Board of Directors Meeting
08.30am – 1.15pm, Wednesday 31 July 2019
Seminar Room, Children's Centre, Dorset County Hospital

AGENDA
PART 1 (PUBLIC SESSION)

			Approx. timings	
1	**Patient Story** For discussion		**8.30**	Andy Brett
2	**Welcome and Apologies for Absence:**		**9.00**	Chair
3	**Declarations of Interest**			All
4	**Chairman's Remarks**	Oral	**9.05**	Chair
5	**Minutes of Board of Directors 29 May 2019** To approve	Enclosure	**9.10**	Chair
6	**Matters Arising from those Minutes and Actions List** To receive	Enclosure	**9.15**	Chair
	QUALITY AND PERFORMANCE ITEMS			
7	**Chief Executive's Report** To receive	Enclosure	**9.20**	Patricia Miller
	BREAK		**9.45**	
8	**Integrated Performance Report** To receive and agree any necessary action **a. Workforce** **b. Quality** **c. Performance** **d. Finance** **e. ICS Update**	Enclosure	**10.00**	 Mark Warner Nicky Lucey Inese Robotham Paul Goddard Nick Johnson
	BREAK		***11.00***	
9	**NHSI Mortality Governance Review** To review	Enclosure	**11.15**	Alastair Hutchison
10	**Board Assurance Framework and Risk Register** To review	Enclosure	**11.30**	Nicky Lucey and Paul Goddard

WORKFORCE ITEMS

11	**Safe Staffing Return** To approve	Enclosure	**11.45**	Nicky Lucey
12	**Annual Equality and Diversity and Gender Pay Gap Report** To approve	Enclosure	**11.55**	Mark Warner
13	**Guardian of Safe Working Report** To receive	Enclosure	**12.15**	Alastair Hutchison

STRATEGIC ITEMS

14	**Charity Annual Report and Accounts** To approve	Enclosure	**12.30**	Nick Johnson
15	**Urgent and Emergency Care Patient Survey** To receive	Enclosure	**12.45**	Nicky Lucey

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.

16	**Annual Infection and Prevention Control Report** To receive	Enclosure	Nicky Lucey
17	**Clinical Audit Plan** To receive	Enclosure	Alastair Hutchison
18	**Medical Re-validation Report** To receive	Enclosure	Alastair Hutchison
19	**Communications Activity Report** To receive	Enclosure	Nick Johnson
20	**Any Other Business**		Chair

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

Questions from the Council of Governors and Members of the Public – 1.00pm to 1.15pm. Fifteen minutes will be allowed for questions, with priority being given to **Governor questions submitted in advance of the meeting.**

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

BOARD OF DIRECTORS
PART 1 (PUBLIC SESSION)

Minutes of the Meeting of Wednesday 29 May 2019
Seminar Room, Children's Centre, Dorset County Hospital

Present:
Mark Addison (Chair)
Sue Atkinson (Non-Executive Director)
Alison Cooper (Divisional Director)
Judy Gillow (Non-Executive Director)
Peter Greensmith (Non-Executive Director)
Paul Goddard (Director of Finance)
Victoria Hodges (Non-Executive Director)
Alastair Hutchison (Medical Director)
Nick Johnson (Director of Strategy, Transformation and Partnerships)
Nicky Lucey (Director of Nursing and Quality)
Ian Metcalfe (Non-Executive Director)
Patricia Miller (Chief Executive)
Matthew Rose (Non-Executive Director)

In Attendance:
Anthony Austin (Patient Research Ambassador)
Rebekah Ley (Trust Board Secretary)
Andy Morris (Head of Estates and Facilities)
Sarah Pamment (Capital Development and Sustainability Officer)
Zoe Sheppard (Head of Research)
Anita Thomas (Divisional Manager)
Dan Thomas (Waste Coordinator)
Catherine Youers (Head of Operational Human Resources)

Apologies:
Inese Robotham (Chief Operating Office)
Mark Warner (Director of Organisational Development and Workforce)

Observers:
Steve Fay, Baxter Healthcare Ltd, Wessex Academic Health Sciences Network
Meghan Hindley, Communications Officer
Philip Jordan, member of the public

BoD19/068 Recycling and Sustainability – Presentation

Andy Morris, Sarah Pamment and Dan Thomas were in attendance for this item.

Andy Morris explained the context nationally around sustainability and the health service. He said that the Department of Health is committed to a 34% reduction in the carbon footprint of the NHS by 2020 and a 50% reduction by 2030. He said that it is a specific challenge for the Trust as it has no energy manager and no sustainability manager.

Andy Morris set out that in the last couple of years the Trust has been making inroads in reducing the consumption of gas and water. However, utility inflation is running ahead of general inflation. He said that the Trust has received an "excellence in

sustainability reporting" award from Public Health England which only one in five Trusts receives. He said that this award is testament to the hard work of his team.

Andy Morris explained the governance and reporting arrangements for sustainability. He highlighted the travel working group that reports into the Finance and Performance Committee with its core purpose being to implement the sustainable management plan. He said the focus of the team is very much on doing and action and delivering initiatives. He said that his colleague Sarah Pamment has developed a network of sustainability champions across the Trust who ensure the whole organisation is informed about what is happening. The team used to attend Trust induction but given the inevitable tension and time pressures they no longer have a dedicated slot around sustainability but instead have a presentation stand outside of the main venue. Sustainability also has a presence on the Trust's website and intranet.

Andy Morris highlighted the Carbon Energy Fund Scheme that is approaching the end of construction phase; he said that this project will have the biggest single impact on the Trust's carbon footprint. He also outlined the work undertaken across the Trust in respect of lighting and air handling units etc. The Trust has also obtained some grant funding that may enable the installation of electric car charging points at the hospital.

Dan Thomas gave the Trust Board a brief overview of waste and recycling and the Trust. He explained the changes to the treatment of clinical waste: shredding and microwaving into flock and then selling it on. They are trialling reusable sharps bins and the use of china cups instead of plastic. He said that he is currently looking at the logistics of getting the cups to the kitchens to be washed and then back to the wards. Dan said that he has also worked on waste segregation including the redesign of bins and signage etc.

Sarah Pamment described some of the other initiatives around ecology and biodiversity. She highlighted the wildflower meadow which was championed by the Trust Chair and the adjustments made at the Trust to encourage hedgehogs onto the site. Sarah said that she is also working on bus passes for staff who live in particular areas to use buses where possible to travel to and from work with an attractive monthly discounts scheme. Sarah highlighted the recent poster competition open to local schoolchildren and highlighted the winners and the overall winning design that will now be used for all Trust posters.

Victoria Hodges said that she had found the link to the intranet and website pages hard to locate and felt that there was more that could be done to embed the sustainability agenda and develop a more strategic approach to this. She said that there was a need to think about the process for change around this and how to inform staff about what is going on.

Sue Atkinson thanked the attendees for their fantastic presentation and congratulated them on their public health award. She said that she would like to see sustainability back on Trust induction but recognised the challenges involved. She said that it was important to get clinicians involved in thinking about the clinical pathways and changes that could be made e.g., wrapping instrument trays in plastic. Sue Atkinson said that there was more that the Trust could do in respect of triple bottom line reporting looking not just at finance and environmental impact but social impact as well.

The Chief Executive said that she is keen that in the Trust's next Annual Report and Accounts, the strategic approach that the Trust is taking and the social impact it has is reflected more fully in the report. She said that the finance team has started to look at this in time for the Annual Report next year.

The Chair said that David Pencheon, former head of sustainability for the NHS, is hoping to attend a Board development session in December. He asked executive colleagues and the communications team to consider messaging around sustainability.

Action: Executive and Communications Team to consider messaging around sustainability including accessibility of Trust intranet and webpages.

The Chair thanked Andy, Sarah and Dan for their presentation.

BoD19/069 Welcome and Apologies for Absence

Apologies were noted as above. The Chair welcomed Steve Fay (Wessex Academic Health Sciences Network) as an observer to the meeting. The Chair said that Meghan Hindley, Communications Officer for the Trust was present as an observer and would be "live tweeting" during the meeting to encourage public attendance at the meetings.

BoD19/070 Declarations of Interest

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

BoD19/071 Chairman's Opening Remarks

The Chair said that the hospital has been under enormous pressure and commended staff for coping so well. However, he said that the point of the Board is to look ahead and not lose sight of the longer term perspective for the hospital.

BoD19/072 Minutes of the Previous Meeting held on 27 March 2019

In apologies for absence Mark Addison was described as the Chief Executive. This should be amended to "Chair". The Chair said that there were some minor typographic errors for correction outside of the meeting. Apart from these, the minutes of the meeting were accepted as a true and accurate record.

BoD19/073 Matters Arising and Action Tracker

Action Tracker:

BoD19/044: Review of HEE funding and other ways the Trust can support junior doctors: The Chief Executive said that the Trust has recently been awarded £30k for use towards the Trust's initiatives in respect of the 8 High Impact Interventions for junior doctors that the Trust is supporting. Item to be closed on the action tracker.

BoD19/009: Consideration is given to whether the Board Assurance Framework (BAF) adequately reflects the likely barriers to achieving its strategic objectives given the financial and performance pressures: the BAF will be refreshed and target risk scores will be included, it will then be reviewed by the Risk and Audit Committee and Trust Board in July. The Executive Team will be looking at the scores on the BAF and Corporate Risk Register in June to ensure consistency and appropriateness of scores and alignment with the Trust's risk appetite statement. Item to be closed on the action tracker.

Matters Arising:

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

QUALITY AND PERFORMANCE ITEMS

BoD19/074 Chief Executive's Report

The Chief Executive said that there were several issues to highlight from a national perspective. She said that a recent study found that three in ten childhood asthma cases in parts of Britain are caused by traffic pollution. A study published in The Lancet found that overall, 19% of new cases each year are attributable to nitrogen dioxide pollution. She said that in busy cities the proportion is far higher, with 23% of cases in Manchester due to pollution and 29% in London.

