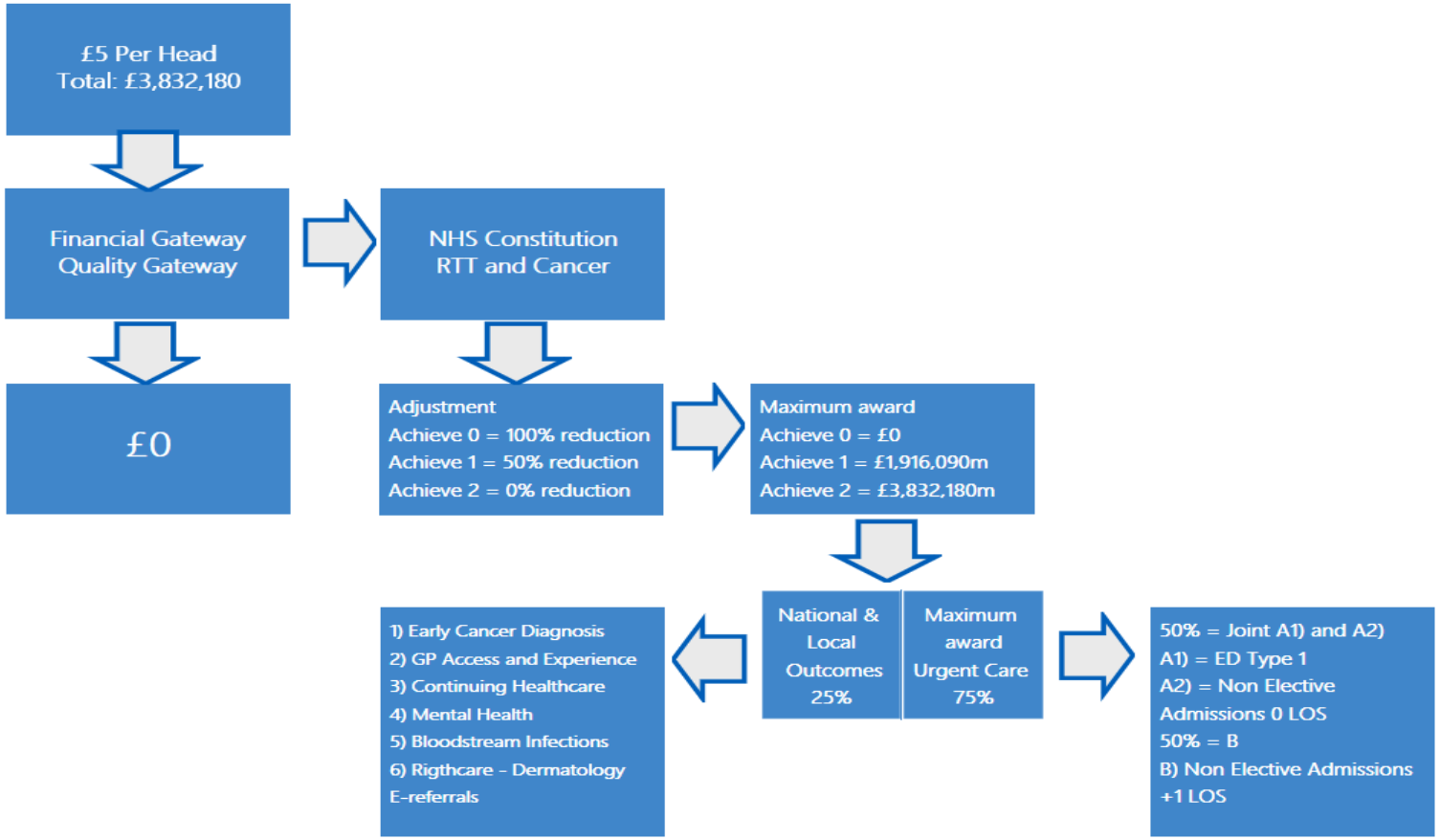
7. Quality Premium – Overview

NHS Quality Premium Constitution Gateway

Dorset Population: 766,436 (£5 per head)

The Quality Premium (QP) scheme is about rewarding Clinical Commissioning Groups (CCGs) for improvements in the quality of the services they commission.
The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

The maximum QP payment for a CCG is expressed as £5 per head of population, calculated using the same methodology as for CCG running costs.



7.1 Quality Premium – Constitution Gateway Position

This table summarises the ICS health overview of quality premium. (Max available £3.8m- Achieved £0m)

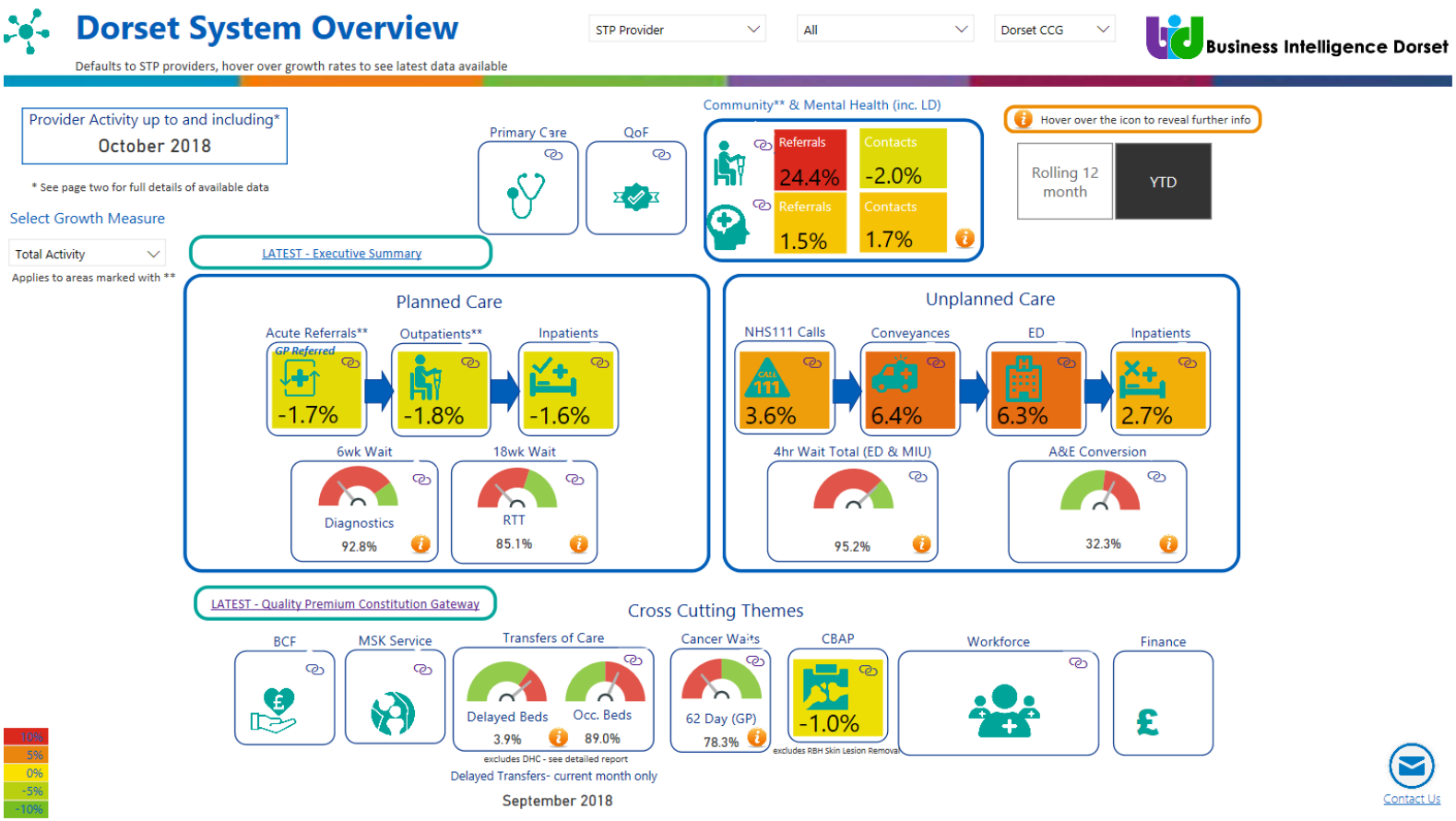
Financial Gateway Achieved	YES				
Quality Gateway	YES				
	2018/19				
Dorset CCG Population	766,436				
Max achieval £5 per head	3,832,180.00				
Constitutional Gateways	Value %	Amend Y or N	Comment	*Potential if achieved Cancer 62-day*	
RTT	50.00%	N	List growth 3,145 cases		
Cancer - 62 Day	50.00%	N	Near miss - 82% need 85%	£	*1,916,090*
	100.00%	0.00%			
Constitutional Acheivement		-	NIL achievement - prevents reward for subsequent deliviery of indicators		
Quality Indicators - 75%	Value	0.00			
Type 1 A&E	50.00%	N	A&E Growth 6%		
Non Elective admissions with (LOS 0)			NEL 0 LoS achieved		
Non Elective admissions with (LOS 1+ Day)	50.00%	Y		£	*718,534*
	100.00%	50.00%			
		-			*718,533.75*
National Indicators - 25%	Value	0.00			
Early Cancer Diagnosis	17.00%	N			
GP Access and Experience	17.00%	N			
Continuing Healthcare	17.00%	N	Missed 28day target		
Mental Health	17.00%	Y		£	*81,434*
Bloodstream Infections	17.00%	Y		£	*81,434*
Dermatology GP Referrals	15.00%	Y		£	*71,853*
	100.00%	49.00%			
		-		£	*234,721*
Forecast acheivement		-	Potential if achieved Cancer 62-day	£	*953,254.78*

Business Intelligence Dorset

ICS Performance Report Executive Summary

Month 8, November 2018/19

Dorset System Overview

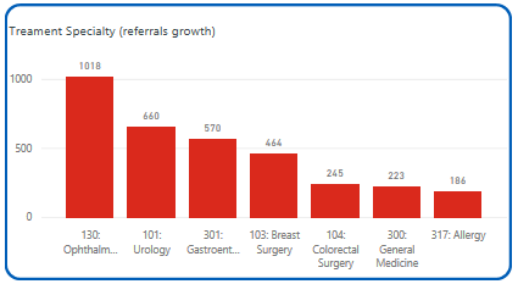


Click here to access the Dorset System Overview

Planned Care, Referrals and RTT (Issues and Actions)

GP Referrals

System	DCH	PHT	RBH
(1.7%)	(0.2%)	(1.2%)	(3.1%)



- GP Referrals across all specialties show a 1.7% reduction compared to 2017/2018.
- Across the three acute Trusts, the highest growth areas are ophthalmology, 13.9%, gastroenterology 17.9% and urology 14.2% (mainly fast-track referrals).
- There has been a 15% increase in 2 Week wait referrals compared to last year. This is particularly impacting on dermatology and urology.
- PHT has continued to see growth in dermatology and urology. Both PHT and RBH remain closed to routine dermatology referrals
- RBH has seen continued growth in urology. There has been a significant reduction in dermatology referrals at RBH reflecting the closed service..

- ✓ Patient Decision Aid tool being developed and refined and CBAP and referral pro-forma has been developed for cataracts.
- ✓ In urology, standardised pathways and follow up protocols for fast track and routine are being reviewed across the whole system
- ✓ The dermatology photoapp continues to be promoted and taken up by GP practices to support the use of Advice and Guidance.
- ✓ CCG funding agreed for allergy backlog at RBH. Service to transfer to Southampton Hospital in the new year with final details being agreed.

Referral to Treatment

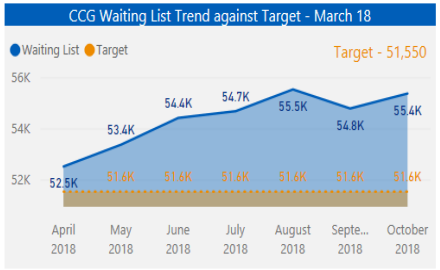
System	DCH	PHT	RBH	DHC
86.0%	80.2%	84.4%	86.9%	93.1%

October 2018 Monthly Performance against the 92% standard.

- MSK Triage performance continues to be an issue with no significant improvement. However the administrative function is now fully staffed.
- Significant reduction in the total waiting list for September 2018. However, system is 6% above plan. The largest increase is at DCH, which is 13% above plan.
- Greatest RTT pressures are in dermatology and trauma and orthopaedics. Continued growth in ophthalmology is also of concern to the system. Non-recurrent funding of £200k agreed to support current pressures.

- ✓ MSK Triage Service one-year review has been completed with options for the future presented to CCC and OFRG in December. A further paper following a physiotherapy review will be presented to CRG in January 2019.
- ✓ Large programme of work led by the Elective Care Board focusing on outpatient redesign has commenced.
- ✓ A system wide Demand and Capacity Review of ophthalmology outpatient and inpatient services is planned to commence in January 2019. PHT monitoring at patient level continues for all patients waiting over 26 weeks and reasons for delay reviewed in more detail together with ongoing validation of the entire waiting list and Demand and Capacity Planning for first outpatient activity.
- ✓ DCH continues a zero tolerance to 52 week waits. Actions are being taken to ensure there are robust clinical risk stratification processes in place as the waiting list increases in size. Work is underway to reduce the follow up backlog with actions including virtual clinics, with the capacity released diverted to new patients.

Waiting List/Plan

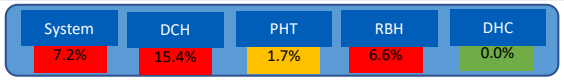


DCH	PHT	RBH	DHC
19%	4%	2%	18%

Click here to access the GP Referral report and here to access further information on Referral to Treatment

Planned Care, Diagnostics and Cancer (Issues and Actions)

Diagnostics



October 2018 Monthly Performance against the 1% standard.

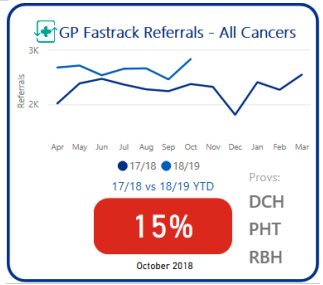
- Diagnostic system performance is 7.2% against target of 1%. The biggest concern is colonoscopy where system performance is at 47% and has deteriorated in each month over the last six months.
- 331 patients (257 DCH, 74 RBH) waiting over 13 weeks across the system for all diagnostics. Largest pressure areas are colonoscopy (RBH and DCH), flexible sigmoidoscopy (RBH) and audiology (DCH).
- Increases also experienced in waiting times for patients undergoing planned surveillance tests as a consequence of capacity issues. Highlighting need for system wide review of capacity and demand.

- ✓ Prioritising cancer diagnostics
- ✓ DCH JAG improvement plan being developed for January
- ✓ RBH to revise endoscopy action plan due to clinical sickness
- ✓ Audiology – workforce redesign and training underway

Cancer (Fast-track referrals)

Comparison of October 2018 against 2017/18 position.

Fast-track referrals remain elevated and were 14% higher in October 2018 than in the corresponding period in 2017/18. October 2018 saw the highest number of fast-track referrals recorded in a single month this year. Urology remains the tumour site with the greatest increase in fast track referrals, with 38.1% more referrals in October 2018 compared to the same period last year. Gynaecology has seen a dramatic increase in the number of fast track referrals, with 19.7% more in October 2018 compared with October 2017. This could be due in part to a current television drama storyline. Despite the challenge of increased fast-track referral rates the Dorset system and all three acute providers are compliant with the 93% Standard for two week referrals.
All Providers are non-compliant with the 62 day standard for October 2018. The Dorset Weekly predictor tool indicates that this standard could be met in the best case scenario, in December 2018. This however will not be enough to meet the standard for Q3 as a whole.
Urological cancer referrals remain of most concern.
Provision of brachytherapy is challenged with waiting times into early 2019.



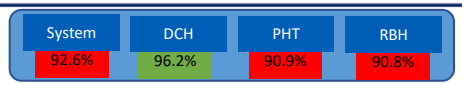
- ✓ Across the system, additional national funding has been secured from NHS England (£365.2k for Dorset) to aid the recovery of the 62 days standard in urology for 2018/19, specifically prostate. Trusts have agreed spending plans that will see an increase in capacity across: MRI to bring forward that part of the pathway, theatres to increase surgical capacity, additional clinic lists / brachytherapy, additional histology reporting time and diagnostics.
- ✓ System implementation of the optimal lung pathway has commenced focusing on improving the existing pathway and quality of information referred. A clinically led, Dorset Optimal Lung Pathway Project Steering Group has formed and the system wide lung navigator role is currently in recruitment. The post will enhance the management of the lung pathway and the relationship/communication with Tertiary Centres contributing to better tracking and improved performance.
- ✓ Dorset wide, the prostate pathway review has been identified as a priority, and a table top review and deep dive has been initiated across the Dorset system. Urology has been identified as a priority for the CSR, and meetings have been put into place to start reviewing this.
- ✓ Dorset wide Implementation of the Risk Stratification project is underway and will impact on colorectal, breast and prostate pathways, along with timed 28 days to diagnosis pathway following success of the RBH pilot of the 28 day referral to diagnosis standard.

Our Dorset
INTELLIGENT WORKING

Click here to access further information on Fast-track referrals and click here to access the Dorset Cancer Overview

Urgent Care (Issues and Actions)

ED Performance

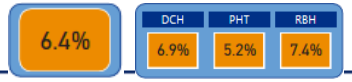


November 2018 Monthly Performance

- **Emergency Department:** demand continues to increase and is above the corresponding period in 2017/18.
- Performance across the Dorset was 92.6% (November 2018). Performance to 9 December 2018 indicates that the Dorset System is at 90.4%.
- **Insufficient headroom built to achieve Quarter 3 trajectories** based on historical December performance. Additional focus required between now and the end of December 2018 to ensure the system meets these challenges.
- Surges in attendance and the weekend increased demand means that recovery within the acutes is taking longer.
- Workforce vacancies continue to impact on the system.
- Impact of estates work (DCH) - contingency plans in place with the use of escalation areas, and to date this has remained a managed risk which is being actively monitored.