The Chief Executive said that some public services face a further squeeze despite the chancellor's pledge to end austerity at the spending review. In a letter to Nicky Morgan, chair of the Treasury Select Committee, the Chancellor, and Philip Hammond said it would be odd to assume that every Government department would see a real-terms increase in spending. He will allocate money in a three-year spending review, which is expected in the summer though this will be dependent upon the political landscape.

The Chief Executive highlighted a recent report by NHS Providers on mental health that found that cuts to benefits and wider economic hardship are increasing demand for mental health care. Mental health leaders in England cited the rollout of universal credit as a key factor. They also said money problems and job worries alongside social factors, such as loneliness, were adding pressure to an already stretched system. The Government acknowledged there were challenges in reforming benefits, but said it was tackling them.

In terms of provider finances, the Chief Executive said that the provider sector is set to miss its financial plan by more than £250m, despite benefitting from significant extra "donated asset" income. NHS Improvement's latest forecast for 2018/19 suggests a year-end deficit of £661m, against the initially planned £394m. The forecast would have been worse, at £917m, were it not for a £256m accounting adjustment which involved two private finance initiative hospitals being brought on to the Government's books as "part-donated assets".

The Chief Executive, member of the NHS Assembly, said that the NHS Assembly held its first meeting on 25 April. She said that there was a breadth of experience and knowledge that will play an important and valuable role in the implementation of the NHS Long Term Plan. She said that the issues for the Assembly will be how to influence the implementation of the Long Term Plan without holding an absolute power of veto and how it will determine where it can add value as opposed to getting caught up in individual issues.

The Chief Executive said that fourteen hospitals have been chosen to pilot a new way to measure performance which could pave the way for the end of the four-hour A&E target in England. Instead of aiming to see and treat virtually all A&E patients in four hours, the sickest patients will be prioritised for quick treatment. She said that the move is controversial, with some seeing it as an attempt to move the goalposts because the target has been missed for more than three years. The Trusts chosen, as part of the pilot, include a mix of rural and urban sites and top and bottom performing Trusts. The pilots will start shortly, with final decisions expected in the autumn with a view to introducing the new measures from next spring. There is heightened anxiety about the timing of this.

The Chief Executive said that in respect of perinatal services, a recent announcement by NHS England says that new and expectant mothers across the country are now able to access specialist mental health care closer to home. Perinatal community services have been rolled out to all of the forty four local NHS areas. NHS England say women with mental health problems have previously not have access to this type of care.

The Chief Executive explained that a report by the Public Accounts Committee (PAC) states that the success of integrated care systems (ICSs) might be hindered by the fact that they are not statutory bodies and rely on goodwill and local working relationships, which may take years to develop. The report on the financial sustainability of the NHS said that under the current legal and regulatory framework it is difficult for the NHS to work as a system. NHS Providers has urged caution in the creation of new organisations that may set national priorities rather than current providers making decisions at a local level.

In respect of workforce shortages, the Chief Executive said that a recently published

workforce report from the King's Fund, Nuffield Trust and Health Foundation predicts that there will be 250,000 NHS vacancies in a decade with signs of strain becoming apparent. More staff are leaving each year, and most cited reason for doing so as dissatisfaction with their work-life balance. The report sets out that the Government's job would be easier if workforce planning for health and care was not so fragmented. This comes in the backdrop of the imminent workforce strategy due to be published in the next few days. The plan is expected to focus on making the NHS a great place to work, leadership development, increasing the workforce but with a workforce model fit for the future, a 25% increase in student nursing placements and the devolvement of workforce planning to a local level.

The workforce implementation plan chair, Dido Harding and national executive lead Julian Hartley, said in a letter sent to Trust chief executives that they would look to devolve more responsibility for workforce issues to sustainability and transformation partnerships and integrated care systems. There will also be a review of how national bodies regulate Trusts, with the letter making clear that positive leadership in the NHS was not consistently demonstrated across the system in national bodies, providers or commissioners and there was a need to acknowledge this and improve the leadership culture and capacity.

The Chief Executive said that the National Health Executive covers a new report from the Health Foundation which found that a short-term approach to NHS funding has led to years of declining and inadequate capital spending for the health service. The charity has warned that an ageing infrastructure together with a substantial and growing repairs backlog was likely to undermine ambitions to transform the health service outlined in the long term plan. The report said the capital budget has declined in real terms over the past eight years, with NHS Trusts experiencing a 21% reduction in their capital funding. Large amounts of funding have been transferred from long-term capital investment to cover the day-today cost of running the NHS which is growing drastically due to rising demand. This year alone, £500m of capital investment was cancelled or postponed. The Chief Executive said that in respect of capital investment, the Department of Health's CDEL limit and adjustments to the spend the forecast, it is likely that the DoH will breach its CDEL limit significantly. There are risks associated with this: (i) STPs have been allocated transformation monies and (ii) backlog maintenance is £6 - £7 billion. These figures therefore need to be reduced and there will be pressure from the centre to do this. It is not clear what STP leads will be asked to do or the basis on which they will be asked to take action as STP leads have no statutory authority. The Director of Strategy, Transformation and Partnerships said that this may have an impact of the Trust's plans for developments.

The Chief Executive said that the latest position in respect of Brexit is that the Government has agreed with the EU a further extension of the Article 50 period to 31 October 2019. The recent resignation of the Prime Minister and a leadership contest may affect this date.

The Chief Executive said that looking locally, although some improvements have been seen a number or risks continue to be evident which could compromise the ability of the Trust to deliver on its key commitments in the coming year. The Trust has a growing elective waiting list, challenges around the 62 day referral to treatment cancer standard, the use of temporary staff, its finances and mortality figures. She said that plans are in place to mitigate these but progress may need to be made at a faster pace to avoid escalation. The Trust will need to make some key decisions soon that will include how to manage elective demand to ensure the size of the waiting list does not deteriorate further, recruitment campaigns and making challenging decisions to meet its financial obligations.

From a strategic perspective, the Chief Executive said that 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 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 so that the Trust feels the full benefit of these programmes within the timescale required.

The Chair thanked the Chief Executive for her report. He noted that the Director of Strategy, Transformation and Partnerships would be updating the meeting on the ICS performance report.

The Chair said that there will be a meeting of the advisory group of Trust Chairs with Dido Harding in the near future to discuss the issues around capital as mentioned by the Chief Executive. He said that it would be helpful to have input from the executive team before the meeting.

The Chair said that the recent changes with Chair and Chief Executive colleagues, and with local authority restructuring, locally may give impetus and drive for STP2 and new ways of working with partners. He said that two new local authorities' leaders and cabinet roles have also been settled.

BoD19/075 Integrated Performance Report

The Head of Operational Human Resources introduced this aspect of the performance report to the Trust Board. She said that workforce capacity (substantive and bank) increased by 25 FTE in month 1. Substantive workforce costs increased by £525k in month 1, which reflects the increase in workforce numbers, as well as the effect of the agenda for change pay increases. She said that agency staff costs increased by £165k in month1; £93k of which related to registered nursing costs as a result of escalation beds being open, high cost agency staff and an increase in the proportion of night shifts. She said that in month 12 there was a reduction in sickness absence levels down 3.09%. Appraisal rates increased to 88% in month 1 and essential skills training compliance was at 87%.

The Head of Operational Human Resources highlighted the work that has been undertaken in respect of job planning and the commitment by the Divisions to complete all areas (apart from two that will be completed in quarter 2) by the end of quarter 1. She said that the well-being agenda had progressed with focussed events for each week during May and a comprehensive benefits leaflet has been produced and that this links to the new staff app.

The Chair of the Workforce Committee, Victoria Hodges said that she wanted to highlight the agency spend and the need for greater detail on the incremental increase to understand the very challenging position in month 1 and what this means for the organisation. The Committee also discussed accommodation and the different staff groups that need it, and who is prioritised and the need for a robust strategy around allocation. The Committee also reviewed the use of "as and when contracts" and the focus on areas that have a high percentage of individuals on these contracts. The volunteer strategy and changes to training were presented by Hannah Robinson. The Chair of the Committee commended the work being undertaken by Hannah and her team in supporting front line staff. The Director of Nursing and Quality said that the volunteers were well supported in the areas where they are placed and the introduction of the sitting volunteers (end of life care patients) has been particularly welcomed by patients and staff.

The Chair of the Workforce Committee said that there are lessons to be learned for job planning next year. The Trust needs a clear timetable for completing this that ensures that plans are linked to the Trust's activity profile to ensure value for money and the link with appraisals so that both processes are meaningful and add value for individuals rather than being seen as a management exercise.
The Chair noted the challenging start to the year and the focus of the Committee in

understanding the underlying issues.

The Director of Nursing and Quality introduced this quality aspects of the performance report to the Trust Board. She said that overall she wanted the Board to note that many of the quality indicators are positive and this highlights the work undertaken by the Infection Prevention and Control and Facilities Team. She said that the Trust remains on routine surveillance following the recent Quality Surveillance Group.

Despite operational pressures the Trust has maintained the standards for factured neck of femur patients which means that patients are getting to theatre in a timely way. Complaint response times have been maintained at 100% which is a testament to how hard staff are working to respond to complaints and concerns. There have been no further never events. The mortality review undertaken by NHS Improvement was largely positive and their report is with the Trust and an action plan is being developed for Executive sign-off. There have been several Getting It Right First Time (GIRFT) reviews and these have been mainly positive with the Medical Director taking forward any actions required.

There has been a slight reduction in the Friends and Family test scores and this will be analysed by the Patient Experience Team with onward reporting to the Patient Experience Group. In respect of sepsis, the Director of Nursing and Quality said that there has been a slight improvement in antibiotic administration within one hour for inpatient areas though this is still below the required standard.

The Director of Nursing and Quality said that problems remain. Dementia screening standards are consistently not being achieved; there is ongoing medical engagement and focus on delirium with Medical Director support. Electronic discharge summaries (EDS) are still not being prepared in a timely way and a validation of them is being undertaken by the Medical Director.