- ✓ ED Action Plan / ED Streaming to Primary Care/Urgent Treatment Centre (RBH)
- ✓ Improve GP streaming throughput. Increase the numbers of patients streamed to a GP or Primary care clinician by looking at other patient groups who could be managed within an alternative care setting. A specific subset of minor injuries are now sent through to GP streaming service.
- ✓ Escalation triggers. ED have developed escalation pathways for all key metrics within ED: triage, ambulance triage, clinician seen time. These triggers will drive an early response to rising pressure.
- ✓ The Winter Resilience Plan is being implemented to ensure appropriate actions are being taken at a ward and divisional level to de-escalate where possible.
- ✓ IAGPS across Dorset
- ✓ Additional SHO Out Of Hours to support capacity / "See & Treat" in minors / direct access to AEC.
- ✓ Social Worker at front door of acutes being trialled
- ✓ Ambulance handovers – working jointly with SWAST to implement GP support to Single Point Of Access.

Conveyances



Comparison of October 2018 against 2017/18 position.

- Conveyance: increases seen across Dorset equates to around 15 patients per day and continue at levels seen across the previous 12 months.
- National benchmarking of 2017/18 data indicates that SWAST have seen the largest increase in 'incidences to ED' across the country recorded in 2017/18.

- ✓ SWAST risk rated '25' for 999 call stacking, accepted this risk as accurate. Risk will be put onto the CCG corporate risk register;
- ✓ Action plan now in place and will focus on the following priority areas:
  - Demand management to focus on 111/HCP calls/High Intensity Users
  - Call management – 999 & 111. To include Revalidation of 111 calls for 999 dispositions of categories 3 & 4; and proposal for category 2 being progressed
  - Business case to support additional clinical (GP) support into the 999 control room has been approved – implementation plan and outcome measures are being developed by SWASFT with commissioner support.
  - Visibility of call stack has now been made available and is being communicated out to system resilience tools. An email detailing the total number of calls (incidents) and the total number of calls (incidents) without a resource is circulated every three hours. This information is Trust wide and is not currently available by CCG or by ARP category. This level of detail is being progressed with SWASFT.
- ✓ Mobilisation of GP support in the 111 hub – This has now gone live, shifts are beginning to fill up – Currently January 2019 has 81% cover. 7 GPs now trained, with 2 more scheduled do their training in the New Year, which should further improve the fill rate and provide some resilience to the service
- ✓ Funding for additional resource has been approved. The role funded will support co-ordination and delivery of the STP Action Plan (focusing on the top three work streams and then the remainder), further supporting Dorset CCG as coordinating commissioner and working with local system subject matter experts. It is expected this will develop into a wider delivery support role, as we move through the contract negotiation process and develop the commissioning support model.

Our Dorset
INTELLIGENT WORKING

Click here to access the Urgent Care Overview

Urgent Care (Issues and Actions)

Delayed Transfer of Care

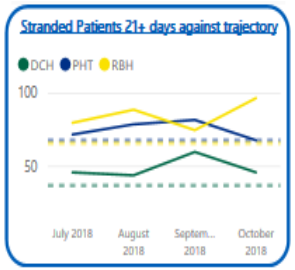
- **Delayed Transfers of Care** (% of delayed occupied bed days) has predominantly performed well throughout 2018/19 however recent concerns are focused around DCH and PHT. Community delays are also seen which are higher than the 7.5% target. Mental Health delays remain close to the 7.5% target. Performance is shown above.

- ✓ Monthly multi-agency DTOC Meetings are being held to reduce delays and to free up additional bed capacity. Meetings take place with the Local Authorities, Housing and Community Services and the CCG to identify barriers in placing delayed Clients and discuss complex cases and escalating accordingly. In addition the Mental Health Community Services Manager meets the Delayed Transfers Coordinator weekly to review protracted cases. Additionally, Local Authorities continue to oversee all DTOCs reported on a weekly basis, and also focus on reducing delays attributable to their authority as well as supporting with NHS delays that can be reduced with their support.
- ✓ Adult Mental Health Inpatient service continues to proactively manage bed capacity and utilise short term accommodation where possible. This has positively reduced the number of bed days blocked by those patients waiting for accommodation. DHC is also exploring the use of a 72 hour admission facility for people with personality disorders to prevent people becoming stuck in the acute hospital system.

Stranded Patients

- ✓ Dedicated focused work continues on stranded patients and weekly calls are progressing the most complex cases and overseeing system performance against the 171 target by 31 December 2018 and are continuing.
- ✓ Increased capacity in the Interim Care Team/redesign of the CHC pathway and scale-up the ability to manage a D2A approach for hospital discharge.
- ✓ Working with local authorities to agree the priorities for improvement from the National Winter Care funds – Winter 18.
- ✓ Transformation funding of £250k utilised on supporting this area.
- ✓ IDS Bureau development ongoing with trusted assessor and D2A schemes .
- ✓ CHC electronic referral process being procured.
- ✓ DHC in-reach offer to acute providers.

- **Stranded Patients,** the Dorset System has a trajectory to reduce stranded patients (over 21 days) to 171 by 31st December 2018, the system is currently behind this trajectory. The position as at 19 December 2018 shows 209 patients currently in hospital. Having dropped below the system target of 171 during the weekend of 20 – 21 October 2018, the number is still above the target. PHT remain above their target of 68 at 85, as are RBH with 89 against their target of 66. DCH are meeting their individual trajectory target of 37.
- This remains a fragile situation though and the main areas of continued concern are delays relating to care capacity, care packages in the community, housing, and complex placements.
- During early December 2018 the number of patients with a Length of Stay of over seven days has decreased significantly from 233 on 4 December to 157 on 10 December. The number with a Length of Stay of over 14 days has however increased over the same period from 97 to 143. This trend is continuing as December progresses.
- From October 2018, Fayrewood Ward patients are reported within the RBH position, this is being reviewed.
- Weekly system calls continue to take place to escalate concerns and trends.



Our Dorset
INTELLIGENT WORKING

Click here to access the Urgent Care Overview

Title of Meeting	**Board of Directors**
Date of Meeting	**30 January 2019**
Report Title	**Corporate Risk Register**
Author	Mandy Ford, Head of Risk Management and Quality Assurance
Responsible Executive	Nicky Lucey, Director of Nursing and Quality

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

Summary

The Corporate Risk Register assists in the assessment and management of the high level risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that risks corporate risks are effectively being managed and that controls are in place to monitor these. All care group risk registers are being reviewed.

The most significant 5 risks which could prevent us from achieving our strategic objectives are below. There are no significant changes from the last update other than the inclusion of a new risk relating to Brexit and the plan to split the Mortality Indicator risk in to two clearly defined risks in relation to coding and mortality risks.

The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework. This may mean that the risk score differs. There will also be a difference in the risk scores as we have moved to the 5x5 matrix.

All current active risks will be reviewed with the leads over the next two months to ensure that the risks are in line with the Risk Management Framework as there is some concern that risks may have been over-scored.

It was anticipated that all of the risk registers would be fully operational on Datix by the end of December 2018. Due to staff sickness throughout December this has been delayed. This work will be complete by the end of January 2019.

OBJECTIVE:
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.

Risk Reference	Description	Current Risk Score	Assurance
1059	Recruitment and retention of medical staff across specialities	Extreme	Work is ongoing. Detail listed in the table to follow as to how this risk is being managed currently **BAF Objective 4 risk R1- R6**
1058	Volume of patients on gastroenterology outpatients Waiting list causing negative outcomes for patients	Extreme	A part time fifth gastro consultant has been appointed. There are currently as at 11.01.19 476 patients on the FOWL backlog. **BAF Objective 1 risk R3**
FR1-1-032	Facilities – COTAG (Security Door Access System) Reliability	Extreme	The Security Door Access System has become

			unreliable and difficult to manage. The system is no longer supported by its original manufacturer and parts are becoming less available. The system is in need of urgent upgrade or renewal. **BAF Objective 5 risk R4**
1045	Ophthalmology Service Capacity	High	Ophthalmology weekday OoHs service is now delivered by Bournemouth Hospital (as of 4/12/18). All OoHs work to be covered by RBCH as from 4/01/19. FOWL is being reviewed by the consultants, these include Glaucoma and macular patients. Weekend nurse led glaucoma clinics are being booked to the end of March 2019, therefore the waiting list is reducing. Liaising with RBCH regarding contact lens and corneal patients. **BAF Objective 1 risk R3**
OBJECTIVE: 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.			
1049	Financial Sustainability	High	This has been rated as HIGH and not as extreme because: • as at the end of November 2018 we were £750k ahead of plan. • We have delivered £2.2million of CIP against plan of £2.8 million • Reduced non pay expenditure (drugs and clinical supplies) from October levels reflecting lower pass through drugs and renal consumables. **BAF Objective 5 risk R1-R5**

Key changes since the last report to the SMT is as below:

Risk Number	Date added to register	Description	Movement	Risk Score	Impact
STAYED THE SAME					
1011	26.10.17	**Access to care in the community**	⇔	High	Ongoing
1045	26.10.17	**Ophthalmology Service Capacity**	⇓	High	Ongoing
1059	22.12.17	**Recruitment and**	⇔	Extreme	Ongoing

		retention of medical staff across specialities			
1062	17.10.17	Fire door maintenance		High	Ongoing
1058	26.10.17	Volume of patients on Gastroenterology Outpatient Waiting lists causing negative outcomes for patients		Extreme	Ongoing
1056	08.03.17	Fire alarm reliability and capacity		High	Ongoing
1050	26.10.17	Mortality indicator		High	Ongoing
1047	19.10.17	Workforce planning and capacity for nursing/midwifery staff		High	Ongoing
1049	23.10.17	Financial sustainability		High	Ongoing
1066	10.09.18	Community Paediatric Long Waits for ASD Patients		High	Ongoing
1055	06.03.17	ENT Medical Staffing		High	Ongoing
1056	08.03.17	Fire Alarm Reliability and Capacity		High	Ongoing
1015	19.10.15	Failure to manage the deteriorating patient effectively including the recognition, diagnosis and early management of Sepsis		High	Ongoing
1065	12.09.2018	Implementation of GDPR		Moderate	Ongoing
1069	**12.09.18**	Review of Co-Tag system and management of issuing/retrieving tags		Extreme	Ongoing
NEW					
CS2-1-020	**05.10.18**	**BREXIT - UK Leaving the EU on 29th March 2019 without a deal**	NEW	High	Ongoing

EMERGING RISKS TO NOTE: Request to add to Corporate Risk Register: • Electronic Discharge Summaries – awaiting confirmation if should be reinstated as performance indicators show a fall in compliance **ESCALATION OF RISK TO NOTE:** **Whilst for December 2018 reporting the risk in relation to Financial Sustainability is rated high, it should be noted that this will move to EXTREME shortly. The Regulators have been informed that we are not going to meet our financial target at the end of March.**
Paper Previously Reviewed By Risk and Audit Committee 22 January 2019
Strategic Impact The Risk Register outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.
Risk Evaluation Each risk item is individually evaluated using the current Trust Risk Matrix.
Impact on Care Quality Commission Registration and/or Clinical Quality It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Governance Implications (legal, clinical, equality and diversity or other): The Risk registers highlights that risks have been identified and captured, that have been escalated from within the Divisions or affects the Trust's strategic objectives. The Document provides an outline of the work being undertaken to manage and mitigate each risk.
Financial Implications The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.

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

Recommendations	The Board are requested to: • review the current Corporate Risk Register ; and • note the high risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances • Provide direction on how the risks in relation to Brexit should be presented in terms of the 7 workstreams, which may score differently to overall risk.

Corporate Risk Register

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

The Trust Risk Register outlines the current position regarding all of the active Risk Items which have been identified by the Trust. There are currently 15 Risk Items on the Corporate Risk Register. These are summarised below.

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
1045	V4	26/10/2017	EXTREME	EXTREME	HIGH	**ON TARGET**	Ophthalmology Service Capacity	Ophthalmology weekday OoHs service is now delivered by Bournemouth Hospital (as of 4/12/18). All OoHs work to be covered by RBCH as from 4/01/19. FOWL is being reviewed by the consultants , these include Glaucoma and macular patients. Weekend nurse led glaucoma clinics are being booked to the end of March 2019, therefore the waiting list is reducing. Liaising with RBCH regarding contact lens and corneal patients. **BAF Objective 1 risk R3**
1058	V2	26/10/2017	EXTREME	EXTREME	MODERATE	One action relating to drafting a job description for a Livery Nurse Specialist appears to be outstanding.	Volume of Patients on Gastroenterology Outpatients Waiting Lists Causing Negative Outcomes for Patients	A part time fifth gastro consultant has been appointed. There are currently as at 11.01.19 476 patients on the FOWL backlog. **BAF Objective 1 risk R3**
1059	V3	22/12/2017	EXTREME	EXTREME	MODERATE		Recruitment and retention of Medical staff across specialities	Work across recruitment and retention of staff continues. • 6 consultants appointed in

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
						Ongoing		the last 6 months, and 7 Specialty Doctors. • Plans for a Medical workforce recruitment video to be created for use within the Trust's recruitment strategy. • Governance and tracking now in place. • Re-design of care pathways is ongoing. • Placements for CCG Care Flex scheme being identified. • MTI recruitment commenced and ongoing. • Establishment of GOSW role to ensure junior doctor wellbeing is maintained. **BAF Objective 4 risk R1- R6**
1011	V4	26/10/2017	HIGH	HIGH	HIGH	Action deadlines extended to April 2018.	Access to Care in the Community	Divisional Manager and Service Manager working with system partners to scope a Discharge to Assess (D2A) model for delivery by Winter 2018. Recognition that resources across the region are stretched, and may require a joint model with a private provider. Service manager working with IT/BI teams to improve data collection processes for delayed discharges, following discovery of failures in the current recording spreadsheet.

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
								This has stalled, with potential solutions being linked to DPR developments. Divisional Manager is supporting scoping of development of an Access data base to use as a short term solution, supported by an external data manager to create the core database. **BAF Objective 2 risk R1-R5**
1049	V4	23/10/2017	HIGH	HIGH	MODERATE	**ON TARGET**	Financial Sustainability	This has been rated as HIGH and not as extreme because: • as at the end of November 2018 we were £750k ahead of plan. • We have delivered £2.2million of CIP against plan of £2.8 million • Reduced non pay expenditure (drugs and clinical supplies) from October levels reflecting lower pass through drugs and renal consumables. **It should be noted that our Regulators have been informed in January 19 that we are not going to meet our target. This risk will be reviewed and is likely to be reported as EXTREME in the next report.** **BAF Objective 5 risk R1-R5**

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
1015	V4	26/10/2017	EXTREME	HIGH	HIGH	Three actions are completed, with the action relating to VitalPAC is ongoing but reviewed daily.	Failure to manage the deteriorating patient effectively including the recognition, diagnosis and early management of Sepsis	Further work is underway reviewing deteriorating patients. **BAF Objective 1 risk R2 refers**
1047	V5	19/10/2017	HIGH	HIGH	MODERATE	**ON TARGET**	Workforce Planning & Capacity for Nursing/Midwifery Staff	• Recruitment events are planned throughout the course of the following year. Attendance at University open days has yielded a good response with many newly qualified staff currently offered positions within the Trust. • Alternative skill mixes and models of working are being progressed to ensure that the Trust is able to sustain and provide services in the longer term, and is being progressed through the Dorset Nursing Strategy project. • Creation of apprenticeship programmes has now been established for both RNs and Nursing Associates. • An overseas recruitment programme with Yeovil hospital is underway, with 9 nurses joining during 2018. • Agreement has been given move forward with a strategic

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
								workforce planning project during 2019. This will look at skills shortages and alternative roles, forecasts and projections for nursing and medical roles. **BAF Objective 1 risk R5 refers**
1050	V4	26/10/2017	HIGH	HIGH	MODERATE	**ONGOING**	Mortality Indicator	Members of the Hospital Mortality Group, led by the Medical Director - will continue to review the care of patients who die in hospital, or who die within 30 days discharge. The following actions have also been recommended: • Capacity planning for SJR – linked to the consultant job planning review (in progress) • Capacity planning for coding quality. Business case to be made. • Identify & implement an information database to support Divisions in the recording of deaths, SJR and outcomes • Medical Director has reviewed 50 consecutive deaths from August. **BAF Objective 1 risk R2 refers**
1055	V1	06/03/2017	HIGH	HIGH	HIGH	Two actions are passed the deadline	ENT Medical staffing	• Ongoing discussions with Yeovil to improve service

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
						dates in regards to recruitment and locum support.		delivered to the Trust and manage the surgical specialism required at DCH on a permanent basis • Risk reviewed and updated to reflect progress with recruitment. Risk score likelihood reduced from Almost Certain frequency to Like likelihood rating. Post mitigation Target Score reviewed and reduced from High risk rating to low **BAF Objective 1 risk R5 refers**
1056	V1	08/03/2017	HIGH	HIGH	LOW	**ON TARGET**	Fire Alarm reliability and capacity	The additional information has been received by the Estates Department. The Head of Estates and Facilities will be presenting the findings and recommendations to the next Capital Planning Group meeting. It should be noted that there are concerns around the gap between the funding available and the estimated project costs to ensure that an acceptable long term solution is installed. **BAF Objective 5 risk R4 refers**
1062	V1	17/10/2017	HIGH	HIGH	MODERATE	**ON TARGET**	Fire door maintenance	This will remain an ongoing issue that we can manage using our standard in-house resource once the outstanding door repairs have been brought to a

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
								manageable level. **BAF Objective 5 risk R4 refers**
1065	V1	12/09/2018	n/a	MODERATE	LOW	**Action timeframe to be defined**	Implementation of General Data Protection Regulations (GDPR) 2016	The GDPR took effect in the UK from the 25/05/2018 and changed the way in which personal, identifiable data is managed . Information Governance, Data Protection Plans and protocols are being updated to reflect the changes. A tool kit action plan is being devised along with the establishment of a data security and protection working group **BAF Objective 4 risk R4 refers**
1069		12/09/2018	n/a	EXTREME	LOW	**Detailed action plan on risk**	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 IG concerns. **BAF Objective 1 risk R4 refers**
1066		10/09/2018	HIGH	HIGH	HIGH	**Community Paediatric Long Waits for Autistic Spectrum Disorder (ASD) Patients**	There is a vacancy within the community paediatric team, which is causing long waits for patients and an increased workload for the clinicians in post	A draft paper has been drawn up by the CCG with input from DCH and PGH to discuss Pan Dorset options to recover the pathway and improve patient care. **BAF Objective 3 risk R3 refers**

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
1069		23/08/2018	EXTREME	EXTREME	LOW	**FACILITIES - COTAG (Security Door Access System) Reliability**	The Security Door Access System has become unreliable and difficult to manage. The system is no longer supported by its original manufacturer and parts are becoming less available. The system is in need of urgent upgrade or renewal.	The short term plan to maintain operation involves Vanderbilt Global (hardware and software specialists) identifying and providing a “fix” to the most immediate problem which is identifying the root cause of the data base transaction log increasing in size daily to the extent that it requires ICT to shrink the transaction log 3 times a week. Instruction has been received as follows: To dump the current transaction log. Backup the database, detach it, browse to the database location, delete the LDF file. Then re-attached just the MDF file and let SQL create a new LDF file. This has proved to be unsuccessful and further discussion is now taking place between ICT and Vanderbuilt. None of the above removes or mitigates the need for full upgrade or replacement, it merely acts as a short term temporary measure to keep the current system functioning.
CS2-	NEW	05/10/2018	HIGH	HIGH	LOW	**BREXIT - UK**	Risk to Trust services due to	DHSC has identified seven

Risk ref	Version	Dated added to register	Previous risk rating	Current risk rating	Post Mitigation	ACTION /COMPLETION DATE	Description of risk	Commentary/ Update
1-020						**Leaving the EU on 29th March 2019 without a deal**	the implication of a 'no deal' exit from the European Union.	priority areas for focus which include: • Supply of medicines and vaccines • Supply of medical devices and clinical consumables • Supply of non-clinical consumables, goods and services • Workforce • Reciprocal healthcare • Research and clinical trials • Data sharing, processing and access These priority areas are reflected for Dorset County Hospital, where relevant. **It should be noted that in addition to the overarching corporate risk, individual services also have risks relating to Brexit on their local registers, e.g. pharmacy, procurement.**

Title of Meeting	**Board of Directors**
Date of Meeting	**30 January 2019**
Report Title	**Board Assurance Framework**
Author	Paul Goddard, Director of Finance and Resources
Responsible Executive	Paul Goddard, Director of Finance and Resources

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

Summary

The Board needs to understand the Trust's strategic objectives and the principle risks that may threaten the achievement of these objectives. The Board Assurance Framework (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has assurance about the effectiveness of these controls.