The Chair of the Quality Committee, Judy Gillow said that despite the pressures on the workforce key quality indicators are being maintained which she commended to the Trust Board. She said that as well as the issues highlighted by the Director of Nursing and Quality she wanted to highlight other matters for the Trust Board from the Committee: the Committee approved the Quality Account for inclusion in the Trust's Annual Report and Accounts. She will be developing the Committee's annual work programme and she will be working with other Committee Chairs to see how alignment with the Committees can be further improved. The Committee approved the Trust's Annual Clinical Audit Plan and recommended it to the Risk and Audit Committee. She said that the Director of Nursing and Quality and the Medical Director are looking at how to integrate mortality data with other quality data and outcomes for review by the Committee. The Committee is also looking at how the Divisional reports can be aligned to improve the level of debate and challenge at the Committee. The Chair of the Quality Committee said that dementia and EDS will be a focus for the Committee in the coming year as there needs to be sustained improvement in these two areas.

Divisional Manager, Anita Thomas presented the performance element of the Performance Report. She said that performance in April, against the four hour Emergency Access Standard (EAS), continued to decline and was variable in the month. The combined performance including MIUs data was 89.5%. Whilst this performance is below the national standard of 95% it was above the national average of 85.1% and the Trust ranked number 28 out of 129 Trusts.

The Divisional Manager said that crowding in the Emergency Department remains a significant risk to patient outcomes and experience. In addition to increased attendances (4,251 in April 19 compared to 3,688 in April 18) and ambulance conveyances (1,400 in April 19 compared to 1,248 in April 18), there was an increase in the number of patients with delayed transfers of care (length of stay over 21 days). An agreement has been reached for the extension of the enhanced domiciliary care

scheme run by Agincare until 31 October 2019 whilst evaluation of the scheme and exploration of longer term options are progressed.

The RTT constitutional standard was not achieved and the performance was below the trajectory at 75% versus trajectory of 76%. For the eighth consecutive month there were no 52 week breaches. The most challenged specialities remain ophthalmology, trauma and orthopaedics and oral surgery.

The Divisional Manager said that performance against 62 day cancer standard shows improvement in April at 81% compared to 79% in February and 80% in March. She said that the backlog reduction is being maintained despite a significant increase in 2 week wait referrals with April. An additional 900 patients have been added to the waiting list.

Performance against the 6 week diagnostic standard declined slightly in month to 88% compared to 89% in March). This was largely due to staffing shortages in audiology, neurophysiology and Dexa scanning. The additional investment in endoscopy has meant that colonoscopy performance increased to 81% in April from a low of 35% in October last year.

The Chair noted the detail in the report and noted the discussions at the Finance and Performance Committee around the demand and capacity challenges. He noted that the Executives are considering next steps around actions that have to be taken and that the safety and care of Trust patients is paramount.

The Chief Executive said that it was important that there was a renewed focus on achieving the 4 hour standard for type 1 activity rather than combined. She said that the waiting list is growing and will reach a tipping point such that the Trust will need to consider further action and in turn discuss the next steps for the Trust with the CCG. The Chief Executive also noted that the changes to current performance targets may see the two week wait move to four weeks in total. Modelling has already started at the Trust to see where further work on the pathway for patients was required. The Chief Executive noted that an overhaul of this metric was overdue as the pathways have been reformed and redesigned since the inception of the two week wait 12 years ago; this presents an opportunity to improve patient care.

The Director of Strategy, Transformation and Partnerships asked the Board to note the work that Anita Thomas had undertaken in ensuring the that the Integrated Urgent Care Service which went live on the 1 April went smoothly. He thanked Anita for her commitment in getting the service up and running. He formally welcomed those members of SWAST staff who were now working for the Trust.

The Director of Finance introduced the financial element of the performance report to the Trust Board. He said that the Trust has agreed a plan with NHS Improvement to deliver a breakeven control total. This requires the Trust to achieve all of its Provider Sustainability Funding (PSF) targets and deliver a cost improvement programme (CIP) of £7.130m. The Trust delivered an income and expenditure deficit of £0.879 million to the end of April 2019 against a planned deficit of £1.051 million; a favourable variance of £0.172 million. The Trust's cash balance at 30 April 2019 was £7.7 million.

Capital expenditure at £192,000 is behind plan by £93,000; he said that this is linked to the timing of schemes that slipped from 2018/19. Overall the Trust's forecast capital expenditure remains in line with the plan.

The Trust's Annual Report and Accounts were audited and signed off by the Risk and Audit Committee; these received an unqualified audit opinion. He said that the accounts have been signed by the Chair and Chief Executive and will now be laid before Parliament.

He said that there are financial risks for the Trust: a shortfall of identified schemes against the annual CIP target of £3m which threatens the deliverability of the financial plan. He also highlighted agency spend in April which is almost double the level of the ceiling set by the regulator. This has been absorbed without affecting the financial position in month due to non-recurrent slippage but he cautioned that this is not sustainable and is a worrying start to the year.

The Chair of the Risk and Audit Committee, Ian Metcalfe said that he remained concerned about the CIP target and said that the longer the Trust waits to find scheme to close the current gap the more challenging and impossible to achieve the target becomes. He said that there is a need to regain focus and impetus in the summer. He concurred with the Director Finance in respect of the Annual Report and Accounts and that the auditor's unqualified opinion was an improvement on the previous year. He said that the only issues, in respect of the Annual Report and Accounts, was around the qualification in respect of the quality account and the ED waits. The Director of Nursing and Quality said that the Chief Operating Officer is leading on the work to ensure that this does not happen again.

The Chair said that the Trust is facing significant pressures this year even based on the original budget. He said that the Board will need to make some difficult decisions and that the July meeting is probably the very latest that it can take them to have any effect on outturn. It may be that that the Board will need to utilise some of its development session in June for early discussions.
Action: Demand and capacity and CIP challenges to be discussed at the July Trust Board with earlier discussions and decisions if required.

The Director of Strategy, Transformation and Partnerships introduced the ICS Performance slides to the Trust Board. He said that there was a lot of information and he would focus on those areas of comparison with other local Trusts:

- Trust ED performance in March was 91.5%, RBH 96.5%, PH 88%. ED attendances at the Trust were up by 7.6% in March compared to 8.6% PH and 4.5% RBH. Conveyances were up 6. 7% at the Trust compared to 3.75 PH and 4.7% RBH.
- The Trust's RTT and diagnostic performance continues to track below PH and RBH. However, he asked the Board to note in particular that the Trust's waiting list has increased by 19.2% since March 2018 compared to 4.3% PH and 4% RBH.
- Outpatient attendances have reduced by 2.4% at the Trust compared to 4.2% PH and 2.2% RBH.
- GP Referrals have increased at the Trust by 1.1% compared to a reduction at RBH (-0.6%) and PH (- 1.8%).
- Delayed transfers of care for the Trust have increased by 5.3% compared to PH (3.4%) and RBH (3.4%).

The Director of Strategy, Transformation and Partnerships said that the outline business case (OBC) of the RBH and PH merger was completed on schedule and signed off by RBCH and PHT Trust Boards. The OBC has now been shared with NHSI.

The Director of Strategy, Transformation and Partnerships said that the analysis of the current STP and working towards STP2 represented an opportunity for the system to understand what has worked in terms of transformation in Dorset and what is not. He said that in terms of clinical networks some good progress is starting to happen around pathology etc. and there is also work on the development of primary care networks bringing together primary care to start working in a more integrated way to impact on pressures across the system. The Director of Nursing and Quality said that the Dorset system requires a workforce that is currently not planned for and that is currently not in training. She said that the Trust as an acute provider must be mindful of recruitment from its own workforce to other parts/Trusts in the Dorset system when the Trust has

significant staffing gaps already. She also highlighted pharmacy vacancies were there real challenges and risks for the Trust.

The Chair said that he was concerned that the Board was not doing justice to the ICS performance information. The Director of Strategy and Transformation said that the updates had previously been occasional to the Trust Board but it was now integrated into the Performance report which meant more discussion on the issues raised there. He said that the value of the information is in the strategic conversations that it prompts. He said that having more space to discuss in the Trust Board meeting would be valuable but that it depends on what the Trust wants as an output from the report. Understanding comparative performance is useful. The Chair said that he and the Chief Executive will consider this point further and in particular about its position on the agenda. He agreed that using the information as a way of prompting questions and influencing system discussions was helpful. The Director for Strategy, Transformation and Partnerships said that as the ICS governance structure matures there will be an increasing expectation for 'decisions' to be made at ICS level and endorsed at the statutory/organisational level.

Action: Chair and Chief Executive to consider the position of ICS performance data on Board meeting agendas and time allocation.

The Chair thanked Board Members for the level of discussion and debate around the complex issues the Trust is facing.

The Trust Board had a break between 11:00 – 11:15

WORKFORCE ITEMS

BoD19/076 Safe Staffing Return

The Director of Nursing and Quality said that there were three shifts with only one registered nurse on duty during this reporting period (Day Lewis, Purbeck, Prince of Wales); these were supported by adjacent ward areas and night sister presence on all occasions. There were 322 shifts that needed to be filled with temporary staffing. She commended the staff bank for filling shifts.

The Chair noted that the report had been discussed at the Quality Committee. He thanked the Director of Nursing and Quality for her report.

STRATEGIC ITEMS

BoD19/077 Research Strategy Update

Zoe Sheppard, Head of Research attended the Trust Board and gave a presentation on the Trust's Research Strategy. The Head of Research said that the document included in the papers for the Board provides the context and current position of the Research and Innovation department. It explains the importance of research and the need for it to be conducted at Dorset County Hospital. Whilst research is conducted in most areas of the Trust, there are challenges.

The Head of Research said that in order to grow research at Dorset County Hospital, engagement is a prerequisite. Support and investment is needed for research to create this culture change. Dedicated time, space, and integrated research/clinical posts will bring a return in investment. She asked the Trust Board to agree the strategy.

The Chair thanked the Head of Research for leading this work and commended department for recently winning two awards. The Medical Director also commended the Head of Research for the awards and explained that this has been a difficult year for the department in terms of staffing and a decrease in funding from Wessex. He

said that the Trust has a really strong base for the future and noted that three nurses are taking on PhDs which is something to be particularly commended. The Medical Director said that over the coming years, the Trust will need to create time and space for people to take part in research. In particular, getting medical staff more actively engaged in research is the main challenge for the coming year.

The Patient Research Ambassador said that working with staff in departments and knowing where you can make a contribution has been an important part of his role. His knowledge base was reasonably high but working with the research department has enhanced that. He is working with one of the PhD students in contributing to effective dialogue and writing.

The Director of Strategy, Transformation and Partnerships asked (i) what the Trust is doing to actively address commercial research and the links with (ii) Research Active Dorset. The Head of Research said that in terms of Research Active Dorset, she has been attending meetings with them but that progress has slowed. She believes that there are economies of scale that could be exploited if we join forces in partnership. In her view, collaboration should just happen. The Trust is looking at commercial aspects of research but there is more work that could be done in this area.

Sue Atkinson said that the strategy was exciting; she welcomed health service research integrating with issues that are relevant to the Trust and the exploitation of data that is already collected. She would like to see greater links with ICS partners around research.

Victoria Hodges asked whether as a researcher the Head of Research would like to see a wider portfolio of more research or less research with more depth. The Head of Research said that this was a constant tension; she favoured the approach of having a balanced portfolio of research with fewer studies that the Trust recruits well to. However, she said that this is hard to balance because you want to the offer patients the opportunity to participate in research where possible.

The Divisional Director noted the earlier comments about job planning and the presentation and paper highlighting the need for protected time for research. She said that job planning could offer an opportunity and that trainees should probably be more involved in education and research. The Director of Nursing and Quality said that for specialist nursing roles research and/or education is included as part of the job plan or job description.

The Trust Board approved the strategy. The Board welcomed the links with the Trust's strategy and that research is an important component of Trust links and wider engagement with the healthcare economy.

BoD19/078 Mortality Report

The Medical Director introduced the report to the Trust Board. He said that the concerns over the Trust's performance in respect of SHMI are well known. The Trust has consistently been in the 'higher than expected' category since April 2012. He said that a 'higher than expected' SHMI should not be interpreted as indicating bad performance but it should be viewed as an issue which requires further investigation. He said that the Trust has recently changed supplier of information analytics to Dr Foster. He said that his report is data heavy. He said that the latest SHMI is fractionally decreased to 1.203 rather than 1.21. HSMR in December was below 100 but he said that it was not clear whether this is a sign of improvement.

The Medical Director said that his report had been reviewed by the Quality Committee.

The Medical Director said that he would like to include the mortality report within the main quality report, thus presenting a unified report. He is working with the Director of

Nursing and Quality on a combined report that will provide a greater level of assurance.

The Medical Director said that following problems with recruitment in the coding department two high quality individuals have recently been appointed by the Trust.

The Chair of the Quality Committee, Judy Gillow said that she supports the work that is being undertaken and that triangulation against other assurance measures will put the Trust in a much better position to understand the mortality data.

The Chair of the Quality Committee had a question relating to the statement in the report regarding diagnosis coding which the report states "will take a considerable amount of time to resolve" and she asked what time period that meant. The Medical Director said that he expected the timeframe would be less than a year now that the Trust has managed to recruit coders. He said that he wants to get the coding department fully staffed so that the coders can spend time with doctors and nurses and discussing the medical records and how and what to code. The Divisional Director said that this working alongside clinicians and the introduction of Medical Examiners will also help as the coders will also work with them around accurate coding of diagnosis etc. The Chief Executive welcomed the fact that coders will be working with clinicians as it will highlight the importance of good record keeping.

Sue Atkinson asked about the reference to eleven Trusts that have a lower mean depth of coding to the Trust and asked if they are in the same position as the Trust in respect of their overall mortality figures. The Medical Director said that he did not know but he will review this.
Action: The Medical Director to review the 11 Trusts identified in his report has having a lower mean depth of coding and their corresponding SHMI scores.

The Chair thanked the Medical Director for his report and ongoing work in this area.

BoD19/079 Finance and Operational Plan 2019/20

The Finance Director said that the plan was included in the papers for governance purposes. He said that at its meeting on 27 March 2019 the Trust Board considered the draft operational plan narrative for 2019/20. Subsequent to the meeting the narrative was updated to take account of feedback from NHS Improvement and the final financial settlement agreed with Dorset CCG for 2019/20.

The updated narrative was reviewed and approved for submission by the Chief Executive, the Director of Finance & Resources and the Chair of the Finance & Performance Committee (in accordance with the delegated authority from Trust Board).

The plan in the papers is the version of the narrative as submitted to NHS Improvement on 4 April 2019 and as noted by the Finance and Performance Committee on 16 April 2019. The Finance Director said that some Trusts had been asked to refresh their plans where there were specific issues. However, this was not the case for the Trust.

BoD19/080 Risk Register and Board Assurance Framework

The Director of Nursing and Quality introduced the report to the Trust Board. She said that the Corporate Risk Register assists in the assessment and management of the high level risks that have been escalated from the Divisions and any risks from the annual plan. It provides the Board with assurance that corporate risks are being managed effectively and that controls are in place to monitor these. All care group risk registers are being reviewed monthly by the Service Manager and the Head of Risk Management. The risks detailed in the report reflect the operational risks, rather than the strategic risks which are reflected in the Board Assurance Framework.

The Director of Finance said that the Board Assurance Framework (BAF) is due a more

fundamental review and refresh in time for the July Risk and Audit Committee meeting and the Trust Board in the same month. Given the strategic position of the Trust he considers that the financial rating remaining as a red rated strategic risk is appropriate at the present time as opposed to the operational risk that has reduced. He will include a target risk score as part of the refresh. He said that the Executive team will consider the strategic objectives in preparation for a deep dive on the BAF for the Risk and Audit Committee meeting in July. They will also be checking the scores and in particular those risks that are rated as extreme as it is not clear that these risks should be scored as they are at the present time.

The Chair of the Risk and Audit Committee said that it was important to note that all the discussions that had taken place at the Committees and the Trust Board were items on the risk register and so it was embedded in decision making and discussion at the Trust.

The Chair of the Quality Committee said that the ophthalmology risk is extreme. The Trust is aware that there have been adverse patient outcomes. She remains concerned that the mitigations aren't adequately reflected in the register and she would like to see more detail about the things that the Trust is doing on a routine basis. The Director of Nursing and Quality said that her team is tracking this and will report back to the Quality Committee.

Action: Director of Nursing and Quality to report back to the Quality Committee in respect of ophthalmology related risks.

The Chair noted that the BAF and Risk Register are items for the July Trust Board.

BoD19/081 Inpatient Survey Results

The Director of Nursing and Quality introduced the report to the Board. She said that Picker was commissioned by 77 inpatient organisations to undertake the inpatient survey. A total of 1250 patients from the Trust were invited to complete the questionnaire. He said that 1204 patients were eligible for the survey, of which 649 returned a completed questionnaire, giving a response rate of 54% (Picker average response rate of 43%); this is good. She said that the Trust's previous response rate (2017) was 46%.

The top five results for the Trust are:

- Hospital: food was very good or good.
- Discharge: delayed by no longer than an hour.
- Care: staff did not contradict each other.
- A&E Department: the right amount of information about treatment or condition.
- Discharge.

There are issues to work on:

- Doctors: providing clear answers to questions.
- Discharge: information about what they should or should not do after leaving hospital.
- Hospital: being bothered by noise from other patients at night. This is difficult to manage with the Trust's existing estate and single rooms.
- Procedure: how they will feel afterwards.

The Director of Nursing and Quality said that action plans will be embedded into Divisional reports rather than separate action plans developed. The Quality Committee will be updated on progress via those reports.

Victoria Hodges suggested that further work was required in those areas where scores were consistently low and as part of that the Director of Nursing and Quality will review the scores in these areas.

Action: Director of Nursing and Quality to review the low scores from the Picker

survey results.

Judy Gillow said that work on the survey would link with the work being undertaken by the Finance and Performance Committee in looking at patient pathways and discharge as had been discussed at the last Committee meeting.

The Chair noted that the Picker results will be incorporated into a broader approach to improvement rather than standalone action plans. The themes around communication with patients and discharge could be incorporated into the work being undertaken and reported to the Finance and Performance Committee. There will be a further report to the Trust Board in a year's time. The Chair said that the Trust is in the top third of the results table which is positive.

CONSENT ITEMS

The Trust Board Secretary confirmed that no questions or concerns had been raised about the Consent Items.

BoD19/082 **Use of Trust Seal**
The report provides the Trust Board with information regarding the use of the Trust Seal from April 2018 to March 2019.
The paper was accepted by the Trust Board.

BoD19/083 **Safeguarding Adults Annual Report April 2018 to March 2019**
The paper had been reviewed by the Quality Committee on the 21 May. The Director of Nursing and Quality asked the Trust Board to note the increased activity for the Safeguarding Adults Team.
The report was accepted by the Trust Board.

BoD19/084 **Safeguarding Children Annual Report April 2018 to March 2019**
The paper had been reviewed by the Quality Committee on the 21 May. The Director of Nursing and Quality asked the Trust Board to note the increased activity for the Safeguarding Children Team.
The report was accepted by the Trust Board.

BoD19/085 **Communications Activity Update Quarter 4 January to March 2019**
The report gives an overview of communications activity for the Trust. Included in the report is information about key campaigns, initiatives and events, and analytics for social media channels and the Trust's public website. There is also a summary of news releases issued over the quarter and associated media coverage.

BoD19/086 **Any Other Business**

The Chair highlighted the following dates for diaries:

- The Going the Extra Mile awards on Friday 14 June at Kingston Maurward College. He would like NEDs to attend if possible. Attendees to let the Trust Secretary now if they are able to attend.
- The Summer Spectacular on the Damers site on Saturday the 6 July 2-5pm. There will be a performance arena and many exciting activities. Funds will be raised for the chemotherapy appeal.
- The Trust's Annual General Meeting on Monday 16 September.