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

The attached Board Assurance Framework has been updated and refreshed (in red italics) with the material changes highlighted below:

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

   New gap in control highlighted (issue 6) reflecting the workforce planning capacity within the trust which is being considered within business planning for 2019/20.

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

   Updated the gaps in control (issue 2) to reflect that the ED Capital bid was unsuccessful.

3. **Collaborative: Working with our patients and partners.**

   New gap in control identified (issue 1) to reflect the need to improve public engagement in proposed changes to service delivery.

4. **Enabling: Empowering Staff.**

   Changed the reporting mechanism risk rating (ref C4) from green to amber on the Dorset Care record project given recent delays in achieving milestones by other partners in the system.

5. Sustainable: Productive, effective and efficient. • Overall strength of assurance raised to Red rating given recent disclosure to the regulator that the 2018/19 control total will not be delivered and the impact this will have on the Trusts financial strategy. • This is driven by escalating risk likelihood scores to R1 Financial sustainability given the 2018/19 year end forecast and R5 failure to deliver sufficient funding due to the inability to secure Q4 PSF and additional system support in 2018/19. • Changed the reporting mechanism assurance RAG rating to red sustainability (C1) given the likelihood that the CIP programme will not deliver in 2018/19.
Paper Previously Reviewed By Executive Management Team Risk and Audit Committee January 2019
Strategic Impact The Board Assurance Framework outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.
Risk Evaluation Each risk item is individually evaluated using the current Trust Risk Matrix.
Impact on Care Quality Commission Registration and/or Clinical Quality It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Governance Implications (legal, clinical, equality and diversity or other): The Board Assurance Framework highlights that risks have been identified and captured. The Document provides an outline of the work being undertaken to manage and mitigate each risk. Where there are governance implications to risks on the Board Assurance Framework these will be considered as part of the mitigating actions.
Financial Implications The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.

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

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

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: January 2019

Summary Narrative

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

Given the recent anouncement to the Trusts regulator that the 18/19 control total will not be delivered and the initial consequences of the financial outlook for 19/20, the strength of assurance for this objective has been raised to Red.

There is a high risk in the strength of controls on ensuring we have INTEGRATED services that ensure the redesign of the discharge pathway for complex patients and demand for secondary care services does not out strip supply. Stranded patient numbers are increasing and the pace of integrated demand management with primary and community services is not progressing with the required pace.

The staff survey results have not put us in the top 20% for the staff engagement score which is a risk to our ENABLING objective.
There is also a high risk in ensuring we have OUTSTANDING services as we may not have the appropriate workforce in place to deliver our patient needs. We have seen an increasing risk due to the increased dependancy on the use of temporary clinical staff and the difficulties in keeping within the regulator ceiling for agency staff.

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.	9-16	G	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.	2-12	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.	4-12	A	A
4. Enabling: Empowering Staff. We will engage with our staff to ensure our workforce is empowered and fit for the future.	4-12	G	G
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.	12-20	R	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		G
		Strength of assurance		G

The most significant risks which could prevent us from achieving this strategic objective are...

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score
R1	Not achieving an outstanding rating from the Care Quality Commission by 2020	NL	3	3	**9**
R2	Failing to be in the top quartle of key quality and clinical outcome indices for safety and quality	NL	3	4	**12**
R3	Not achieving national and constitutional performance and access standards	IR	3	4	12
R4	Not having effective Emergency Preparedness, Resilience and business continuity plans	IR	3	3	9
R5	Not having the appropriate worforce in place to deliver our patient needs	MW	4	4	16
R6	High dependency on the use of temporary clinical staff	MW	3	5	15

We will CONTROL these risks by...		Strength	The REPORTING MECHANISM...	Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits) (R1)	G	Quality Committee reports on CQC, CQC Provider Information Collection & Insight data, CQC quarterly meetings. Dorset Quality Surveillance meeting in	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 and KPIs via The Quality Committee, alongside safety visits (NEDs) and back to floor time for Executive Directors to triagulate data with direct observations of care quality and safety. National NHSI /CCG and CQC reporting .	G
C3	Quality improvement plans within Divisions and key workstreams to support delivery of key KPIs supporting quality improvement (R3)	G	Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Qualtiy Committee	G
C4	Performance Framework - triggers for intervention/support (R3)	G	Performance monitoring via Divisional Performance Meetings (through to Sub-Board and Board; Internal Audit to audit the 2016/17 Performance Framework and report to Audit Committee (then to Board); Quality Account (KPMG) External Auditors will review key performance indicator reporting	G
C5	Emergency Preparedeness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE (R4)	G	Reporting from EPRR Committee to Audit Committee and via assigned NED to Board	G
C6	Establishment of a Resourcing Strategy Group. Monthly review of vacancies at Finance and Performance Committee (FPC) 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 Strategy Board.	G
C7	Refresh of current People Strategy (See objective 4). (R5)	G	Board sign off of 2018-2021 people Strategy in March 2018.	G
C6	Weekly review of medical workforce recruitment activity B7(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	A
Overall Strength		G		G

We have actually received these POSITIVE ASSURANCES...		
Add actual assurances recevied that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.		
CONTROL	**ASSURANCE**	**EVIDENCE**
C1	Internal Audit of CQC action plan and assurances. November 2018 CQC rating as 'Good'.	KPMG audit report and published CQC report
C2	Internal Audit of Medicines management	KPMG audit report
C3	CCG assurance visits and contract monitoring	CCG assurance reports
C4	Internal performance reports	Board and QC reports
C5	External auditors - Quality Account (transparency and accuracy of reporting)	Board and QC reports
C6	Internal Audit of systems and processes; and CCG assurance of the EPRR standards	Audit Committee and Board
C7	External review of Divisional Governance Structures and the PWC Well Led Review	Quality Committee and Board
C8	Monthly workforce reports detailing vacancies and trajectories.	Strategic Resourcing Group, Workforce Committee and Board Reports

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**
	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**
	Performance issues may not be escalated in a timely manner due to gaps in business intelligence or audit data	Divisional quality improvement plans and triagulation through regular PIC reporting and monitoring, alonside informal triagulation of visits by Board Members into services. Alongside open transparency with other regulators (CCG and NHSI). Information Strategy being implemented
ISSUE 3		**ACTION**
	EPRR assurance - strength of the testing of the business continuity plans	Focus for 2018/19 on strengthening business continuity testing. Internal Audit focus on internal business continuity planning and testing.
ISSUE 4		**ACTION**
	Sensitivity of Performance Framework for early warning on performance concerns	Internal audit should be asked to review framework and advise on measures to improve.
ISSUE 5		**ACTION**
	Late visibility in junior doctor gaps from Deanery rotations	Regular communications with the Deanery, and profiling of historic gaps. "At risk" recruitment in anticipation of gaps.

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

Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score
R1	Emergency Department admissions continuing to increase per 100,000 population	IR	3	4	**12**
R2	Occupied hospital beds days continue to increase per 100,000 population	IR	3	4	**12**
R3	Having delayed discharges	IR	3	4	**12**
R4	Not achieving an integrated community health care hub based on the DCH site	IR	3	2	**6**
R5	Not achieving a minimum of 35% of our outpatient activity being delivered away from the DCH site	IR	2	1	**2**

We will CONTROL these risks by...		Strength	The REPORTING MECHANISM...
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?
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**
C1	System agreed actions through Urgent Emergency Care/Accountable Care Community (ACC) (West) Project 4 Urgent and Emergency Care; Integrated Primary and Community Care Services ; and internal Patient Flow Programme (R1)	A	Division performance Quarterly Meetings and Transformation (SMT) exception reporting - through to Board via strategy updates
C2	Performance Framework reporting - triggers for intervention/support (R2)	G	Ward to Board reporting
C3	Redesign of the discharge pathway for complex patients to ensure that assessment of ongoing health & social care needs occurs outside hospital (R3)	A	Patient flow project board & SMT. Whole system reporting via WEST ACC
C4	Integrated Hub Meetings (R4)	G	Transformation (SMT) Reporting and Strategic updates to Board
C5	Outpatient Improvements (within Elective Care Recovery and Sustainability Programme) and Project 3 of the IPCS outcomes for elective care (R5)	A	Steering Group reports to SMT and through to Board via Strategy updates
Overall Strength		A	

We have actually received these POSITIVE ASSURANCES...

Add actual

CONTROL	ASSURANCE	EVIDENCE
C1	Continuous achievement of Emergency Department standard for over one year	Performance reporting
C2	Primary Care engagement with Locality Projects - Cardiology, Dermatology, Ophthalmology, Diabetes and Paediatrics.	SMT (Transformation) reporting and updates to Board
C3	Full community and primary care engagement in the Mid-Dorset Hub Steering Group.	SMT (Transformation) reporting and updates to Board
C4	Good relationships with Dorset County Council and Dorset Health Care at both a strategic and operational level	Joint working through West Accountable Care Community and Urgent Emergency Care.

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
Delayed Discharges - above national requirements	Discussion with DCC regarding management of court of protection cases Urgent Emergency Care and ACC (West) project for monitoring system measures for Delayed Transfers of Care and agreeing required system actions to reduce. Winter money now allocated.
ISSUE 2	**ACTION**
Emergency Department capacity	*STP bid made for capital funds was unsuccessful.* Increase Access to GP Services provision in addition to Out of Hours Services with the South West Ambulance Trust.
ISSUE 3	**ACTION**
CCG acceptance of new models of Outpatient Service delivery which meets the expectations of the Clinical Services Review outcomes	Ensure Contract discussions and formal meetings formally record shifts in delivery of Outpatient care.

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

REF	STRATEGIC OBJECTIVE	Risk		Rating
3	**Collaborative: 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		A

Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score
R1	Not achieving a 96%+ score on our friends and family test	NL	3	4	**12**
R2	Failing to deliver services which have been co-designed with patients and partners	NL	3	3	**9**
R3	Not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities	PM	2	2	**4**
R4	Failing to be an integral part of full system multi-disciplinary teams	IR	3	2	**6**

We will CONTROL these risks by...		Strength	The REPORTING MECHANISM...		Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?		green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**		**RAG**
C1	Patient and Public engagement as part of transformation framework, with Trust Transformation lead and team trained in service improvement; plus Patient Experience lead in place; Communications team link with CCG for public consultations and engagement events where relevant (R1)	A	Senior Management Team (SMT), Executive Management Team (EMT), Patient Experience Group (PEG) - via CCG , Health Oversight and Scrutiny Committee, Healthwatch, special interest groups		A
C2	CEO Leadership role in ACC (West) and broader membership of ACC (West) meetings including leading on two of the 6 key projects (R2)	A	SMT (Transformation) meeting minutes and updates on ACC to Board via Strategy Update		A
C3	Locality Projects (Elective Care Recovery and Sustainability Programme) (R3)	G	SMT (Transformation) meeting minutes and updates on ACC to Board via Strategy Update		G
C4	Transformation Team (DCH) integral part of Locality Transformation Meetings (R4)	G	SMT (Transformation) Meeting updates		G
Overall Strength		A			A

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.		
CONTR	**ASSURANCE**	**EVIDENCE**
C1	Learning Disabilities engagement system wide (R2)	Safeguarding Adults work plan
C2	CSR collaboration of engagement with CCG (R3)	CSR outcome publication
C3	Leadership of Project 3 (Elective Care) and Project 4 (Urgent and Emergency Care) for Accountable Care Community (West) (R3)	ACC Minutes, exception reports
C4	Primary Care collaboration in locality projects and DHC/Primary Care collaboration in frailty pathway. (R4)	Mid-Dorset Hub/ACC Minutes

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**
Public engagement in all elements of developments is not embedded and requires strengthening strategies to deliver this	Communciaiton Team, Head of PALS/Complaints and Transformation team to build and embed processes to deliver patient and public engagement
ISSUE 2	**ACTION**
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		G

Principle RISKS					
REF	**RISK**	**Exec Lead**	**Consequence Score**	**Likelihood Score**	**Risk Score**
R1	Not achieving a staff engagement score in the top 20% nationally	MW	2	5	**10**
R2	Not benefitting from the successful delivery of our People Strategy	MW	4	2	**8**
R3	Failure to deliver flexible and appropriate support service models	NJ	3	4	**12**
R4	Not achieving a Dorset wide integrated electronic shared care record	PG	2	3	6
R5	Not being an exemplar site for clinical research and innovation	AH	2	2	6
R6	Loss of training status for junior doctors	MW	4	1	4

We will CONTROL these risks by...		**Strength**	**The REPORTING MECHANISM...**	**Strength**
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Appointment of HR Engagement and Wellbeing Manager to provided a dedicated resource to Staff engagement, Health and Wellbeing and Equality and Diversity issues. Divisional champions to be identifed to ensure local action plans developed and discussed. (R1)	A	Quarterly Family & Friends test results reported to the Finance and Performance Committee. Staff Survey action plan presented to Board. Review of Equality & Diversity associated issues at Equality & Diversity Steering Board.	A
C2	People Strategy approved at March 2018 Trust Board. (R2)	G	Workforce Board sub-committee formed October 2018 to consider and report progress against people Strategy.	G
C3	Better Value Better Care Group provides model hospital overview. Proposal to establish SLAs and performance measures for support services.	A	Proposal to establish SLAs and performance measures for support services	A
C4	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. (R4)	G	Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	A
C5	Strong clincal research and innovation programme	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 Strategy Group, and FPC as necessary. (R6)	G	Medical Education update provided at Resourcing Strategy Group. GMC junior doctor survey presented to board annually.	G
Overall Strength		G		G

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.	Confirmation of appointment
C2	Assurance provided through Board agreement of the refreshed People Strategy. Progress updates to be provided regularly to the Workforce Committee.	Trust Board approved People Strategy in March 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.	Benchmarking information
C4	No independent assurance received on the controls in place (R4)	N/a

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

ISSUE 1		**ACTION**
C1	Poor responses to the quarterly Staff Family and Friends test do not provide assurance of staff engagement.	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.	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.	n/a
ISSUE 4		**ACTION**
C4	No independent assurance on controls in place for the Dorset Care Record	Progress reported through the Dorset Informatics Group. DCH input is progressing well but other partners are behind their milestones.

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		R
		Strength of assurance		*R*

Principle RISKS					
REF	**RISK**	**Exec Lead**	**Consequence Score**	**Likelihood Score**	**Risk Score**
R1	Not returning to financial sustainability, with an operating surplus of 1% and self sufficient in terms of cash	PG	4	*5*	**20**
R2	Failing to be efficient as outlined in the Model Hospital	PG	4	4	**16**
R3	Not generating 25% more commercial income with an average gross profit of 20%	NJ	3	4	**12**
R4	Not using our estate efficiently and flexibly to deliver safe services	PG	4	3	**12**
R5	Failure to secure sufficient funding to ensure financial sustainability	PG	4	*4*	**16**

We will CONTROL these risks by...		The REPORTING MECHANISM...		Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	The 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
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.	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	G
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	G	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 to identify backlog maintenance needs and included in the capital plan. (R4)	A	Capital Planning Group review the 6 facet survey and capital investment required. This is report 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)	R	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	R
Overall Strength		R		R

We have actually received these POSITIVE ASSURANCES... *Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.*		
CONTROL	**ASSURANCE**	**EVIDENCE**
C1	Internal audit report 17/18 gave significant assurance with minor improvements. (R1) and (R2).	KPMG audit report
C2	Model hospital information provides the information on our level of efficiency. (R2)	Model Hospital
C3	Estates Benchmarking (ERIC) return confirms efficient use of estate with opportunities in waste management (R2)	Estates Benchmarking (Eric) Return

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**
(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**
(R4) No independent assurance on compliance with statutory estates legislation	(R4) This is an item for consideration for the 2019/20 Internal Audit plan
ISSUE 3	**ACTION**
(R1) There is a risk we do not have the resource to make all of the transformation change happen timely.	A review 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 Inadequateperformance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Hospital Mortality Report

November 2018

Produced by the Performance and Information Team

Executive Summary

The Trust continues to monitor closely all the mortality indicators in line with the recommendations from NHS England. This report provides an in depth analysis of the main mortality indicators for the last 12 months in conjunction with other related data quality indicators. The main findings of the report are:

- Crude mortality continues to be lower than our peers. Since the end of March 2018 the trend had been improving as per the normal seasonality. However from June 2018 the rate has slightly increased which is contrary to our peers.
- HSMR performance has deteriorated from 104.68 (Sept-16 to Aug-17) to 120.06 (Sep-17 to Aug-18) over the previous twelve month period whereas our peers have seen an improvement over the same time frames 99.96 (Sept-16 to Aug-17) to 99.05 (Sep-17 to Aug-18). This needs further investigation.
- SHMI performance has deteriorated from 1.14 (Jan-17 to Dec-17) to 1.17 (Apr17 to Mar18), meaning DCH remain in the 'higher than expected band'. The current prediction for the next reporting period is that our SHMI will have continued to increase.
- 11.3% decrease in the proportion of spells with a sign or symptom as primary diagnosis since the previous reporting period.
- 2 specialties have generated a red alert for crude mortality which require further investigation.
- 4 diagnosis groups generated red alerts for latest HSMRI score which require further investigation.