The Chair also had three other matters:

- The Committees to prepare forward work plans to follow the previously agreed format: a review of the Committee's achievements from last year, a forward look in narrative style setting out the priorities for the forthcoming year and the spreadsheet that sets out the items that will be reviewed at each Committee meeting.

- The Chair has had his appraisal and the Chief Executive's is being done. Once these are agreed, their objectives should be reviewed by the Trust Board so that the Board can see the issues that are going to be the subject of focus.

Action: Appraisal objectives for review in Part 2 of the July Trust Board.

Finally, the Chair said that this was Peter Greensmith's last meeting. The Chair offered Peter a personal thank you for the chairing of the Charitable Funds Committee and his role as the Trust's Vice Chair. The Chair noted that Peter has been a consistent patient champion and ensured the Board did not lose sight of patients in its discussions and deliberations.

Peter said that he was sorry to be leaving the Trust a year earlier than planned. He said that in his opinion The Trust is one of the most important organisations in the area and he will be pleased to watch its performance and progress. He will be sitting on a locality partnership board with GPs and other partners, looking at the issues in terms of the seven surgeries in Weymouth and Portland to bring the themes and issues into Dorset County Hospital and Dorset Healthcare. He said that this will keep him involved and he will hear about what is going on the hospital.

BoD19/087 Questions from the Public

Mr Jordan said he wanted to highlight to the achievements of nursing staff at the Trust. He had recently been in the pre-assessment unit at the Trust had had been seen by a student nurse from Southampton University (he did not know her name) and another nurse called Carly. He had personally thanked them at the time for the good patient care he received but wanted the Board to note that while they were doing their jobs, their professional approach was welcome.

Mr Jordan said that the Board is managed and led by an inspirational Chief Executive and an exemplary Chair. He welcomed the sustainability item on the agenda and that the Trust found time to put this at the top of its agenda which he said must put the Trust at the forefront of the climate change agenda. He noted the Dorset Council declaration of a climate change emergency which he believes to be helpful. In his opinion, the county would benefit from developing a Citizens Assembly type approach. He welcomed the inclusion of information in the Board pack on One Dorset. He said that he remains concerned about the resolution of the Trust's website that makes it hard to read and asked that the Trust reviews this.

The Chief Executive welcomed Mr Jordan's comments. She said that the Trust is working on building relationships with the new council and forging a common agenda between the two organisations. She said that the timetable to rewrite the transformation plan for Dorset presents an opportunity to have a wider conversation that looks not just at health but housing, transport and education as well.

BoD19/088 Date of Next Meeting (open to the public): Wednesday 31 July, 8.30am Seminar Room, Children's Centre, Dorset County Hospital, 2019.

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 29 MAY 2019

Minute	Action	Owner	Timescale	Outcome
BoD19/068	Consider messaging around sustainability including accessibility of the Trust's intranet and webpages.	Executive Team and Communications Team	TBA	
BoD19/075	Demand and capacity and CIP challenges to be discussed at the July Trust Board with earlier discussions and decisions if required.	Executive Team	June/July	
BoD19/075	Consider the position of ICS performance data on Board meeting agendas and time allocation.	Chair and Chief Executive	July	
BoD19/078	To review the 11 Trusts identified in the mortality report as having a lower mean depth of coding and their corresponding SHMI scores.	Medical Director	July	
BoD19/080	Ophthalmology related risks to be reported to the Quality Committee.	Director of Nursing and Quality	July	
BoD19/086	To review the appraisal objectives of the Chair and Chief Executives in Part 2 of the Trust Board meeting	Chair and Chief Executive	July	

Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 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:

NHS Long Term Plan
The implementation framework has been published and all systems are required to submit the next version of their plans by October. These plans will be expected to articulate how each system will implement the key deliverables outlined in the Long Term Plan. Nine work streams have been developed at a national level to inform the implementation phase.

Capital Backlog
The fire brigade has warned four NHS trusts that they plan to shut down parts of their hospitals because they are so decrepit that they pose a threat to patients and staff. Management at the four trusts are worried about the disruption to services if the fire brigades follow through on their warnings. They have raised concerns multibillion-pound government raids on the NHS' capital budget in recent years have created a situation where they have been left without the money to fix worsening problems with hospital buildings such as broken lifts and leaks of water and sewage.

The overall bill facing the NHS in England to tackle its backlog of maintenance shot up from £5.5bn in 2016-17 to almost £6bn in 2017-18, including £3bn needed to tackle problems that involve a "high" or "significant" risk, of which more than £1bn are problems posing a high risk. NHS England has told trusts to spend 20% less than they planned on capital projects this year in order to help the Department of Health and Social Care stick to its departmental spending limit.

'No deal' preparations
The Department of Health and Social Care plans to spend £3m on 'no deal' Brexit measures to transport medication. It wants to hire an "express freight service" to transport medicines, blood and transplant tissue. However, experts have warned that the deadline of 1 September set for the deal is a "tight" timeframe. The government's current plan is to leave the EU on 31 October, with or without a trade deal.

Key local developments are as follows

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

- Growing elective waiting list

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

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

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

Paper Previously Reviewed By
Chief Executive.

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

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

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

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

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

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

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

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

Chief Executive's report

Strategic Update

National Perspective

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

National Context

NHS Long Term Plan

The implementation framework has been published and all systems are required to submit the next version of their plans by October. These plans will be expected to articulate how each system will implement the key deliverables outlined in the Long Term Plan. Nine work streams have been developed at a national level to inform the implementation phase:

- Outpatient reform
- Diagnostics
- The NHS Financial Framework
- The NHS Capital Regime
- Ways of working across NHS Improvement and NHS England including with regions
- The NHS Improvement and NHS England shared improvement offer
- Workforce development
- Primary Care Network and Community Services expansion and development
- Digitising the NHS

It is important to recognise that successful implementation of the plan will depend on a number of supporting actions:

- Adequate funding is provided for the provision of social care
- Full implementation of the NHS People Plan including any funding necessary to meet the workforce challenges the NHS faces
- A guarantee around commissioning and funding for public health
- A solution around the current pensions crisis

NHS Assembly

The Assembly met for the second time in July. This session was opened with a presentation from the new Chief People Officer at NHSE/I Prerana Issar. Prerana focused on the interim NHS People Plan and its core ambition 'to make the NHS a great place to work'. She talked about the first phase of her role as being helping us as leaders to see the NHS as a great place to work before moving on to discuss how this could be translated to the rest of the workforce.

Following feedback from the inaugural meeting this session then focused on a number of key areas:

The national strategy for carers and what actions need to be taken to ensure that caring is choice not a necessity and that those who choose to care for relatives are adequately supported to do so.

Local authority strategies around citizenship. We heard a fantastic presentation from the CEO of Oldham Council on the work they have done with their communities to create a partnership around local government services which in turn has led to services being used more appropriately and increased effectiveness of provision available.

In the afternoon we held two 'fishbowl' sessions. The first dealt with **workforce and focused primarily on race equality** and how the NHS could truly become an inclusive organisation. The second focused on **environmental sustainability** and what contribution the NHS should be making to this agenda.

Each member of the Assembly has been asked to join one of the nine work programmes relating to the NHS Long Term Plan

DHSC budget 2018/19

The Department of Health and Social Care (DHSC) avoided breaching its key spending limits in 2018-19, after receiving £600m of additional in-year support from the Treasury. The department's annual accounts, which include the financial performance of all NHS organisations, showed a £646m underspend against its Parliament-approved revenue spending limit, representing 0.005% of the £126bn budget. A separate key spending limit controlled directly by the Treasury would have been overspent without the in-year support. This £124.3bn limit excludes ring-fenced spending on depreciation, and was underspent by just £34m.

With respect to the detail under pinning this result, the provider sector ended the year with a deficit of £571m. This was £177m worse than planned and includes £256m of donated asset income. Without this the end of year position would have been a deficit of £827m. The underlying provider deficit sits at around £5b, which is £700m worse than last year.

Access to GP appointments

Patients are finding it increasingly difficult to see their family doctor as the NHS struggles with record waiting lists and under-pressure A&Es. A third of patients have a problem getting through on the phone to book GP appointments and less than half are able to see their preferred doctor, according to the NHS England annual GP survey of 770,000 patients, which also found that just 57% saw a doctor at a time they wanted to or sooner. One in five people found their doctors' surgery closed when they needed it, with 37% of these turning to A&E instead.

NHS Providers' Chair appointment

NHS Providers has announced that Sir Ron Kerr will take over as the next chair of the organisation on 1 January 2020, when the term of the current chair, Dame Gill Morgan, ends. Sir Ron Kerr's experience spans acute, community and primary care services, as well as mental health and social care, and he has worked in both provider and commissioning organisations.

Carers

A report by charity Carers UK found that unpaid carers are being forced to use their own income or savings to cover the cost of caring for friends or relatives as well as providing significant levels of care themselves. For its *State of Caring 2019* report the charity surveyed over 7,500 people currently providing unpaid care for family or friends. Two in five carers said that they were struggling to make ends meet as they tried to juggle a job with their caring commitments. Many carers have reduced their working hours, turned down promotions, or left work altogether. Over three quarters of carers who reported struggling financially were paying towards the cost of essential care services or equipment for the person they supported. Over half said that they were unable to save for retirement.

NHS collaboration with Amazon

The NHS has teamed up with Amazon to allow people to access information through the AI-powered voice assistant Alexa. The health service hopes patients asking Alexa for health advice will ease pressure on the NHS, with Amazon's algorithm using information from the NHS website to provide answers to questions. The Department of Health said it would empower patients and hopefully reduce the pressure on the NHS by providing reliable information on common illnesses.

Promoting professionalism, reforming regulation: consultation outcome

The government has published its response to the *Promoting professionalism, reforming regulation* consultation, which set out proposals to make professional regulation faster, simpler and more responsive to the needs of patients, professionals, the public and employers. Currently, the professional regulators' operating procedures can only be amended with the agreement of Parliament; the government intends to provide the regulatory bodies with powers to amend their own operating procedures to allow for a more responsive approach to regulation. The government will also bring forward secondary legislation to give all nine regulatory bodies broadly consistent powers to handle fitness to practice cases in a more responsive and proportionate manner. The most significant change will enable regulators to resolve fitness to practice cases without the need for a full panel hearing where it is appropriate to do so.

Local Relevance

Rural hospitals

The first national workshop for acute rural hospitals was held in July. This was very well attended. It was good to see work at DCH mentioned particularly our focus on social value and the benefits to our local economy. The workshop was very good and ended with an agreement to focus on a small number of areas where political influence was most likely. The national team will communicate the next steps in the coming weeks.

NHS Providers have also set a date for the first meeting of the NHS rural hospitals network. This will take place in early September.

Capital Backlog

The fire brigade has warned four NHS trusts that they plan to shut down parts of their hospitals because they are so decrepit that they pose a threat to patients and staff. Management at the four trusts are worried about the disruption to services if the fire brigades follow through on their warnings. They have raised concerns multibillion-pound government raids on the NHS' capital budget in recent years have created a situation where they have been left without the money to fix worsening problems with hospital buildings such as broken lifts and leaks of water and sewage. The overall bill facing the NHS in England to tackle its backlog of maintenance shot up from £5.5bn in 2016-17 to almost £6bn in 2017-18, including £3bn needed to tackle problems that involve a "high" or "significant" risk, of which more than £1bn are problems posing a high risk. NHS England has told trusts to spend 20% less than they planned on capital projects this year in order to help the Department of Health and Social Care stick to its departmental spending limit.

'No deal' preparations

The Department of Health and Social Care plans to spend £3m on 'no deal' Brexit measures to transport medication. It wants to hire an express freight service to transport medicines, blood and transplant tissue. However, experts have warned that the deadline of 1 September set for the deal is a tight timeframe. The government's current plan is to leave the EU on 31 October, with or without a trade deal.

Being Fair Charter

NHS staff are requiring significant amounts of support after being involved in patient safety incidents, prompting a national body to draw up a new charter for how trusts should respond. The *Being Fair* charter has been created by NHS Resolution in a bid to ensure trusts respond to incidents in a way that is fair to both the patient and staff involved, and that errors are not repeated. The charter, which will be issued to trust boards and regulators, recommends that trusts make 20 commitments, including taking the blame out of failure and changing the mindset from blame to learning, while retaining accountability, notifying people who report concerns in a

timely way of steps taken in response, ensuring suspension is rare and never a kneejerk response to an incident, and ensuring that advice given by occupational health workers is followed to help with staff wellbeing. Additional guidance will be published alongside the charter.

Six principles to achieve integrated care

NHS Providers has partnered with Local Government Association, NHS Clinical Commissioners, NHS Confederation, Association of Directors in Adult Social Services, and the Association of Directors of Public Health to produce six principles that underpin successful integration. These principles inform the work of our organisations, helping our partners and members to work across organisational boundaries to plan and deliver person-centred care and support.

NHS inequalities & inclusion research

The King's Fund are researching to find out about experiences as Black, Asian and minority ethnic (BAME) staff within the NHS, particularly so they can learn more about the impact of discrimination on individuals. They would like to hear from NHS staff, anyone working in an NHS organisation, and welcome honest thoughts and reflections. The first step is the survey which should take no longer than 10-15 minutes to complete, based on these responses there will be interviews with 10 participants to gain more insight into their experiences. The deadline to take part is 26 July.

DCH Performance

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

- Inability to meet the NHS operating standards for RTT, cancer and the waiting list size.
- The significant risk of 52 week breaches and harm being caused to patients where waits are excessive.
- Increasing numbers of stranded and super stranded patients.
- Increasing agency costs and a run rate above plan places a risk on the achievement of the Trust control total.
- The Urgent and Emergency Care Board are currently conducting a deep dive into the reasons for these spikes of relentless emergency pressures so that some corrective action can be taken as we approach winter.

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

As a new Prime Minister takes residence in Number 10 the negotiations will continue with the EU around the UK's exit, planned for 31 October 2019. This presents a genuine risk that the NHS will face a 'no deal' exit as it heads into what is going to be the busiest winter it has faced in a generation. Preparations continue across the NHS for a 'no deal' situation, but we do need to be live to the potential risks this may create during such a busy time when demand for supplies is high.

Dorset Integrated Care System

The Dorset ICS has commenced the development of the next iteration of the STP. At a visioning session with local authority colleagues the ICS took the decision to accept the Prime Minister's challenge around an extra five years of health life expectancy. Much of the discussion focused on how this would be achieved whilst at the same time tackling health inequalities across the county. There was also recognition that this may require differential investment across communities.

Some very good news …..

Natalie Harper, Nurse Consultant in the Respiratory Service, was awarded the Queen's nursing award last month. This is a very prestigious award given to someone each year. The title of Queens Nurse has historically and is still predominantly awarded to nurses working within the community, however over the last few years they have recognised the work of those who contribute not just locally but regionally and nationally to policies and who strive to improve care at this level in order to keep patients within their own homes. Natalie's work both locally and within the national committees she sits on, along with the work with stakeholder organisations such as national audits as well as the teaching from diploma to masters level that Natalie undertakes across the country was a part of what led Natalie to being awarded the title. Huge congratulations, well deserved!

Patricia Miller, Chief Executive
July 2019

Balanced-Score Card Performance Report

Report to Board: 31 July 2019

Performance Summary:

June's performance against the four hour Emergency Access Standard (EAS) declined when compared to May. The type one performance for June was 85.9%, the combined types one and three performance was 93.3%. Whilst this performance is below the national standard of 95% it remains above the national average. Crowding in the Emergency Department remains an ongoing risk to patient outcomes and experience. Whilst the number of attendances and ambulance conveyances was at the same levels as in June 2018, the average number of admissions per day increased from 44 to 50 indicating a higher acuity of patients using the service. The increase of admissions was partially mitigated by a reduction in the number of super-stranded patients (patients with length of stay of 21 days or over) from an average of 67 per day in May 2019 to 41 in June 2019. An agreement has been reached for the extension of the Enhanced Domiciliary Care Scheme run by Agincare until 31 October 2019 whilst evaluation of the scheme and exploration of longer term options are being progressed. The RTT constitutional standard was not achieved and the performance was below the trajectory (76.02% versus trajectory of 78.57%), however for the tenth consecutive month there were no 52 week breaches. The most challenged specialities remain Ophthalmology, Trauma and Orthopaedics, Oral Surgery/Max Fax and Dermatology. A paper outlining recovery options for the aforementioned specialties was presented to the July Finance and Performance Committee. It has to be noted that there will be three confirmed 52 week breaches in Orthopaedics as at the end of July 2019 with a potential to incur more if any of the long waiting patients who are booked in July get cancelled for clinical reasons or to accommodate priority trauma cases. Performance against 62 day cancer standard remains over 80%, the latest finalised performance is for May 2019 at 80.74%; June performance will be final in the first week of August and is anticipated to remain above 80%. Performance against 6 week diagnostic standard improved 90.29% and exceeded the improvement trajectory of 84.82% by 5.47%. It has to be noted that there have been significant improvements in audiology, DEXA scanning and neurophysiology. There remains an underlying capacity shortfall for endoscopic procedures which continues to be mitigated by insourcing activity from an independent provider

Main Performance Risks facing the Trust in 2019/20

Quality and Access risks:

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

Financial risks

- The Trust has a shortfall of identified schemes against the annual CIP target of £2m which threatens the deliverability of the financial plan.
- Agency spending in June continues to be in the region of £500k and has been at that level for the third consecutive month. This high level has been absorbed without affecting the financial position in month, and the quarter to date, due to non recurrent slippage but this is not sustainable over the remainder of the year and places the financial control total at risk without corrective action.

Workforce Committee Recommendations

- Agency spend is a focus for the committee and it noted that a task and finish group will work intensively over the next 3 months on this.
- Job planning has largely been completed but the quality of plans needs to be addressed.
- The Equality and Diversity and Gender Pay Gap reports were reviewed by the committee. The Board will be concentrating on these areas in the next six months.

Quality and FPC Recommendations

Escalation from Quality Committee in 24/07/2019:

- The committee commended the excellent results in respect of Infection Prevention Control that was set out in the annual report.
- Dementia screening, electronic discharge summaries and VTE assessments remain a concern and focus for the committee.
- A deep dive into sepsis is planned and will a report prepared for the committee later in the year.
- A lot of work has been undertaken looking at TIA patients.
- The committee received the mortality report and action plan and will be updated on progress on a quarterly basis.

Escalation from FPC:

- The committee reviewed demand and capacity ophthalmology and approved recommendations made.
- The committee noted the pressures on Trust accommodation and the plans in place increase capacity. This risk will be added to the Board Assurance Framework and Corporate Risk Register.

Escalation from Risk and Audit Committee

- The committee focussed on the BAF and Corporate Risk Register. The committee recommended some changes to the BAF to improve visibility of assurance measures.