1. Mortality Indicators

There are four mortality indicators used to assess hospital mortality in England. It is important to understand that each of these indices; SHMI (Summary Hospital Mortality Index), HSMR (Hospital Standardised Mortality Rate) and RAMI (Risk Adjusted Mortality Index) are based on statistical models and employ different algorithms which impact on the overall index, see Table 1.

Indicator	Numerator	Denominator	Attribution rules and the basis of scoring
Crude Mortality	All deaths	All hospital stays	There is no risk model for crude mortality and is not affected by any clinical coding
SHMI in Hospital (Source: CHKS)	All in hospital deaths + out of hospital deaths within 30 days of discharge	SHMI included spells (elective day cases are excluded)	First diagnosis if only one episode. If two or more episodes and the first diagnosis is a sign and symptom code, diagnosis in the second episode will be used. If not identified will use the first diagnosis
SHMI (Source: NHS Digital)	All in hospital deaths + out of hospital deaths within 30 days of discharge	SHMI included spells (elective day cases are excluded)	
DFI HSMR (Methodology: Dr Foster) (Source: CHKS)	Deaths in the specific range of diagnosis – 56 diagnostic groups (80% of deaths)	Spells covered by the diagnostic groups	Diagnosis based on the primary diagnosis in the first episode of care. However, if the primary diagnosis is a vague symptom or sign the second episode is used to derive a diagnosis
RAMI (Methodology & Source: CHKS)	Deaths excluding palliative care	Spells excluding maternity, stillbirths, mental illness, day cases, emergency 0 LoS	

Table 1: Variation in the information captured by the Crude and Risk Adjusted Mortality Models

Table 2 shows the main indicator score card (based on the latest SHMI time period which only goes up to March 18 in CHKS), which shows that DCH has a better crude mortality rate than the peer group (South England trusts, see Appendix A for provider listing) but has performed worse that the peers for SHMI, RAMI and HSMR. **HSMR in particular has seen a sharp increase and needs further investigation, especially for November 2017 where the rate was 158.82.** It should be noted that the CHKS SHMI model is re-baselined every three months which means that the associated risk for the previous period, as calculated by CHKS, is higher than the one published by NHS Digital (see Section 1.2 for details).

	Measure	% Diff Since previous period	April 17 to Mar 18	April 16 to Mar 17	Peer Group
Mortality Summary	Crude Mortality (CHKS)	2.60%	0.75%	0.73%	1.50%
	SHMI *(CHKS)	4.77%	117.03	111.71	99.02
	HSMR	13.90%	117.25	102.94	101.56
	RAMI	- 0.32%	104.99	105.33	87.50

Table 2: Main Mortality Indicators Scorecard for the period April 17 to March 18

*** CHKS methodology means the SHMI result has been recalculated based on the updated risk model**

Figure 1 shows monthly values for the 3 risk adjusted mortality indicators (RAMI, SHMI and HSMR) as well as the crude mortality rate (no risk adjustment). RAMI and HSMR are more closely linked to the crude mortality rate following the variation, while SHMI is impacted by the modelled risk.

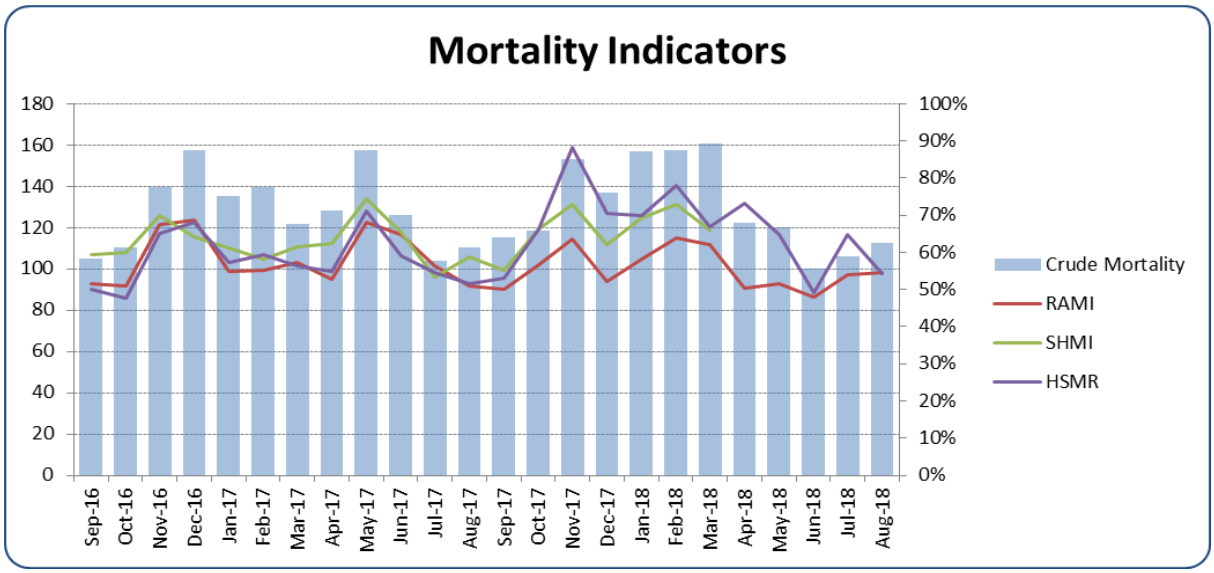


Figure 1: Crude mortality rate (%) with risk modelled mortality scores (RAMI, HSMR & SHMI) data from CHKS

1.1. Crude Mortality

Description	Number of Deaths	Total Spells*	Current Period (Sep17–Aug18)	Comparison Period (Sep16 – Aug17)	% Diff Since previous period	Peer Value	Alert
Mortality Rate	759	105,275	0.72%	0.71%	1.45%	1.47%	-
Elective	17	80,306	0.02%	0.01%	36.62%	0.06%	-
Non-Elective	742	24,969	2.97%	2.76%	7.64%	3.05%	-

Table 3: Crude Mortality for latest 12 month rolling period

**Includes regular day attenders (eg dialysis patients)*

Figure 2 shows the crude mortality rate with upper (UCL) and lower control limits (LCL) for DCH compared to our peer group. DCH trend, although lower follows much the same seasonality as the peers, the one main exception being a rise from Jun-18 comparted to peers continued to reduction.

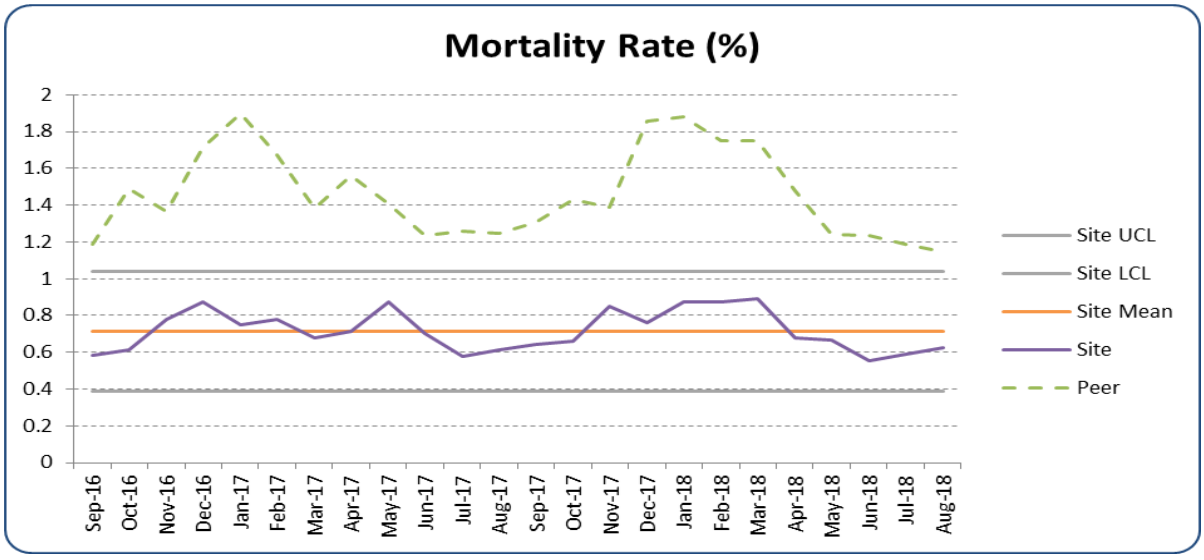


Figure 2: Trust Crude Mortality (SPC) with Peer Group

The non-elective mortality rate shown in figure 3 appears to follow much the same pattern as our peers and is well within the control limits.

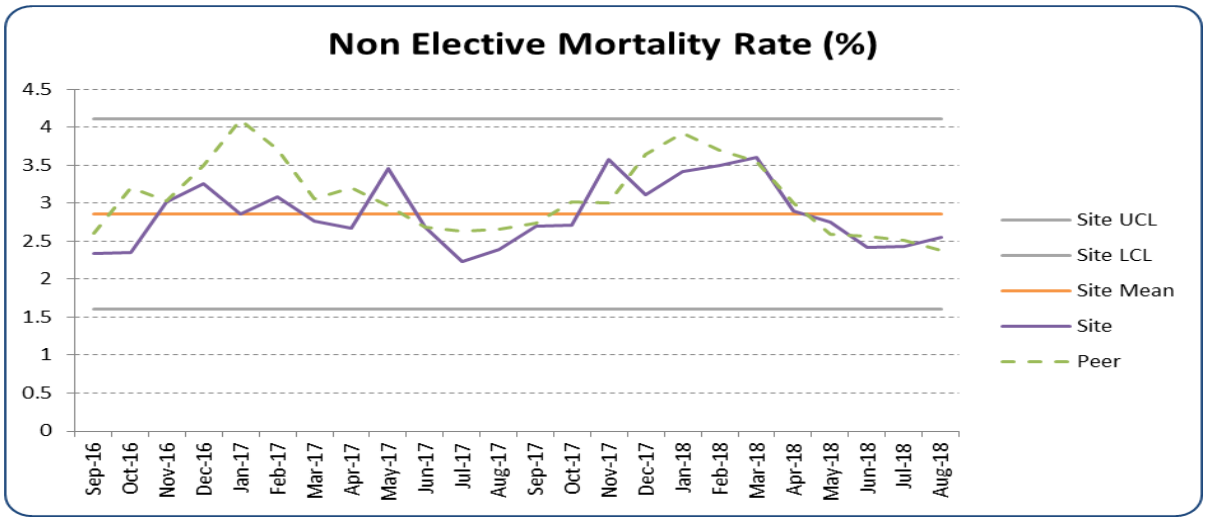


Figure 3: Trust Crude Mortality (SPC) with Peer Group for Non-Elective Spells

Elective mortality rates, displayed in Figure 4, continue to be lower than our peer performance except for Jan-18 and Feb-18. Patient detail suggests these were acutely ill patients.

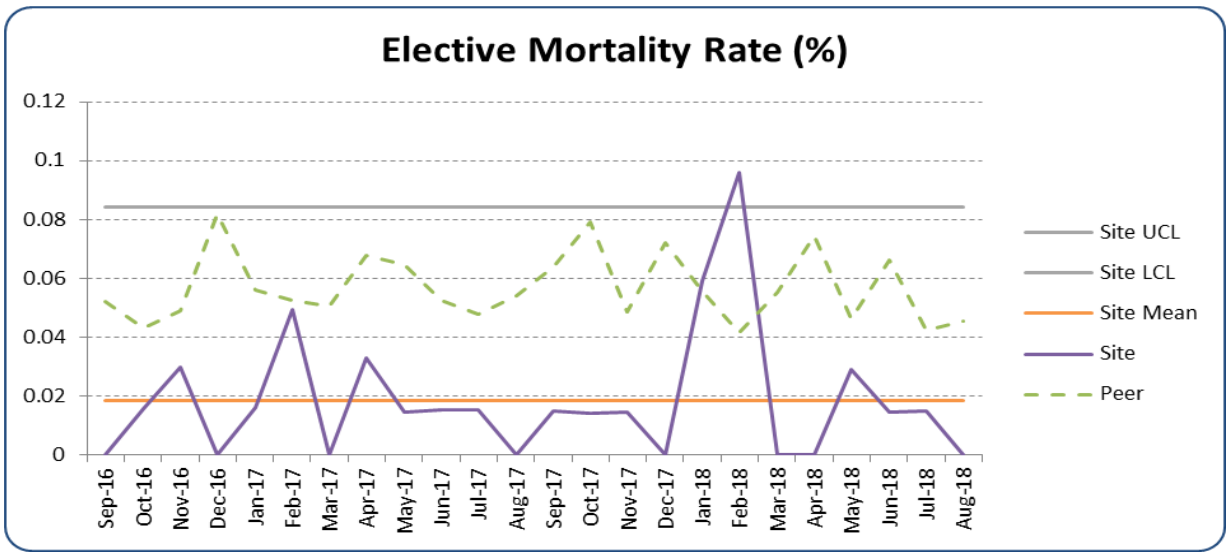


Figure 4: Trust Crude Mortality (SPC) with Peer Group for Elective Spells

1.2. Mortality Alerts

An alert is generated when there is a deviation from the average rate which is greater than 3x the standard deviation. Specialties showing crude mortality alerts are shown in Table 4 whilst Table 5 lists some of the conditions flagging HSMR alerts where the numbers are significant enough to warrant further investigation.

Description	*Current Period (Sep17–Aug18)*	*Comparison Period (Sep16 – Aug17)*	*% Diff*	*Number of Deaths*	*Total Spells*	*Peer Value*	*Alert*
430 - Geriatric Medicine	*16.80%*	*17.33%*	*-3.09%*	*107*	*637*	*9.35%*	*Red*
300 - General Medicine	*6.36%*	*4.95%*	*28.64%*	*462*	*7263*	*4.50%*	*Red*

***Table 4: Specialty Crude Mortality* Rate Alerts**

Description Current Period (Sep17–Aug18)	Number of Deaths	Expected Deaths	Value	Alert
Pleurisy; pneumothorax; pulmonary collapse	11	5.5	198.30	Red
Intracranial injury	14	8.4	166.99	Red
Urinary tract infections	23	14.2	161.58	Red
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	133	99	133.77	Red
Gastrointestinal haemorrhage	18	11.1	162.33	Amber
Acute Bronchitis	10	6.4	155.17	Amber
Congestive heart failure; non-hypertensive	41	27	151.81	Amber
Chronic obstructive pulmonary disease and bronchiectasis	30	20.3	148.01	Amber

Table 5: Top HSMR - Mortality Alerts by condition

1.3. SHMI (as published by NHS Digital)

For any given number of deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the Trust is considered to have a higher or lower SHMI than expected. The extremes of this range are called **control limits** and they are shown in the funnel plot (Figure 5) by the two dotted lines. Trusts whose SHMI falls above the upper control limit are categorised as '**higher than expected'**. Trusts whose SHMI falls between the upper and lower control limit are categorised as '**as expected'**. Trusts whose SHMI falls below the lower control limit are categorised as '**lower than expected'**. There were 13 Trusts with higher than expected deaths - DCH was one of these Trusts.

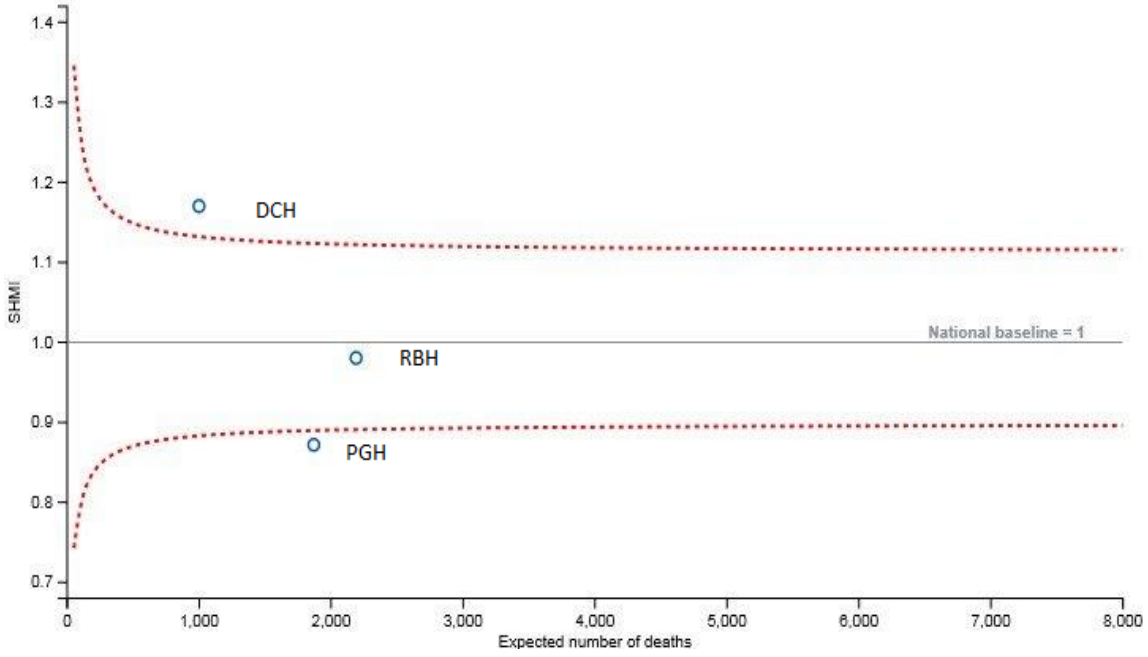


Figure 5: SHMI as published by NHS Digital

Over the last year, the Trust has made a significant effort to improve the data quality issues related to how SHMI is calculated. As a result we had seen some improvements to the overall SHMI score. However, we have again started to see an increase.