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	May-19	Jun-19
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	0	0 (0.0)	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	50% reduction by 2021	0 (0.0)	3 (0.4)
	Infection Control - C-Diff Hospital Onset Healthcare Associated and Community Onset Healthcare Associated (Rate per 1000 bed days)	16	2 (0.2)	1 (0.1)
	Never Events	0	0	0
	Serious Incidents declared on STEIS (under investigation)	51 (4 per month)	0	0
	SHMI - Rolling 12 months, 5 months in arrears (Feb-18 to Jan-19)	<1.12	1.20	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-18 to Mar-19)	100	110.0	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	92%	76.6%	76.0%
	RTT Incomplete Pathway Waiting List size	11,991	15,189	15,135
	All cancers maximum 62 day wait for first treatment from urgent GP referral	85%	80.7%	79.0%
	Maximum 6 week wait for diagnostic tests	99%	89.0%	90.3%
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	95%	95.5%	93.3%
Finance	Elective levels of contracted activity (£)	2019/20 = £30,721,866 £2,560,155/month	2,331,578	2,466,976
	Surplus/(deficit) (year to date)	2019/20 = Breakeven YTD M3 = (2,418)	(1,536)	(1,972)
	CIP - year to date (aggressive cost reduction plans)	2019/20 = 7,130 YTD M3 = 1,075	692	971
	Agency spend YTD	2019/20 = 2,929 YTD M3 = 777	970	1,502

Rating Key

Achieving Standard

Not Achieving Standard

INTEGRATED PERFORMANCE REPORT – Exception Reports by Domain

Safe

- **Hand Hygiene compliance** – A slight deterioration has been noted in month. This has been highlighted to the contributing areas for improvement.
- **MRSA Screening** – Elective – General Surgery and ENT are below the standards required. Non- Elective Urology and Cardiology
- **Sepsis:** There has been an improvement for screening and antibiotic administration within 1 hour in all areas, although the standard for antibiotic administration remains below the standard required
- **VTE Risk assessment:** The standard has not been achieved. The prompting of this assessment on the VitalPac system has been discussed with the Medical Director and changes were implemented on 24th June (slightly delayed due to response from company). Repetition of the 'flag' will be removed to assist clinical staff in identifying the need for assessment to be performed and its effectiveness will be evaluated. Therefore new reporting will be seen from July data onwards
- **WHO Checklist –** There has been a slight decrease in compliance with the WHO checklist observed this month; this has been highlighted to the Theatre department for further analysis.

Effective

- **Fracture Neck of femur** – 83.3% of #NOF patients were operated on within 36 hours in June compared to 85.7% in May. Four patients missed the 36 hour target, 2 due to clinical reasons. Two other patients missed the 36 hour target, one due to a clinically limb saving emergency case and the other due excess trauma.
- **Dementia**: Standards required are consistently not being achieved. Ongoing medical engagement and focus upon delirium with Medical Director support.
- **EDS:** Remains below the standard required. Medical Director validation ongoing.

Caring

- **Mixed sex breaches –** All breaches relate to the timely discharge of patients from the Critical Care area to suitable ward beds. Due to capacity and demand this has not been possible within the timescale and the standard has not been achieved.
- **Friends and Family Test –** There has been a slight deterioration in the recommendation rates for the Emergency Department, no general theme has been identified and will be explored further by the Patient Experience Group.

Responsive

The access standards for June 2019 remained challenging with increased emergency activity including trauma, increased elective cancellations and sustained high levels of fast track referrals. Despite the demand challenges there has been sustained performance above 80% against the 62 day cancer standard. Equally the performance against the diagnostic standard exceeded the Trust's improvement trajectory by 5.47%

The following standards were met:

- Cancer 31 day from decision to treat to Surgery
- Cancer 31 day from decision to treat to anti-cancer drug treatment
- Zero 52 week waits

Standards not met:

- ED- 4 hour standard combined with MIU
  - Increase in acuity leading to higher number of admissions
  - Reduction in the numbers of stranded and super stranded patients; executive led long stay PTL meetings have been established
  - System wide work ongoing on demand management and expediting of complex discharges
  - Recruitment to key posts in Emergency Department to improve out of hours resilience
  - Embedding of Integrated Urgent Care and Same Day Emergency Care
  - Implementation of recommendations from peer reviews
- Cancer 62 days referral to treatment
  - Urology, Lung and Colorectal remain the main underperforming specialties
  - Weekly tracking meeting taking place chaired by COO
  - 250K cancer funding to become available in July 2019
- Cancer 2 week wait - all cancers and breast symptomatic
  - Significant month on month growth in fast track referrals, in particular breast, skin and colorectal
  - Exploration of private sector capacity for 2week wait breast appointments
  - Daily capacity escalation
  - Additional ad-hoc clinics and conversion of routine capacity to fast track
- RTT
  - Future risk of 52 week waiters in Ophthalmology and Trauma and Orthopaedics due to the size of the backlog
  - Successful recruitment to a number of vacancies in Ophthalmology and potential to transfer appropriate referrals to a community provider
  - Recovery options for four most challenged specialties presented to the Trust Finance and Performance Committee
  - Waiting list validation in Dermatology with plans to roll out across other specialties
- Diagnostic 6 week wait
  - Significant improvement in performance for audiology, DEXA scanning and neurophysiology
  - Ongoing insourcing of capacity for endoscopic procedures from an independent provider
  - Residual backlog in Urodynamics due to equipment failure in Quarter 4 of 2018/19 (now resolved)

Well Led

Workforce capacity increased by 3.15 FTE in Month 03 and was 110.79 FTE above prior year: the net increase was in substantive staffing numbers. Overall staff costs increased £12k in month, with increased costs in agency and bank staff being partially offset by a reduction in substantive staff costs. Agency spend continues to track significantly above our NHSI cap of 2.6% which has primarily be as a result of staffing escalation capacity and covering vacancies. Staff turnover reduced slightly in month to 8.9% and staff sickness also reduced to 2.99%. Appraisal rates remained at 88% and statutory training compliance also remained unchanged at 87%.

The Trust delivered a year to date deficit in June of £1,972k which is nearly £446k better than plan, although £233k of this variance relates to additional Provider Sustainability Funding received in relation to last year, which will not count against the current year control total. Despite agency spend levels rising in month to over £500k for the first time, the overall pay budget is close to balance due to slippage on staffing investments. Current levels of demand continue to be high and have led to extra capacity provision which is driving over performance on patient care contracts.

Metric	Threshold/ Standard	Type of Standard	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Q1	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)	↔	
Infection Control - C-Diff hospital acquired post 72 hours - Due to lapses in care (Rate per 1000 bed days)	**13**	Contractual (National Quality Requirement) 2018/19	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	N/A	N/A	N/A	N/A	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated and Community Onset Healthcare Associated (Rate per 1000 bed days)	**16**	Contractual (National Quality Requirement) 2019/20	N/A	N/A	N/A	N/A	1 (0.1)	**2 (0.2)**	1 (0.1)	4 (0.2)	↑	**N/A**
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	95.7%	**94.7%**	98.4%	97.5%	**94.1%**	**93.4%**	96.0%	**94.4%**	↑	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	1	0	0	1	0	0	1	1	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	1	0	1	0	1	0	0	1	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	0	**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**	**3**	0	0	**3**	**3**	**5**	**11**	↓	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	**1 (0.1)**	0 (0.0)	0 (0.0)	0 (0.0)	**2 (0.2)**	0 (0.0)	2 (0.1)	↑	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Emergency caesarean section rate			13.8%	21.3%	12.2%	14.1%	11.2%	13.6%	14.3%	13.2%	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	92.7%	**73.1%**	**81.6%**	**75.6%**	92.5%	**71.7%**	91.9%	**84.6%**	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	90.9%	92.1%	**80.6%**	**84.0%**	92.2%	94.4%	97.4%	94.4%	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**80.8%**	100.0%	100.0%	**87.0%**	91.3%	**86.2%**	**54.2%**	**77.6%**	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**73.7%**	**75.0%**	**60.0%**	**73.2%**	**78.0%**	**75.0%**	**85.3%**	**79.6%**	↑	
Effective												
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	**1**	**1**	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**<1.12 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	**1.20**	**1.20**	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**116.7**	**114.6**	**112.2**	**110.0**	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**111.1**	**112.0**	**109.4**	**105.1**	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	B	C			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)	**70.8%**	**66.2%**	**51.4%**	**60.5%**	**62.8%**	**64.3%**	**47.0%**	**57.9%**	↓	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	96.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	Contractual (Local Quality Requirement)	**48.0%**	**47.8%**	**64.7%**	**51.2%**	**86.4%**	**62.9%**	**62.5%**	**68.5%**	↓	
Caring												
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	23	29	43	28	30	29	24	83	↑	
Complaints - Percentage response timescale met (1 month in arrears)	**Dec '18 = 95%**	Local Trajectory	95.0%	100.0%	100.0%	100.0%	100.0%	97.0%	N/A	N/A	↓	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	99.7%	99.1%	99.1%	99.5%	98.4%	98.5%	98.7%	98.5%	↑	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	86.5%	85.0%	**82.4%**	85.0%	**82.3%**	84.5%	**83.0%**	**83.2%**	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	94.5%	94.1%	**93.9%**	94.6%	**91.7%**	94.5%	**93.9%**	**93.4%**	↓	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	**15**	**14**	**26**	**18**	**22**	**18**	**14**	**54**	↓	