The most recent published data for this indicator is April 2017 to March 2018 (published on 20th September). The Trust was banded in the 'Higher Than Expected' group with a SHMI value of 1.17 (upper limit = 1.1321, a difference of 0.0379).

Figure 6 shows Trust performance during the last ten reporting periods as published by NHS Digital.

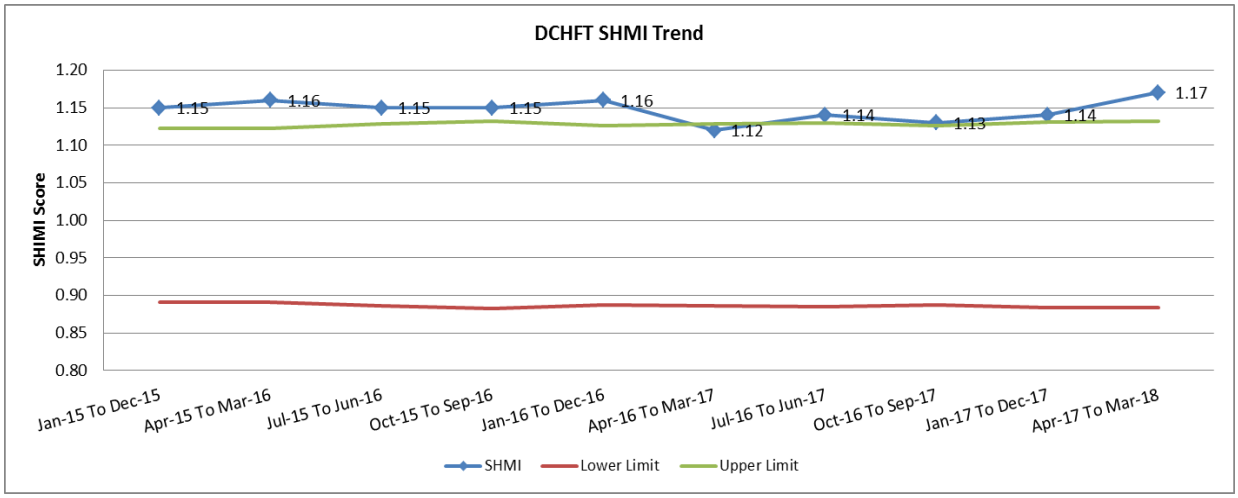


Figure 6: SHMI as published by NHS Digital

The difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths for the trust. Whether or not a death could have been prevented can only be determined by a detailed case-note review. The SHMI is not a direct measure of quality of care. The expected number of deaths for each trust is not an actual count of patients, but is a statistical construct which estimates the number of deaths that may be expected at the trust on the basis of average England figures and characteristics of the patients treated there.

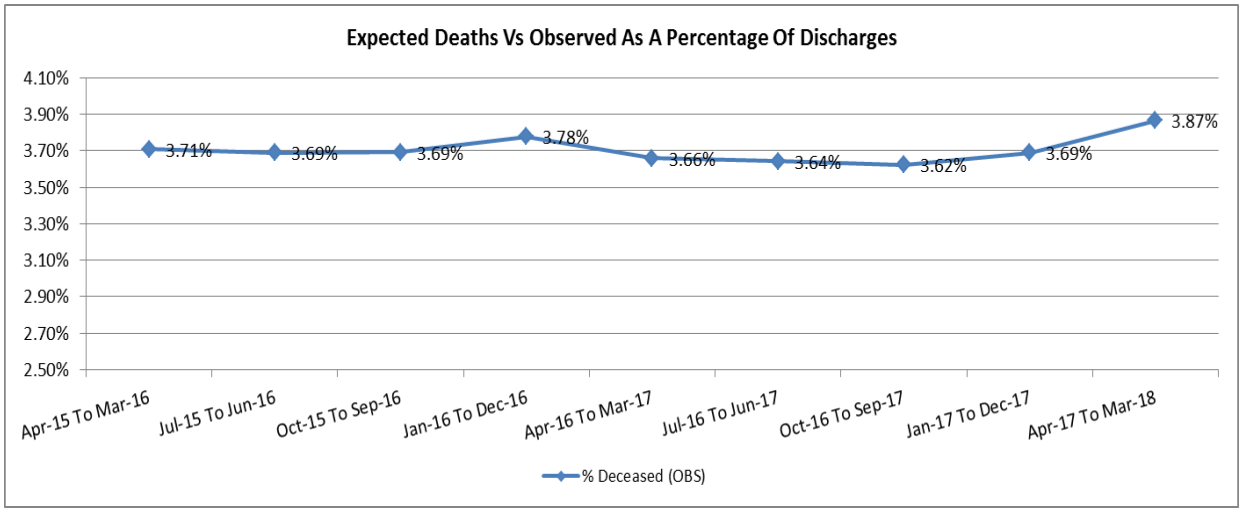


Figure 7: SHMI as published by NHS Digital

The advance notice of our performance for July 17 to June 18 (which will be released on 22nd November 18) has been received and bands the Trust in the '**Higher than expected**' group with a further increase in the SHMI value. The performance and information department will be producing a report analysing the data once it has been uploaded to the national website.

2. Diagnosis Coding

Clinical coding for financial as well as mortality reporting is based on the concepts of spells and episodes of care. A spell is the period from admission to discharge within a single provider for a single patient. Whilst admitted, a patient may see more than one consultant during a spell of care. These are called finished consultant episodes (FCEs). The majority of patient spells have only one FCE but when complex treatment pathways are followed, some patients will have two, three or more.

2.1. Signs & symptoms Signs & symptoms

The SHMI model uses the primary diagnoses in episode one or two of the spell to determine its definitive diagnosis. If the clinicians cannot reach a definitive diagnosis, then the coders will code the episode with a Sign and Symptom code (R Code). If the primary diagnosis in episode one is a Sign and Symptom (R Code) it will review the diagnosis in episode two. If the primary diagnosis in episode two is not a Sign and Symptom it will use this primary diagnosis. If it is a Sign and Symptom it will revert to the code used in episode one e.g.

- Episode 1 – Chest Pain (R-code), Episode 2 - Anterior Myocardial Infarction, the diagnosis in episode two will be used
- Episode 1 – Chest Pain (R-code), Episode 2 – Chest pain (R-code), the diagnosis in episode one will be used

Measure	(Apr17 – Mar18)	(Jan17 – Dec17)	Oct16 – Sept17)
No of Spells with a primary diagnosis which is a symptom or sign	3,977	4,090	4,330
No of Spells	30,214	30,686	31,025
% of Spells with a primary diagnosis which is a symptom or sign	13.2%	13.3%	14.0%

Table 5: Diagnosis Data Quality (taken from NHS Digital)

When patients are coded with a with a Sign and Symptom code, the associated risk tends to be lower, as SHMI takes into account the sum of the risk of every patient admitted, therefore the use of R-codes has a negative impact to the overall SHMI. The following information has been taken from CHKS in order to provide more recent data and also peer group analysis. **(For all of the following tables and figures. regular day attenders have been excluded as these distort the data.)**

Description	Current Period (Sep17 – Aug18)	Comparison Period (Sep16 – Aug17)	% Diff Since previous period	Peer Value
Total	**10.69%**	**12.06%**	**-11.34%**	**11.03%**
Elective	7.08%	7.20%	-1.73%	5.40%
Non-elective	13.89%	16.05%	-13.47%	14.94%

Table 6: Signs and Symptoms as Primary Diagnosis (Source: CHKS)

Although the trust had seen an improvement during previous reporting periods, the CHKS data would indicate that this has started to deteriorate slightly over recent months.

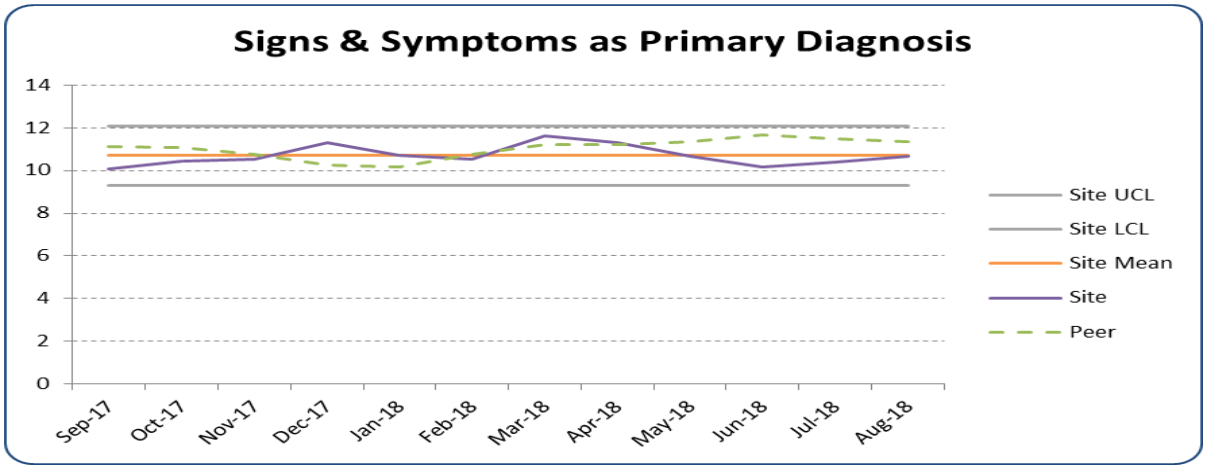


Figure 8: Signs and Symptoms as Primary Diagnosis SPC Chart (Source: CHKS)

The following gives a breakdown of the data into elective and non-elective, split by day of the week:-

Description	Current Period (Sep17 – Aug18)	Comparison Period (Sep16 – Aug17)	% Diff Since previous period	Peer Value
Elective Spells	**7.080%**	**7.205%**	**-1.7308%**	**5.399%**
1 - Monday	9.419%	9.047%	4.106%	5.360%
2 - Tuesday	7.334%	6.925%	5.903%	5.416%
3 - Wednesday	6.842%	6.239%	9.671%	5.168%
4 - Thursday	6.401%	7.743%	-17.327%	5.625%
5 - Friday	6.922%	7.477%	-7.433%	4.596%
6 - Saturday	3.450%	2.7532%	25.322%	8.152%
7 - Sunday	4.890%	3.0189%	61.98%	11.957%

Table 7: Signs and Symptoms as Primary Diagnosis for Elective Spells by day of week

Description	Current Period (Sep17 – Aug18)	Comparison Period Sep16 – Aug17)	% Diff Since previous period	Peer Value
Non-elective Spells	**13.890%**	**16.052%**	**-13.470%**	**14.943%**
1 - Monday	12.469%	14.160%	-11.942%	14.141%
2 - Tuesday	13.182%	15.538%	-15.159%	14.972%
3 - Wednesday	13.754%	15.983%	-13.945%	15.114%
4 - Thursday	14.319%	17.043%	-15.984%	15.279%
5 - Friday	14.681%	16.692%	-12.051%	15.065%
6 - Saturday	14.536%	16.937%	-14.173%	15.346%
7 - Sunday	15.408%	16.979%	-9.252%	14.952%

Table 8: Signs and Symptoms as Primary Diagnosis for Non-Elective Spells by day of week

2.2. Finished Consultant Episodes (FCE) per Spell

As discussed earlier, following the decision to admit a patient, a consultant, nurse or midwife assumes responsibility for his/her care. This is when the first episode of care starts. However, during the patient's spell in hospital a transfer of the patient to another consultant will result in one or more episodes of care. The data recorded in the system should actually reflect the actual clinical practice but we should be mindful that definitive diagnosis should be reached within the first two episodes of care. Table 9 below shows that the Trust has less FCE's per spell than its peers and that there has been a reduction in the number of FCEs per non-elective spell.

Description	Current Period (Sep17 – Aug18)	Comparison Period Sep16 – Aug17)	% Diff Since Previous Period	Peer Value
Average FCEs per Spell	1.19	1.21	-1.7%	1.26
Elective Spells	1.04	1.04	-0.3%	1.01
Non-Elective Spells	1.37	1.40	-2.2%	1.51

Table 9: Trust and Peer Average FCE per Spell, Elective and Non-Elective Activity

2.3. Diagnosis per FCE

SHMI calculates a patient's risk according to the comorbidities recorded in the clinical notes, if some are missed then the overall risk calculated is lower than expected and the overall SHMI is higher than expected. The number of diagnosis per FCE identifies the depth of coding, which is a measure that reflects how the clinical coding team translates the information recorded by the clinicians into diagnosis.

There has been a slight decrease in the average Diagnosis per FCE for the Trust with a similar trend for the Peer Group. Figure 9 shows this is within the control limits. Figure 10 demonstrates that the trend is the same for elective and non-elective patients.

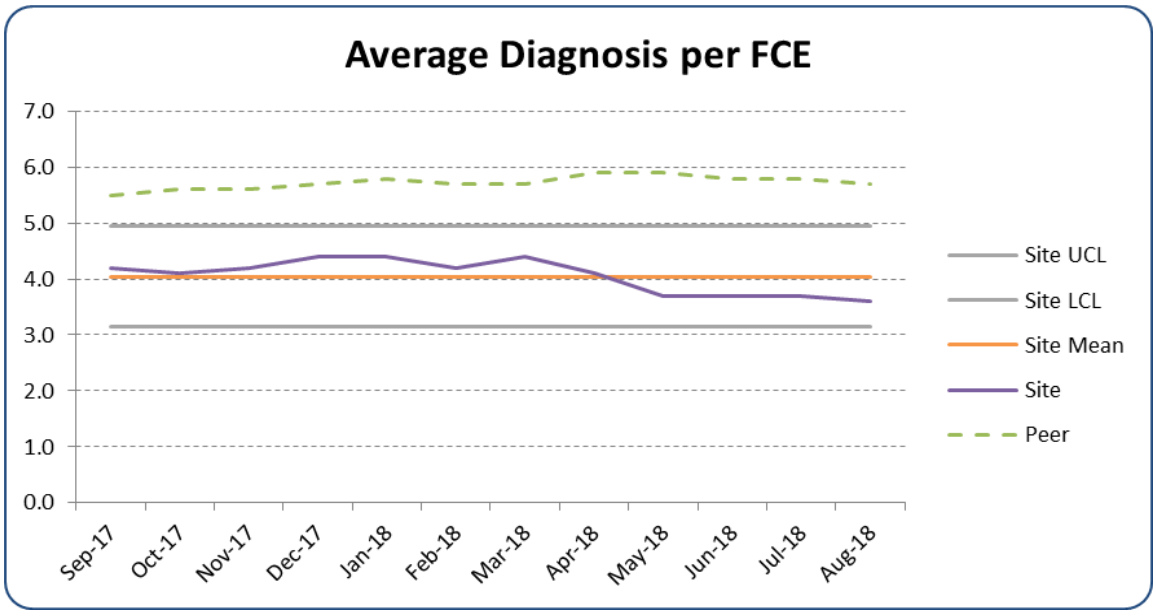


Figure 9: Average Diagnosis per FCE (Source CHKS)

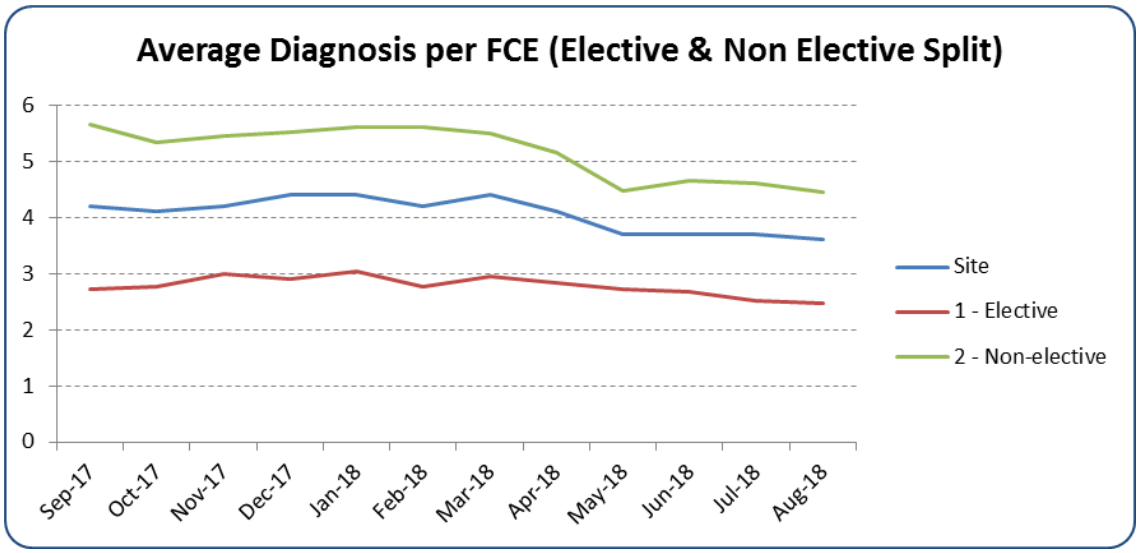


Figure 10: Average Diagnosis per FCE (Source CHKS)

2.4. Consultant Allocation: Cardiology Pilot

A pilot has been run on Cardiology Wards where a consultant of the week was the proposed model for allocation patients to consultants. This was introduced in June 2017, with handovers occurring at 8:30am on Mondays. The tables below show the non-elective cardiology activity by day of the week for the 9 months following the change compared to the same period the previous year.

The percentage of Signs & Symptoms as a Primary Diagnosis has decreased in the most recent 12 months compared to the baseline period and is now lower than the Peer Group for non –elective admissions (please see table 10). The number has halved on a Saturday but still remains very high for patients admitted on a Sunday.

Description	Current Rolling 9 Months (Dec17 – Aug18)	Baseline 9 Months (Jun16 – Feb17)	Peer Value
Non-Elective Spells	**11.28%**	**13.36%**	**11.37%**
1 – Monday	8.26%	12.82%	9.67%
2 – Tuesday	11.45%	19.48%	10.64%
3 – Wednesday	9.68%	7.43%	11.84%
4 – Thursday	14.93%	15.70%	12.64%
5 – Friday	14.50%	8.86%	11.63%
6 – Saturday	10.31%	21.43%	11.99%
7 – Sunday	23.53%	21.62%	12.046%

Table 10: Signs & Symptoms as Primary Diagnosis for Non-Elective, Cardiology activity

Table 11 shows an improvement in average diagnosis per Cardiology non-elective FCE from the baseline period but is still below the peer group.

Description	Current Rolling 9 Months (Dec17 – Aug18)	Baseline 9 Months (Jun16 – Feb17)	Peer Value
Non-Elective Spells	**7.5**	**6.2**	**9.0**
1 – Monday	8.2	6.5	**9.5**
2 – Tuesday	7	6.4	**8.9**
3 – Wednesday	7	6.4	**8.9**
4 – Thursday	6.8	5.4	**8.9**
5 – Friday	7.1	6.2	**8.6**
6 – Saturday	7.1	5.8	**8.6**
7 – Sunday	6.2	6.5	**8.6**

Table 7: Average Diagnosis per FCE for Non-Elective, Cardiology activity

Conclusions

The main conclusions from this mortality report are:

- Crude mortality continues to be lower than our peers. Since the end of March 2018 the trend had been improving as per the normal seasonality. However from June 2018 the rate has slightly increased which is contrary to our peers.
- HSMR performance has deteriorated from 104.68 (Sept-16 to Aug-17) to 120.06 (Sep-17 to Aug-18) over the previous twelve month period whereas our peers have seen an improvement over the same time frames 99.96 (Sept-16 to Aug-17) to 99.05 (Sep-17 to Aug-18). This needs further investigation.
- SHMI performance has deteriorated from 1.14 (Jan-17 to Dec-17) to 1.17 (Apr17 to Mar18), meaning DCH remain in the 'higher than expected band'. The current prediction for the next reporting period is that our SHMI will have continued to increase.
- Geriatric Medicine and General Medicine have generated a red alert for crude mortality
- 4 diagnosis groups generated red alerts for latest HSMRI score; Pleurisy; pneumothorax; pulmonary collapse, Intracranial injury and Urinary tract infections, Pneumonia (except that caused by tuberculosis or sexually transmitted disease)
- 11.3% decrease in the proportion of spells with a sign or symptom as primary diagnosis since the previous reporting period.
- There has been a slight decrease in the average Diagnosis per FCE for the Trust with a similar trend for the Peer Group. The trend is the same for elective and non-elective patients.
- Consultant allocation pilot in Cardiology has seen a reduction in the number of spells with a sign or symptom as primary diagnosis for those admitted towards the start of the week, with a greater depth of coding (increase in the number of diagnosis per spell).

Appendix A

The peer group used in this paper is the South England Acute Trusts Similar Case Mix which is shown below:

- ttRA4 - Yeovil District Hospital NHS Foundation Trust
- ttRA3 - Weston Area Health NHS Trust
- ttRDZ - The Royal Bournemouth And Christchurch Hospitals NHSFT
- ttRA9 - Torbay And South Devon NHS Foundation Trust
- ttRBZ - Northern Devon Healthcare NHS Trust
- ttRD3 - Poole Hospital NHS Foundation Trust
- ttREF - Royal Cornwall Hospitals NHS Trust
- ttRHU - Portsmouth Hospitals NHS Trust
- ttRK9 - Plymouth Hospitals NHS Trust
- ttRXC - East Sussex Healthcare NHS Trust
- ttRXH - Brighton And Sussex University Hospitals NHS Trust
- ttRYR - Western Sussex Hospitals NHS Foundation Trust

Title of Meeting	Board of Directors
Date of Meeting	30 January 2019
Report Title	Medical Revalidation Progress Report (Bi-Annual)
Author	Julie Doherty, Responsible Officer Catherine Youers, Acting Deputy Director of Workforce
Responsible Executive	Alistair Hutchison, Medical Director

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

The purpose of this report is to demonstrate to the Board that the Trust continues to meet all statutory duties in relation to medical revalidation.

Summary

Robust systems continue to remain place to ensure that our statutory duties relating to medical revalidation are being adequately discharged. Revalidation progress reports are provided to the Board on a bi-annual basis.

Paper Previously Reviewed By

N/A

Strategic Impact

All the elements of medical revalidation have been designed to facilitate quality improvement, which is required in order for the Trust to achieve its key strategic objectives.

Risk Evaluation

Analysis of the appraisal and revalidation results has assisted in identifying key areas of concern and potential risk.

Impact on Care Quality Commission Registration and/or Clinical Quality

Medical revalidation is one of the mechanisms used to provide assurance of clinical quality.

Governance Implications (legal, clinical, equality and diversity or other)

No specific implications relating to the contents of the paper.

Financial Implications

No specific implications relating to the contents of the paper.

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

TRUST BOARD PAPER

MEDICAL REVALIDATION PROGRESS REPORT

JANAURY 2019

1.0 Purpose

1.1 The purpose of this report is to demonstrate to the Board that the Trust continues to meet all statutory duties in relation to medical revalidation.

1.2 The data within this report relates to the revalidation activity during quarters 1 and 2 of 2018/19 (1 April 2018 – 30 September 2018)

2.0 Introduction

2.1 All licensed doctors are required to revalidate every five years by demonstrating fitness to practice based on the 4 main core standards of medical practice, as detailed in the General Medical Council (GMC) Good Medical Practice Guide.

2.2 Dr Julie Doherty, Deputy Medical Director, undertakes the role of Responsible Officer (RO) for the Trust. Responsible Officer meaning that he/she is responsible for making revalidation recommendations to the GMC on behalf of the Trust. The Trust also has a nominated Appraisal Lead which is held by Dr Joseph Illes, Consultant Radiologist.

2.3 The mechanism used to assess suitability for revalidation is the appraisal process. During the reporting period; the compliance rate for medical appraisals averaged at 87%, with a minimum monthly compliance rate of 80% and maximum of 90%.

2.4 99 doctors were successfully appraised during this period.

3.0 Progress

3.1 The number of clinicians who have a prescribed connection the Trust for the purposes of medical revalidation has increased from 213 to 223.

3.2 10 of the 223 doctors were due to be revalidated between 1 April and 30 September 2018; all 10 were successfully revalidated.

3.3 The divisions continue to face a challenge of having a sufficient number of trained and practising appraisers to accommodate the annual appraisals for all clinicians. Since the previous bi-annual report the total number of appraisers has reduced from 30 to 27. The divisional split is as follows:

Urgent and Integrated Care division = 11
Family and Surgical Services division = 16

3.4 The Trust continues to support new and existing clinicians in the completion of appraisal training which is provided externally. The recent job planning project is anticipated to positively impact this area due to accurate recording of PA allocation for undertaking appraisals as per the Medical Appraisal policy. The Responsible Officer, Appraisal Lead and workforce department review

the position of appraiser numbers on a monthly basis, liaising with the Divisional Managers and Directors when further action may be required.

4.0 Assurance

4.1 The Responsible Officer undertook a full review of the Medical Appraisal and Revalidation policy making a number of changes to ensure the policy and associated processes were robust and fit for purpose. The policy was ratified by the Local Negotiating Committee in Month 8.

4.1 The revalidation process is continuous. Revalidation progress reports are provided to the Board on a bi-annual basis and the next progress report us due to be submitted in July 2019; this coincides with the South West Revalidation report submissions.

4.2 The Trust completes quarterly revalidation returns to NHSE Revalidation South West.

Title of Meeting	**Trust Board**
Date of Meeting	**30 January 2019**
Report Title	**Quarterly Guardian Report on Safe Working House: Doctors in Training (September 2018 – November 2018)**
Author	**Dr Jonathan Chambers, Guardian of Safe Working**

1 Introduction

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

This is the quarterly report covering the period of 1 September 2018 – 30 November 2018.

2 Overview

- Number of training post (total): 154 training posts in total (same as report for June – Aug 2018 report)
- Number of doctors sat in training post (total): 143.2 in total (the10.8 posts equivalent of GPVTS vacancies and LTFT trainees sat in a WTE post)
- Number of doctors in training on the new 2016 contract (total): 143.2 (All DiT in post at DCH have now transitioned to the 2016 T&C).Amount of time available in job plan for guardian to undertake the role: Remunerated 1 Additional PA per week
- Admin support provided to the guardian: Support from the Workforce department but set amount not stipulated.
- Amount of job-planned time for educational supervisors: 0.125 PA per week

3 Exception reports (with regard to working hours)

During the period covered by this report 45 exception reports were submitted. On closer scrutiny these exception reports are related to additional hours worked (64%), missed educational opportunities (18%), service support available (18%) and pattern of work undertaken (4%). Of the additional hours worked the majority were returned as time in lieu. Of the 45 exception reports, 43 have been addressed and closed.

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

4 Diary Monitoring Results

There have been no monitoring exercises undertaken within this period therefore there are no changes to this data.

5 Work schedule reviews

6 work schedule reviews were conducted between trainees and their educational supervisors. These were triggered in relation to exception reports.

6 Locum bookings

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

7 Vacancies

During this quarter there was an average of 15 training grade vacancies, this is lower than the previous quarter (22). A number of these vacancies continue to arise due to a reduction in the number of trainees coming to DCH through the national training programmes. This is an ongoing and significant issue for the effective and safe delivery of this contract.
Details are found within Appendix 4.

8 Fines

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

9 Key issues arising during this quarter

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

A) Medical Staffing & Rota Gaps

Vacancy rates remain an issue at DCH. Exception reports have been triggered by doctors who have been required to work solo on a firm due to the limited flexibility within the current workforce to cover gaps, annual and study leave. In the short term these gaps cause challenges for the divisions to manage safe staffing, but the long-term effect of the vacancies will be an impact on both the training and moral of the junior doctor workforce within the hospital. Specific areas of concern during this last quarter include Orthopaedics and the Emergency Department. Temporary medical staff (as & when) are still required to maintain a safe service in orthopaedics and this will continue for the coming months due to vacancies. The requirements for consultant cover of ongoing Middle Grade vacancies in ED have led to a number of exception reports from trainees who have missed educational opportunities or been limited in their ability to take breaks. Resilience in the medical rotas in ED is vital to ensure the safety and efficiency of the essential service. I would like to pay credit to the hard work

of the consultant body in ED who have personally pro-actively covered gaps, but I am concerned that this is not sustainable in the medium to long term.

B) Surgical CST/FY2 rota

Towards the end of the last quarter a number of exception reports were submitted as a result of the workload experienced on the junior surgical rota. This was also raised as a concern at the recent Junior Doctors Forum. The pressure of admissions through ED has had an impact on the surgical team present in the hospital out of hours and has led to concerns over the capacity of the available team to manage the workload.

10 Actions taken to resolve issues this quarter

In response to the issues raised the following actions have been undertaken:

A) Medical Staffing & Rota Gaps

a. Medical Workforce Committee (MWC)

This group is now established to look at developing resilience within the medical staffing at DCH. The group are looking at effective rostering and sharing best practice between divisions. It is important that this work is now focused on supporting recruitment in ED & Orthopaedics.

b. Clinical Assistants & Physicians Associates

We need to deliver this work programme to help support the workload of our current medical workforce. Looking at new ways of working will be essential to developing resilience within the system over the coming few years. One Clinical Assistant has been appointed and we will continue to recruit a further two. One PA is in post and, with the imminent arrival of PA students at DCH, further posts will need to be established to maximise the benefit of the Trust supporting this new training programme

c. F3 Fellowships

As part of the MWC output we are looking at establishing 6/12 month fellowships for doctors who have come to the end of their foundation training. These fellowships will combine service provision with the development of a special interest and will support the needs of the organisation along with supporting the educational development of the individual doctor.

B) Surgical CST/FY2 rota

In response to the concerns raised and in consultation with Medical Director, DME and Foundation Programme Director, the following actions have been agreed:

a. Awareness that Hospital@Night needs to be relaunched. Currently it is working as a version of Critical Care Outreach Team (CCOT) and this is limiting support to Surgical Fs. This will be addressed via DME, Medical Director & CCOT

b. Information Analysis Team are looking at activity times of Surgical admissions through ED. There has always been an awareness that the end of GP Surgery times coincides with a rise in patient numbers, but there is a suspicion that earlier closing of Weymouth Urgent Care Centre (8pm rather than 10pm) is exacerbating this rise. Once the data is available the Surgical

Division will look at Surgical Shift times to consider the best timings to suit activity, whilst safeguarding learning opportunities.

11 Other Information:

I continue to reiterate the importance, and value, of Exception Reporting at DCH. I will be looking to reinforce the necessity of doctors in training at DCH raising concerns, especially over the winter period, to enable the divisional leadership to address issues with staffing, supervision, educational opportunities missed and any immediate safety concerns in a timely fashion.

12 Summary

With ongoing rota gaps I still remain unable to provide full assurance to the Board that all junior doctor working hours at DCHFT are compliant with the terms and conditions of the 2016 contract. Further recruitment is still required to develop the resilience needed to avoid our current doctors in training working outside of their agreed contracts. All exception reports raised have been dealt with in line with the T&Cs of the junior doctor contract. I am grateful for the support of the SMT at DCH and for the engagement shown in addressing the challenges outlined in this report. With the ongoing support of the SMT, Trust Board and working alongside the DME and BMA reps, my aim is to continue to work to improve the working lives of, and training environment experienced by, doctors in training at DCH.

APPENDICES - TRUST BOARD PAPER DECEMBER 2018

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

Appendix 1 – Exception Reports by department, grade and rota

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Paediatrics	0	0	0	0
Obstetrics & Gynaecology	0	3	3	0
ENT	0	1	1	0
Urology	0	2	2	0
Colorectal/Breast	0	7	7	0
Upper GI/Vascular	0	3	3	0
Orthopaedics	0	9	7	2
Anaesthetics	0	0	0	0
Anaesthetics ICU	0	0	0	0
Haematology	0	0	0	0
Histopathology	0	0	0	0
A&E	0	6	6	0
Acute Medicine	0	5	5	0
Elderly Care	0	3	3	0
Stroke	0	0	0	0
Clinical Oncology	0	0	0	0
Cardiology	0	4	4	0
Respiratory	0	1	1	0
Renal	0	1	1	0
Gastroenterology	0	0	0	0
Diabetes & Endocrinology	0	0	0	0
Adult Psychiatry	0	0	0	0
General Psychiatry	0	0	0	0
General Practice	0	0	0	0
Total	**0**	**45**	**43**	**2**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	30	28	2
F2	0	7	7	0
CT1-2/ST1-2	0	4	4	0
ST3-8	0	4	4	0
Total	**0**	**45**	**43**	**2**

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Paediatrics ST3-8	0	0	0	0
Paediatrics FY2/GPVTS	0	0	0	0
Obstetrics & Gynaecology FY2/ST1-2	0	0	0	0
Obstetrics & Gynaecology ST3-8	0	3	3	0
General Surgery FY2/CT1/2/GPVTS	0	4	4	0
General Surgery ST3-8	0	0	0	0
Orthopaedics ST3-8	0	0	0	0
Anaesthetics CT1-2	0	0	0	0
Anaesthetics ICU CT1-2	0	0	0	0
Anaesthetics ICM FY2	0	0	0	0
Anaesthetics ST3-8	0	0	0	0
Haematology ST3-8	0	0	0	0
Histopathology ST1-2	0	0	0	0
A&E FY2/GPVTS	0	6	6	0
General Medicine FY2/CT1/2/GPVTS	0	1	1	0
CMT/GPVTS Cardiology	0	0	0	0
CMT – FW Clinical Oncology	0	0	0	0
General Medicine ST3-8	0	1	1	0
ST3+ Cardiology	0	0	0	0
GPVTS Palliative Care	0	0	0	0
GPVTS – GP	0	0	0	0
FY2 General Practice (AHAH – Med On Call)	0	0	0	0
FY2 AHAH	0	0	0	0
FY2 GP – Med On Call	0	0	0	0
FY2/CT Gastro	0	0	0	0
FY1 CAMHS	0	0	0	0

(Gen Adult)				
FY1 Geriatric/Stroke	0	3	3	0
FY1 Respiratory	0	1	1	0
FY1 Renal	0	0	0	0
FY1 Acute Internal Medicine	0	4	4	0
FY1 Cardiology	0	4	4	0
FY1 Gastroenterology	0	0	0	0
FY1 Colorectal/UGI	0	7	7	0
FY1Urology	0	1	1	0
FY1 ENT	0	1	1	0
FY1 Breast/Vascular	0	0	0	0
FY1Orthopaedic	0	9	7	2
Paediatric FY1	0	0	0	0
FY1 Adult Psychiatry (Surgical on call)	0	0	0	0
FY1 Child & Adolescent Psychiatry (Orthopaedic On call)	0	0	0	0
Total	**0**	**45**	**43**	**2**

Standard Exception Reports - response time			
	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	19	9	2
F2	2	5	0
CT1-2 / ST1-2	1	3	0
ST3-8	3	1	0
Total	**25**	**18**	**2**

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

Appendix 2 – Work schedule reviews by grade and department

Work schedule reviews by grade	
F1	1
F2	4
CT1-2 / ST1-2	0
ST3+	1

Work schedule reviews by department	
Paediatrics	0
Obstetrics & Gynaecology	1
ENT	0
Urology	1
Vascular	0
Breast	0
Upper GI	0
Colorectal	0
Orthopaedics	0
Anaesthetics	0
Anaesthetics ICU	0
Orthodontics	0
Ophthalmology	0
Haematology	0
Histopathology	0
A&E	2
Acute Medicine	1
Elderly Care	0
Stoke	0
Clinical Oncology	0
Cardiology	0
Respiratory	0
Renal	1
Gastroenterology	0
Diabetes & Endocrinology	0
Adult Psychiatry	0
General Psychiatry	0
General Practice	0
Total	**6**

Appendix 3 - Locum agency bookings and bank usage

Locum agency bookings

Division	Cost Centre Narrative	Grade Code	Booking Reason	Hours Booked	Avg Total Charge Rate	Booking Value
FS&S division	Med Staff Anaes	Staff Grade	Vacancy	53	£74.43	£3,945
FS&S division	Obs & Gynae Med Staff	ST3	Vacancy	116	£85.73	£9,945
FS&S division	Obs & Gynae Med Staff	Staff Grade	Annual Leave	72	£99.92	£7,195
FS&S division	Opth Medical Staff/Sec	Staff Grade	Vacancy	126	£75.28	£9,485
FS&S division	RADIOLOGY DCH	AHP07	Vacancy	80	£45.66	£3,653
FS&S division	Urology Medical Staff	Consultant	Sickness - Short Term	141	£117.26	£16,534
U&IC division	CLINICAL PATHOLOGY	AHP06	Vacancy	332	£33.21	£11,012
U&IC division	CLINICAL PATHOLOGY	AHP07	Annual Leave	160	£33.75	£5,400
U&IC division	Elderly Care Medical Staff/Sec	Consultant	Vacancy	488	£134.90	£65,765
U&IC division	Emergency Dept Medical Staff	FY2	Annual Leave	10	£71.99	£720
U&IC division	Emergency Dept Medical Staff	Staff Grade	Vacancy	21	£96.00	£1,968
U&IC division	Gen Med Medical Staff/Sec	ST3	Vacancy	43	£101.94	£4,332
U&IC division	Histopathology	AHP05	Vacancy	16	£18.03	£289
U&IC division	Histopathology	AHP07	Vacancy	400	£28.96	£11,584

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

	Sep-18	Oct-18	Nov-18
DIVISION A	**£56,341.91**	**£26,895.76**	**£45,929.14**
CONSULTANT BANK	**£29,224.04**	**£19,810.15**	**£21,438.85**
CHEMICAL PATHOLOGY	£4,596.82	£0.00	£0.00
CLINICAL NEUROPHYSIOLOGY	£183.67	£0.00	£0.00
HISTOPATHOLOGY	-£6,530.00	£0.00	£0.00
LOCUM ACUTE INTERNAL MEDICINE	-£183.77	£0.00	£0.00
LOCUM EMERGENCY MEDICINE	-£49.79	£0.00	£0.00

LOCUM GERIATRIC MEDICINE	£4,359.97	£4,659.74	£4,659.74
LOCUM HISTOPATHOLOGY	£5,593.50	£5,915.68	£11,474.35
LOCUM MEDICAL MICROBIOLOGY	-£215.59	£0.00	£0.00
MEDICAL MICROBIOLOGY	£21,469.23	£9,234.73	£5,304.76
FOUNDATION YEAR 1 BANK	**£0.00**	**£907.26**	**-£907.26**
ACUTE INTERNAL MEDICINE	£0.00	£240.00	-£240.00
CARDIOLOGY	£0.00	£360.00	-£360.00
GENERAL SURGERY	£0.00	£307.26	-£307.26
FOUNDATION YEAR 2 BANK	**£5,971.99**	**£2,474.98**	**£1,240.42**
EMERGENCY MEDICINE	£5,350.82	£1,311.40	£0.00
GENERAL (INTERNAL) MEDICINE	£621.17	£7,889.16	£0.00
GP DOCTORS IN TRAINING	£0.00	£0.00	£375.54
TRAUMA AND ORTHOPAEDIC SURGERY	£2,685.68	-£6,725.58	£0.00
UROLOGY	-£2,685.68	£0.00	£864.88
SPECIALTY DOCTOR BANK	**£3,393.25**	**£9,131.23**	**£202.44**
EMERGENCY MEDICINE	£1,712.20	£3,919.29	£911.17
GENERAL (INTERNAL) MEDICINE	-£123.53	£0.00	£0.00
LOCUM EMERGENCY MEDICINE	£1,804.58	£5,211.94	-£2,241.86
LOCUM TRAUMA AND ORTHOPAEDIC	£0.00	£0.00	£0.00
PALLIATIVE MEDICINE (LOCUM)	£0.00	£0.00	£1,533.13
SPECIALTY TRAINEE BANK	**£17,752.63**	**-£5,427.86**	**£23,954.69**
ACUTE INTERNAL MEDICINE	£0.00	£0.00	£14,067.98
CARDIOLOGY	£0.00	£0.00	£409.68
EMERGENCY MEDICINE	£0.00	£4,125.26	-£793.29
GENERAL (INTERNAL) MEDICINE	£262.49	£1,635.12	£6,816.50
LOCUM EMERGENCY MEDICINE	-£3,880.52	£2,417.70	£0.00
LOCUM GENERAL (INTERNAL) MED	£6,370.66	£0.00	£0.00
LOCUM UROLOGY	£0.00	£0.00	£4,460.96
NO ACTIVITY	£15,000.00	-£15,000.00	£0.00
TRAUMA AND ORTHOPAEDIC SURGERY	£0.00	£1,394.06	-£1,007.14
DIVISION B	**£97,557.41**	**£56,613.41**	**£96,359.33**
ASSOCIATE SPECIALIST BANK	**£0.00**	**£0.00**	**£0.00**
GENITIO-URINARY MEDICINE	£0.00	£0.00	£0.00
CONSULTANT BANK	**£38,550.61**	**£28,571.64**	**£48,207.48**
ANAESTHETICS	£0.00	£0.00	£853.30
CLINICAL RADIOLOGY	£0.00	£1,576.88	£5,706.57
DERMATOLOGY	£5,170.64	£1,751.96	-£365.00
GENERAL SURGERY	£0.00	£813.52	£400.00
LOCUM ANAESTHETICS	-£6.33	£0.00	£853.50
LOCUM CLINICAL RADIOLOGY	£5,200.82	-£2,504.00	-£3,000.00
LOCUM DERMATOLOGY	£8,636.25	£9,267.21	£9,267.21
LOCUM GENERAL SURGERY	-£95.63	£0.00	£0.00
LOCUM OBSTETRICS AND GYNAE	£187.22	£0.00	£0.00
LOCUM PAEDIATRICS	-£352.61	£9,579.46	£8,090.80
LOCUM TRAUMA AND ORTHOPAEDIC	£0.00	£9,667.63	£9,677.21
PAEDIATRICS	£8,168.39	-£8,192.02	£0.00
TRAUMA AND ORTHOPAEDIC SURGERY	£8,731.72	£0.00	£0.00
YEOVIL DISTRICT HOSP NHS FT	£2,910.14	£6,611.00	£16,723.89

FOUNDATION YEAR 1 BANK	**£0.00**	**£895.66**	**-£218.54**
GENERAL SURGERY	£0.00	£895.66	-£895.66
TRAUMA AND ORTHOPAEDIC SURGERY	£0.00	£0.00	£677.12
FOUNDATION YEAR 2 BANK	**£23,953.20**	**£9,046.80**	**£16,888.78**
LOCUM TRAUMA AND ORTHOPAEDIC	£3,074.18	£7,601.90	-£6,954.56
OTOLARYNGOLOGY	£0.00	£0.00	£0.00
PAEDIATRICS	£4,966.39	£8,347.09	£4,525.64
TRAUMA AND ORTHOPAEDIC SURGERY	£13,226.95	-£6,902.19	£18,930.78
UROLOGY	£2,685.68	£0.00	£386.92
SPECIALTY DOCTOR BANK	**£12,470.65**	**£5,202.06**	**£12,790.59**
ANAESTHETICS	£6,583.59	£13,298.53	£11,238.75
DERMATOLOGY	£0.00	£0.00	£0.00
GASTRO-ENTEROLOGY	£0.00	£0.00	£0.00
GENERAL SURGERY	£7,948.78	-£314.05	£1,551.84
LOCUM GENERAL SURGERY	£0.00	£0.00	£0.00
LOCUM OTOLARYNGOLOGY	£0.00	£0.00	£0.00
LOCUM TRAUMA AND ORTHOPAEDIC	-£17.84	£0.00	£0.00
OTOLARYNGOLOGY	-£2,043.88	-£7,782.42	£0.00
SPECIALTY TRAINEE BANK	**£20,162.62**	**£10,326.58**	**£23,832.36**
ANAESTHETICS	-£120.08	£0.00	£432.44
DERMATOLOGY	£0.00	£547.78	£0.00
LOCUM OBSTETRICS AND GYNAE	£0.00	£2,570.96	£867.79
LOCUM PAEDIATRICS	-£7.05	£0.00	£0.00
LOCUM TRAUMA AND ORTHOPAEDIC	-£328.49	£0.00	£0.00
LOCUM UROLOGY	£7,013.38	£2,143.89	£23,542.39
PAEDIATRICS	£10,210.28	£2,457.93	£5,430.82
TRAUMA AND ORTHOPAEDIC SURGERY	£3,394.58	£2,606.02	-£7,123.88
VASCULAR SURGERY	£0.00	£0.00	£682.80
STAFF GRADE BANK	**£2,420.33**	**£2,570.67**	**-£5,141.34**
OPHTHALMOLOGY	£0.00	£0.00	£0.00
YEOVIL DISTRICT HOSP NHS FT	£2,420.33	£2,570.67	-£5,141.34

Appendix 4 – Medical training grade vacancies

Specialty	Grade	Sep 18	Oct 18	Dec 18	Total gaps (average)
Paediatrics	ST3+ GPVTS	0.40 2.60	0.40 2.60	0.40 2.60	0.40 2.60
Obstetrics & Gynaecology	ST3+	0.30 0.40	0.40 0.40	0.40 0.40	0.50 0.40
Elderly Med	GPVTS	0.40	0.40	0.40	0.40
Breast	ST3+	1.00	0.00	0.00	0.33
Orthopaedics	GPVTS	1.00	1.00	1.00	1.00
Anaesthetics	CT2 ST3+	0.30 2.40	0.30 2.40	0.30 2.40	0.30 2.40
A&E	GPVTS	1.00	1.00	1.00	1.00
Renal	ST3+	1.00	1.00	1.00	1.00
Old Age Psych	FY2	1.00	1.00	0.00	0.66
Respiratory	FY2	1.00	1.00	0.00	0.66
Renal	FY2	0.00	0.00	1.00	0.33
Diabetes & Endocrinology	ST3+	1.00	1.00	1.00	1.00
T&O	FY2	0.00	0.00	1.00	0.33
Palliative	GPVTS	1.00	0.00	0.00	0.33
Cardiology	GPVTS	0.00	1.00	1.00	0.66
GP	GPVTS	0.00	1.00	1.00	0.66
Total		**14.80**	**14.90**	**14.90**	**14.90**

Appendix 5 – Fines levied by Department and Cumulative Total

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

Respiratory	0	0
Renal	0	0
Gastroenterology	0	0
Diabetes & Endocrinology	0	0
Adult Psychiatry	0	0
General Psychiatry	0	0
General Practice	0	0

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

TERMS OF REFERENCE
WORKFORCE STRATEGY AND DEVELOPMENT COMMITTEE

1. Membership

1.1 The Committee Chairman (the **Chairman**) shall be a Non-Executive Director. In the absence of the Chairman the deputy Chair shall be another Non-Executive Director.

1.2 Standing members of the Committee shall include two Non-Executive Directors, Chief Executive, Director of Workforce & OD, Medical Director, Director of Nursing and Quality, Director of Medical Education, Head of Education and Development, Head of Workforce Resourcing, Head of HR Operations, Divisional Manager for Surgery and Family Services or Divisional Manager Integrated Community Care.

1.3 Only members of the Committee have the right to attend Committee meetings but if a standing member is unable to attend it is expected that he/she will ensure their nominated deputy is invited and can attend in his/her place, notifying the Chairman.

1.4 There will be three governors attending each meeting as observers one of whom shall be an elected Staff Governor. Observers are not members of the Committee but may ask questions at the end of each meeting.

1.5 It is expected that members attend a minimum of three meetings per year.

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

2. In attendance

2.1 The Trust Secretary or his/her nominee shall act as the Secretary of the Committee.

3. Appointment of Committee Chair and Members

3.1 The Trust Chair shall decide which non-executive Directors will be most suitable for nomination as Chairs and/or members of each Committee.

4. Purpose

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

4.2 The Committee will act as a means of internal assurance for compliance against the Care Quality Commission's fundamental standards of quality and safety and safe, caring, effective and well-led domains.

4.3.1 Supported Strategic Goals are:

- To strive towards excellence in the services and care we provide;
- To listen to, support, motivate and develop staff;
- To support the Trust's corporate objectives and vision.

[5. Duties

a. People Strategy

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

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

b. Workforce Development and Planning

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

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

c. Recruitment and Retention

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

d. Training and Development

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

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

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

e. Organisational Development and Leadership

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

f. Equality, Diversity and Inclusion

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

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

g. Risk Management and the Committee

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

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

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

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

h. General

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

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

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

6. Quorum

6.1 The Committee shall be deemed quorate if there is representation of a minimum of two non-executive Directors and three Executive Directors, including the Director of Operations, Medical Director and Director of Nursing and Quality. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. Authority

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

7.2 The Committee is authorised by the Board to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice to be arranged in consultation with the Trust Secretary.

8. Frequency of Meetings

8.1 The Committee shall meet every month.

9. Minutes and Reporting

9.1 Agendas and papers should be prepared and circulated in sufficient time for Committee Members to give them due consideration.

9.2 Minutes of Committee meetings should be formally recorded and sent to the Committee Chair for checking within 5 working days of the meetings. The Minutes (following their approval in draft by the Committee Chair) will be submitted to the Trust Board at its next meeting and may be presented by the Committee Chair.

9.3 The Committee will prepare an annual work plan for the Board that will demonstrate the Committee's discharge of its duties. This report should be produced as required according to the Board's Annual Work Plan.

9.4 The Committee should report to the Board as appropriate, to inform the Board of any issues that require resolution by the Board.

9.5 The Committee shall provide annual assurance report to the Board of Directors that the Care Quality Commission's relevant fundamental standards for quality and safety (Regulation 18) are monitored and shall highlight any risks, gaps in compliance, controls or assurance.

Regulation 18	**Staffing** 1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. 2. Persons employed by the service provider in the provision of a regulated activity must - a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, b. be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and c. where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

9.6 The Committee will have a framework in place for monitoring the Key Lines of Enquiry for the CQC and provide annual assurance to the Board of Directors.

10. Reporting Groups

10.1 The following reporting groups will be formally constituted sub-groups of the Committee and will submit to each meeting of the Committee in a timely manner an exception/issues report and copies of their Minutes for formal ratification.

a. Equality, Diversity & Inclusion Group

b. Education & Training Group

c. Medical Education Group

d. Health & Wellbeing Steering Group

e. Rostering Steering Group

f. Workforce Resources Strategy Group

11. Conduct of Business

11.1 The conduct of business will conform to guidance set out in the Board of Directors Standing Orders, unless alternative arrangements are defined in these Terms of Reference.

August 2018

Title of Meeting	**Board of Directors**
Date of Meeting	**23 January 2019**
Report Title	**Seven Day Services**
Author	Anita Thomas, Divisional Manager for Urgent and Integrated Care Liz Hemsley, Clinical Quality Facilitator
Responsible Executive	Alastair Hutchison, Medical Director

Purpose of Report (e.g. for decision, information)
To summarise the Trust performance against the Seven Day Standards using the new template (in trial form) for Board Assurance on Seven Day Services.

Summary
The Board has previously been informed of the Trust performance against the four key standards in an audit carried out in Spring 2018. The national team have refreshed their approach and will be requiring a twice yearly Board Assurance submission to be completed. The attached version is a trial approach and Trusts can use their 2018 performance in this submission. Deadline for return to be made to NHS England is 28 February 2019. Further quality improvement audits are already being planned for Spring with junior Doctor support and the action plan will be monitored by an improvement group chaired by the Medical Director.

In 2018 the Trust met all four standards. In 2019 the only amendment to date is that surrounding MRI provision as it is only routinely provided on 6 days of the week. Sunday provision is only as part of extended elective services as required by waiting times or funded for specific elective purposes.

Paper Previously Reviewed By
Alastair Hutchison, Medical Director

Strategic Impact
The Board Assurance submissions are required to be shared with the CCG via the Urgent and Emergency Care Board. The CQC and other inspection regimes will require sight of submissions as part of their assurance schemes.

Risk Evaluation
Provision of high standard seven day services are an indication of the overall quality of care provided by the Trust. The Trust has shown a consistent improvement against the required standards and achieved all four in 2018. It is necessary to continue to monitor that the Trust continues to demonstrate achievement of the key standards and to report findings and any associated action plans.

Impact on Care Quality Commission Registration and/or Clinical Quality
The sight of the Board Assurance papers on Seven Day Services as part of any inspection

Governance Implications (legal, clinical, equality and diversity or other):
Continuous Quality improvement in these quality standards is important to patients, their care and to the staff providing the care.

Financial Implications None	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	a) Read the assurance document b) Accept the findings of the quality improvement audits

Organisation	Dorset County Hospital NHS FT
Year	2018/19
Period	Autumn/Winter

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The patient survey takes place over the course of 7 days, from Wednesday 00:01 to Tuesday 24:00. A list of all emergency admissions is generated from PAS. The list is filtered to exclude patients meeting the following criteria: • Patients admitted to short stay ambulatory care • Patients who are admitted as an emergency but who stay in hospital for fewer than 14 hours from arrival • Patients on an inpatient pathway on which care for the entire patient group is, by design, routinely delivered by non-consultants e.g. Midwife led care on a maternity unit Patient groups for whom: • There is a clear written local protocol for the pathway the patient is on which has been agreed within the trust clinical governance system and supported by the commissioners AND • The protocol describes actions to be taken in the event of clinical concern, including robust and rapid escalation to a consultant where appropriate: eg a maternity patient who develops the need for an emergency Caesarean section, or a patient with a superficial abscess who appears to be developing sepsis AND • The patient's care is still recorded as being under a named consultant for the purpose of clinical governance (excluding patients specifically on midwife-led care pathways).	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes mix of on site and off site by formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Each service is covered by a 7 day roster in the relevant dept. In addtion ED and the Acute Medical Assessment Units have their own ultrasound capability. MRI is currently under review as only available 6 days a week consistently with Sundays only covered as part of an elective care provision.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	No the test is not available	
		Upper GI endoscopy	Yes available on site	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Each dept has a 7 day roster. Cardiology is in a formal network with another acute provider for out of hours support. Radiotherapy takes place at the Cancer Centre for Dorset and an agreed urgent pathway is in place to support patient transferral in urgent cases.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Ongoing review is captured for all patients included in the survey, for up to 5 days following day of admission, unless discharged before this. The requirement for twice-daily review depends on the acuity of the patient, and can be delegated by the consultant to other grades of staff. There is no threshold to reach for this standard. Ideally, it should be documented in the patient record as to the level and frequency of review, but in practice, this is rarely done. During the survey, there was no evidence that there was a failure to escalate a deteriorating patient, or that a review was missed, or carried out an inappropriate grade of staff.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
These standards have not been assessed during the previous 7DSAT surveys - the focus has been on Standards 2,5,6 and 8. Standard 1 – Patient Experience Standard 3 – MDT review Standard 4 – Shift handovers Standard 7 – Mental Health Standard 9 – Transfer to community primary and social care Standard 10 – Quality Improvement The Urgent and Integrated Care Division will fold a reveiw of these aspects into the 2019/20 Patient Flow Programme, with support from the Transformation Team and Executive support.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
As part of an Integrated Care System the Trust forms part of the 'One Dorset Acute Network' of Acute Trusts that offer networked arrangements for emergency care.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Title of Meeting	**Trust Board**
Date of Meeting	**30 January 2019**
Report Title	**Communications Activity Report – Q3 Oct-Dec 2018**
Author	Susie Palmer, Communications Manager
Responsible Executive	Nick Johnson, Director of Strategy and Business Development

Purpose of Report (e.g. for decision, information) For information	
Summary This quarterly report gives an overview of communications activity for the Trust.	
Paper Previously Reviewed By	
Strategic Impact	
Risk Evaluation	
Impact on Care Quality Commission Registration and/or Clinical Quality	
Governance Implications (legal, clinical, equality and diversity or other):	
Financial Implications	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	a) To receive for information

Communications Activity Report

Quarter 3: October – December 2018

1. Introduction

This quarterly report gives an overview of communications activity for the Trust. It is by no means an exhaustive list of what the communications team has been involved with over the quarter but the aim is to give a flavour of key areas of our work and a summary of activity.

The increased capacity of the communications team continues to make a hugely positive impact on the organisation. This was most strongly illustrated this quarter with the great success of sustained, widespread communications to support the staff flu vaccination campaign.

As explained in the last report, while there is still a place for the traditional press release, we will be increasingly focusing on our social media platforms and digital channels to communicate with our public and staff audiences.

Press and broadcast media are still important outlets but we can now directly reach large audiences through our own channels and frame the messages how we wish. Social media also offers us an effective method of two-way communication and an increasing number of people are choosing to contact the hospital via our social media pages.

2. Key Campaigns, Initiatives and Events

Flu Vaccination Campaign

The increased capacity of the communications team allowed us to support the staff flu vaccination programme more effectively than ever before this year with a widespread internal and external communications campaign. The campaign included:

- Regular email reminders about flu jab drop-in sessions
- Regular social media posts
- A dedicated intranet page about why getting the flu jab is so important
- A powerful and well-received video with our Medical Director
- Team Brief presentations
- Staff Weekly Bulletin reminders and updates
- CEO Brief reminders and updates
- Posters throughout the hospital

The focussed and sustained communications campaign undoubtedly made a huge difference in the engagement of staff. The Trust saw the highest ever rate of flu vaccination and we were among the highest performing trusts in the country.

At the time of writing this report our overall staff vaccination rate was 77.67% (national target is 75%) and frontline staff 81.15%, a fantastic achievement.

CQC Result
We planned ahead for the comms around the announcement of our CQC result and were able to inform staff in a timely way and attract positive media coverage. Social media posts were well-received by staff and the public and we produced a large banner to display on the corner of the hospital site to further publicly thank our staff and promote our positive result.

Robert White Centre Opening
The communications team supported the charity team with the pre-event planning, coordination of local media representatives and social media coverage of the opening event. Live tweets from the event and a video of the opening ceremony proved extremely popular. A video charting the different stages of the build also attracted a lot of positive attention. Media coverage was very good with items on BBC South and BBC Spotlight as well as local newspapers and radio.

Staff App
This is an exciting development for staff communications. Through researching the available options we have identified a supplier who will develop a DCH staff app for us for free as they will fund it through low-key advertising within certain sections of the app. The supplier has previously produced our printed staff handbook and has developed staff apps for other trusts throughout the country. Feedback from trusts already using the app has been very positive with high take-up from their staff.

The Trust's Communications and Engagement Group has fed into the development of the content of the app and other staff groups have been approached to give their thoughts about what information would be useful to access via the app.

The app will be designed to reflect the Trust's visual identity and will allow staff to access key information on their smartphones which they would usually only be able to access via the intranet on Trust devices. We will also gain the benefit of being able to send key messages to staff via 'push notifications'.

Examples of information which will be available to staff via the app include: CEO Brief, Weekly Staff Bulletin, key HR policies, links to systems such as email and ESR, jobs and training details and wellbeing information.

The advertising within the app will consist of special offers from retailers and services via a 'Hot Deals' button which staff have to choose to press, plus an occasional static banner advert. It's not intrusive, there are no pop-up style adverts.

We are currently finalising timescales for the visual design, technical build and uploading of content.

Dorset Integrated Care System
We continue to take an active role in the Our Dorset Communications Network. We are working closely with comms colleagues from partners to develop awareness of Dorset's Integrated Care System and the work going on between organisations. We are currently working with Dorset CCG's comms team on a series of Our Dorset videos to highlight the work DCH has been involved with – the next focus will be on the successful work around reducing the number of 'super stranded' patients at the hospital.

Use of Video
We plan to make much more use of video as a way of communicating with staff and the public. Our Communications Officer is developing her video skills to great effect for social media and internal use. Video posts on our social media channels attract a lot of views and this is certainly a highly effective way to engage people online. Wordy posts won't get read – more and more, people expect short and sharp visuals they can easily digest at a glance.

Design Work
With the appointment of our Communications Officer and additional design software we can now meet more of our design requirements in-house which will generate significant savings over time as we outsource less and less work to external graphic design firms. As an example, the next issue of our membership magazine 'The DCH Way' is being designed by our Communications Officer, saving us over £300 on the usual design costs for each issue.

Media Training
We ran a successful media training session as part of our emergency planning work to prepare senior staff who may be called upon to do media interviews during a major incident. The feedback from participants was very positive and we are aiming to run another session in the spring.

Hospital Open Day
The annual hospital open day was held in October and went well, with positive feedback from visitors and staff who took part. We have run this event in a similar format for several years so feel it is time to refresh our event offering this year. As we still have use of the field on the old school site we are going to stage a summer event (probably in July) this year along the lines of a school fete/fundraising type of event, a family fun day for both staff and the public. Planning is in the early stages and we will be pulling together staff from throughout the Trust to help organise and run the day.

Recruitment Microsite
The communications and recruitment teams are working in partnership with Dorset Clinical Commissioning Group's digital team to develop a new recruitment microsite to offer a wealth of information about job opportunities and the benefits working at DCH. The CCG team are providing technical support and we will be generating and maintaining the content. Content is currently being gathered for the site and then the CCG team will provide technical/design input.

Social Media Policy
The Trust's Social Media Policy was refreshed to reflect the wider use of social media by the communications team and staff in general for professional use as well as supporting patients and staff groups.

3. Social Media

Social media engagement continues to flourish since the appointment of our Communications Officer. We are now using a social media management tool, Sprout Social, to manage all our channels more efficiently.

Engagement on Facebook and Twitter pages has increased greatly and we are now looking towards developing other channels such as LinkedIn and Instagram. We will be working with

the recruitment team to develop LinkedIn and also aim to regularly post jobs on Facebook and Twitter as soon as we can establish a reliable process. Instagram will reach out to a younger audience which we are keen to explore.

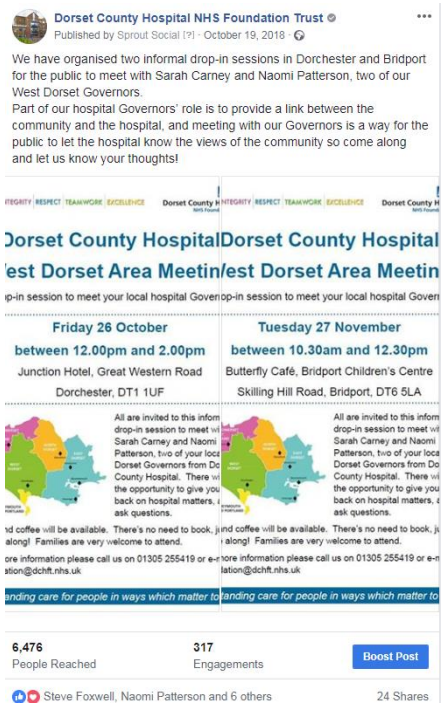
As well as the main DCHFT Facebook page, we have gained ownership of a page which was automatically generated by Facebook for Kingfisher Ward so we can monitor and control content. As followers grow, this page could prove useful as another way to engage with parents regarding the development of children's hospital services: www.facebook.com/KingfisherWard

The statistics below demonstrate how many people we are reaching each month. Also included is a small selection of the most popular posts.

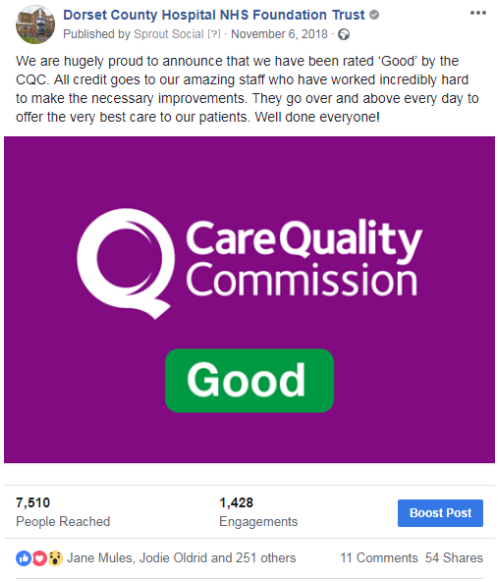
Quarter 3 Facebook Analytics – www.facebook.com/DCHFT

	Q2	Q3
Engaged users	90,673	102,546
Number of posts	148	222
Number of followers	3,700	4,020

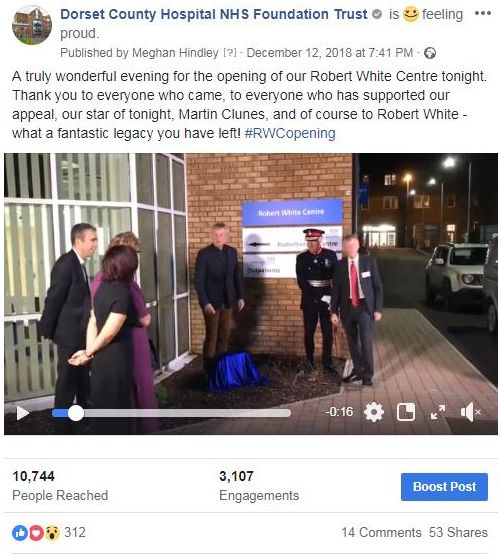
Facebook Highlights for October



Facebook Highlights for November



Facebook Highlights for December



Quarter 3 Twitter Analytics - @DCHFT www.twitter.com/DCHFT

	Q2	Q3
Tweets	203	348
Tweet impressions	146,700	264,000
Profile visits	6,873	10,488
Mentions	851	798
Number of followers	3,238	3,414

Twitter Highlights for October

Top media Tweet earned 1,748 impressions

Our very own Karen Baylis, Deputy Sister on Barnes Ward, will be taking part in her first 10k run at the Bournemouth Marathon Festival this weekend with her 17-year-old daughter Lucy.
They are raising money for @ParkinsonsUK
Show your support here bit.ly/2ReLhRC
pic.twitter.com/7mrPmmhT5P

2 3 9

Twitter Highlights for November

Top Tweet earned 12.1K impressions

We recently had a visit from these little monsters! They came to our Kingfisher Ward after raising money at a #Halloween party. A massive thank you to Nikki Smith for organising the party and for thinking of us, it's greatly appreciated!
pic.twitter.com/qvaMReQd5b

1 4

Top media Tweet earned 6,412 impressions

We are hugely proud to announce that we have been rated 'Good' by the CQC. All credit goes to our amazing staff who have worked incredibly hard to make the necessary improvements. They go over and above every day to offer the very best care to our patients. Well done everyone!
pic.twitter.com/Lr7K3gnZhX

11 32 130

Top mention earned 200 engagements

Maz Evans
@MaryAliceEvans · Nov 21

My boundless thanks to the angels across all cardiac departments **@DCHFT** for the incredible, life-saving care they have taken of my Dad. You've given my kids their grandad for Christmas - I cannot thank you enough xxx

7 4 123

Twitter Highlights for December

Top Tweet earned 2,622 impressions

Our Emergency Department is currently extremely busy. Please help us spread the word - the Emergency Department should only be used for serious or life threatening conditions **#StayWellDorset #HelpUsToHelpYou**
pic.twitter.com/elqdOQ39Ew

1 37 25

Top mention earned 212 engagements

physiokat
@physiokat1 · Dec 17

Promoting therapy at the front door for **@DCHFT #homefirst #NHSI @CarolineNhs @leigh_rehab**
pic.twitter.com/6ImDgw8Beq

5 14 44

Top media Tweet earned 2,527 impressions

The Robert White Centre is officially open! **@Poole_Hospital #RWCopening**
pic.twitter.com/pBX0bk8rnU

16 46

4. Public Website

We are due to refresh our public website, working with our web designers to make it more user-friendly and streamlined, as well as reviewing and updating content.

The analytics below show general usage of the website over the quarter and the most visited pages:

Quarter 2 Website Analytics – www.dchft.nhs.uk

	Q2	Q3
Page Views*	161,130	160,712
Unique Page Views**	118,468	118,189
Users	38,014	38,107
Average Session Duration	00:01:46	00:01:49

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

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

Quarter 2 Top 10 Most Popular Webpages (Oct – Dec 2018)

Page	Page Views	Unique Page Views	Average Time on Page
Site Homepage	20,160	15,831	00:00:49
Staff Section Homepage	6,116	4,235	00:00:53
Visiting Hours	4,942	3,535	00:01:35
Contact Us	4,595	3,880	00:01:57
Visitors Section Homepage	4,123	2,724	00:00:21
Wards Section Homepage	3,810	2,844	00:00:26
Getting Here	3,589	2,529	00:01:50
Departments A-F Homepage	3,496	2,404	00:00:22
Patients Section Homepage	3,479	2,492	00:00:26
Departments P-Z Homepage	3,265	2,265	00:00:27

5. StaffNet (Intranet)

Another long-term project is developing the staff intranet, StaffNet. The changeover to the new Sharepoint content management system has been successful but departments need encouragement and support to maintain and refresh their pages.

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

6. News Releases

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

Christmas lights switch-on highlights organ donation - 21 December 2018
Staff at Dorset County Hospital asked people to think about the gift of organ donation as they switched on their Christmas tree lights.

Dorset County Hospital saves Christmas - 20 December 2018
Christmas could have been a different story this year if it wasn't for the fast action of staff at Dorset County Hospital.

Robert White Centre official opening - 13 December 2018
A very special guest helps officially open a new £9 million cancer centre for Dorset at DCH.

Golden Lulworth oak arrives at Dorset County Hospital - 16 November 2018
The creation of a unique sculpture at Dorset County Hospital has taken an exciting step forward.

Dorset County Hospital rated 'good' by CQC - 5 November 2018
We are delighted to have improved our Care Quality Rating to 'good' thanks to the fantastic efforts of our staff to provide the very best care.

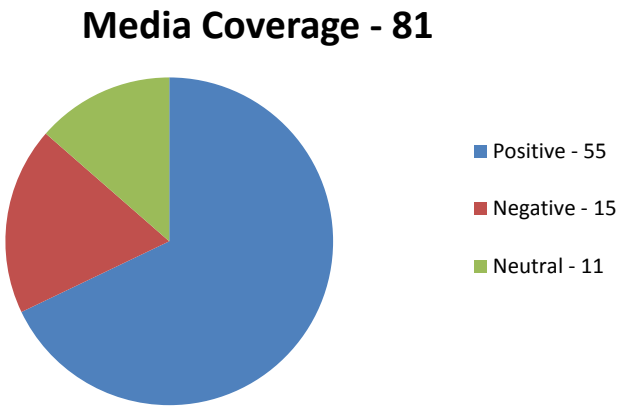
7. Media Coverage

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

- CQC result
- Cancer Appeal target reached
- Bowel cancer test waits
- CSR referred to health secretary
- GMC report on junior doctors
- Hospital open day
- Buckham Fair
- Car park charges
- Autism diagnosis waits
- Financial performance
- Estates backlog
- Pelvic scan waits

- Organ donation tree sculpture
- Legal claim cases
- Robert White Centre opening
- Christmas coverage
- Winter pressures

There were a total of 81 media stories relating to Dorset County Hospital (newspaper, radio, television, news websites), the vast majority of which were positive and an increase on the last quarter. The chart below shows the balance of positive, negative and neutral stories, and the table shows each quarter.



	Q2	Q3
Media stories	68	81
Positive	46	55
Negative	12	15
Neutral	10	11

Susie Palmer
Communications Manager
January 2019