Metric	Threshold/ Standard	Type of Standard	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Q1	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)	**79.0%**	**78.4%**	**77.5%**	**76.1%**	**75.1%**	**76.6%**	**76.0%**	**76.0%**	↓	
RTT Incomplete Pathway Waiting List size	**11,991**		**13,807**	**13,793**	**14,292**	**14,532**	**15,179**	**15,189**	**15,135**	**15,135**	↑	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	94.9%	95.0%	**92.4%**	**80.2%**	**68.7%**	**61.8%**	**75.7%**	**68.3%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**79.3%**	100.0%	**80.0%**	**21.9%**	**3.6%**	**4.5%**	**37.5%**	**8.6%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	99.1%	99.2%	98.9%	100.0%	100.0%	100.0%	**95.7%**	98.7%	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**88.9%**	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%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	100.0%	-	-	-	-	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	86.0%	**82.2%**	**78.4%**	**79.5%**	**83.5%**	**80.7%**	**79.0%**	**81.1%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	100.0%	**88.9%**	**87.5%**	100.0%	94.1%	93.3%	**72.7%**	**88.4%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**82.8%**	**82.0%**	**87.3%**	**89.9%**	**88.2%**	**89.0%**	**90.3%**	**89.2%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**89.6%**	**87.0%**	**82.8%**	**82.8%**	**78.3%**	**90.4%**	**85.9%**	**84.8%**	↓	
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)	**94.8%**	**93.5%**	**91.4%**	**91.5%**	**89.5%**	95.5%	**93.3%**	**92.8%**	↓	
Well Led												
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		54.31%	32.76%	50.00%	50.86%	36.21%	46.55%	N/A	N/A		
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	4.14%	4.5%	3.5%	3.1%	3.2%	3.0%	N/A	3.10%	↑	
Appraisal rate	**90%**	Internal Standard reported to FPC	**82%**	**85%**	**86%**	**87%**	**88%**	**88%**	**88%**	88%	↔	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.9%	8.8%	8.7%	8.5%	8.8%	8.8%	8.9%	8.8%	↓	
Total Workforce Capacity	**2,630.0**	Internal Standard reported to FPC	2,355.6	2,376.3	2,368.9	2,376.4	2,392.9	2,423.1	2,430.4	2,415.5	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	3.8%	3.0%	3.3%	3.0%	**6.1%**	4.9%	**7.6%**	N/A	↓	
Total Pay Cost	**10,420.1**	Internal Standard reported to FPC	**9,832.9**	**10,069.7**	**9,842.0**	**9,991.1**	**9,583.1**	**9,287.4**	**9,181.3**	**9,350.6**	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	0	0	0	0	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**84%**	**86%**	**87%**	**87%**	**87%**	**87%**	**87%**	**87%**	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**1,944**	2,522	**2,066**	2,512	**2,328**	**2,378**	**2,415**	**7,121**	↑	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£1,941,887**	**£2,086,190**	**£1,904,757**	£2,573,187	**£2,219,213**	**£2,331,578**	**£2,466,976**	**£7,017,767**	↑	
Surplus/(deficit) (year to date)	**2019/20 = Breakeven YTD M3 = (2,418)**	Local Plan	(5,679)	**(6,494)**	**(7,328)**	**(8,029)**	(879)	(1,536)	(1,972)	(1,536)	**N/A**	**N/A**
Cash Balance	**2019/20 - 1303 M2 = 3978**		10,453	9,672	7,728	3,536	7,738	8,348	7,700	7,700	↓	
CIP - year to date (aggressive cost reduction plans)	**2019/20 = 7,130 YTD M3 = 1,075**	Local Plan	**2,677**	**3,530**	**4,325**	**5,060**	379	**692**	**971**	**692**	**N/A**	**N/A**
Agency spend YTD	**2019/20 = 2,929 YTD M3 = 777**		**2,733**	**3,223**	**3,588**	**4,160**	**482**	**970**	**1,502**	**970**	**N/A**	**N/A**
Agency % of pay expenditure	**2019/20 = 2.3%**		**3.6%**	**4.9%**	**3.3%**	**5.5%**	**4.5%**	**4.7%**	**4.8%**	**4.6%**	↓	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Title of Meeting	**Trust Board**
Date of Meeting	**31st July 2019**
Report Title	**Integrated Care System (ICS) Summary**
Author	Nick Johnson
Responsible Executive	Nick Johnson – Director of Strategy, Transformation and Partnerships

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

1. Summary

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

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

2. Quality Report (Appendix A)

- SWAST call-stacking remains high and ambulance handover delays are increasing in prominence with NHSI/E providing a support programme to DCH and RBH to address;
- Initial Health Assessments for looked after children remain variable with standards not being met by the LAs;
- All Trusts are not meeting the Level 3 Safeguarding Children Training; and
- DCH comparative performance against SHMI and mixed-sex breaches is highlighted.

3. Performance Report (Appendix A)

- DCH ED performance in May was 95.5%, RBH 92.8%, PH not available.
- ED attendances at DCH were up by 5.5% compared to contract plan in May, compared to 7.4% RBH and 1.1% PH.
- Conveyances were up 0.7% at DCH compared to previous year and 1.3% PH and 1% RBH.
- Delayed transfers of care at DCH were up by 6.7% in April compared to 3.5% in Poole and 2.7% in RBH.
- DCH RTT and diagnostic performance continues to track below PH and RBH. DCH waiting list has increased by a further 4.5% from March to April 19 compared to 1.6% and 0.9% for PH and RBH.
- Outpatient attendances versus contract plans ytd are up by 11.9% at DCH compared to reduction of 9.8% PH and 1.9% RBH.
- GP Referrals compared to previous financial year to date at DCH is down by 0.8% compared to a 1.8% reduction at RBH and PH 7.2% reduction.
- Cancer (April 2019) 2 week wait is 68.7% compared to 93.4% (PH) and 94.5% (RBH) and 62 day standard is 84.7% compared to 84.5% (PH) and 85.9% (RBH).
- In April 2019 Dorset Healthcare had 91.6% Occupied Beds. This is the same as the February figure.
- NHS 111 calls were up by 4.4% in May compared to previous year
- ICPCS recruitment against target was at 64.3% and Improving Access to GP surgeries was at 75% utilization (i.e 25% shifts unfilled).

4. Financial Report (Appendix B)

- Overall system on plan in May and will achieve provider sustainability fund
- Forecast on plan for year end albeit with significant cost pressures and £13.9m of unidentified savings for 19/20
- Most significant risks are; Personal Health Commissioning costs; non-delivery of individual or system control total; non-delivery of demand management.

- DCH is flagged as Red risk on liquidity
- There is a requirement for NHS provider capital plans to be resubmitted with a 20% reduction in system spend for 19/20

5. Sustainability and Transformation Plan Report (Appendix C)

5.1 Dorset Clinical Networks:

Pathology:

- Clinical leadership is being reviewed in line with the agreed plans for the move to One Dorset Pathology. This looks to develop cross site, discipline specific leads for each of the four main areas within Pathology (Biochemistry, Haematology, Microbiology and Cellular Pathology).
- Pathology IT replacement programme (LIMS) is reaching the end of the due diligence with the aim to get contracts and collaboration agreements ready for sign off by the end of August.
- Value engineering exercises relating to the pathology hub continue to review the options which will be presented to the Pathology Board later this month.
- Evaluation of the OJEU tender for the replacement of all equipment in pathology continues.

Radiology:

- The new pan Dorset CT scanner will go live for all Dorset patients on 12th August 2019. Majority of the logistics for booking and scanning are in place. Productive lung cancer pathway meeting held on 15th July 2019. The image sharing IT solution was discussed at this meeting. The specification is ready to go out to test the market and get actual costs. JK from RBH is leading the tender with CCG procurement manager located at RBH.
- Report from external review of Dorset Medical Physics has been released and will help inform next steps to redesign services.
- ISAS now rebranded as Quality Standard for Imaging. DHUFT have their assessment visit booked. DCH decision to delay until early 2020 to allow for some internal work on reporting KPIs but QSI principles and improvement work will continue.
- Joint procurement of Out of Hours reporting using existing supplier completed – savings of £22K / annum expected due to benefits of scale from joint procurement. DCH to go ahead with a short term contract and realise £7000 saving.

Stroke:

- Dorset eFAB TIA clinic appointment booking system will enter test phase in July 2019, scoping to ensure it can include either 5 trusts over three counties or two 'compartments' East/West is underway.
- PDSA cycles to test modelling of stroke patient flow across Dorset with proposed single HASU for East Dorset ongoing.
- Practicalities of DCH joining the current East Dorset / Salisbury based rotational weekend service being explored.

Haematology:

- Myeloma mapping and to be confirmed by DCH consultants prior to pan Dorset agreement and further steps agreed with Trust clinical leads.
- Lymphoma Risk Stratification Follow up initiative – invite to present at October CRG meeting.
- Setting up meeting to progress with additional deliverable – to consider the potential of expanding Haematology community clinics within West Dorset (Abi Orchard DCH).

Rheumatology:

- Pan Dorset Rheumatology Service dashboard on Power BI under development.
- Template for production of standardised disease guidelines for new network approved – pan Dorset guidelines for now being developed collaboratively by clinicians from all sites.
- Final team now agreed to join eA&G - Ongoing monitoring of impact of adoption of eA&G and new rheumatology triage pathway – significant improvements maintained.
- Planning for whole team Staff engagement event Sept 19 with Workforce team continues.

Maternity:

- The LMS delivery plan for 2019/20 has been approved and submitted to NHSE National Team. This has been accompanied by the LMS investment plan for this year Colleagues from NHS's regional team joined the LMS Strategic Board meeting in June. The feedback was extremely positive and the Dorset LMS was congratulated on the progress being made.
- The proportion of women in Dorset who were breastfeeding at the time of discharge from midwifery to

health visiting has increased from an average rate of 14.3% in 2017/18 to 40.4% in the first three quarters of 2018-19. It is difficult to attribute this to any one single change and the LMS will review the initiatives implemented across Midwifery and Health Visiting in the past year to understand success factors to increased rates.

- The Maternity Digital Project Board will meet in July with a view to make a decision to initiate the procurement process for single maternity I.T solution Pan Dorset.

5.2 Integrated Community & Primary Care Services

- Dementia Services Review Stage II NHSE Assurance complete.
- Eighteen PCN applications providing 100% geographic coverage were submitted by the 15 May 2019 deadline and approved by the CCG panel. The PCN Directed Enhanced Services is due to go live from 1 July 2019. Each PCN has appointed a Clinical Director.
- Award and mobilisation of the 'Health Coaching and Social Prescribing Service' contract.
- Activity data to date shows over 1,200 personal health budgets and integrated personal budgets in Q4 of 2018/19, which exceeds the 2018/19 target.

5.3 Prevention at Scale

- Collaborative practice: Over the last quarter a second Leadership Programme has started with 19 participants representing 8 practices across Dorset. These participants have met 3 times to date and the first Practice Health Champion workshop was held at the beginning of June.
- A record high 6,600 people used the LiveWell service during the last year, bringing the total of number supported to more than 25,000.

5.4 Digitally Transformed Dorset

- Updates are being planned for CRG and OFRG. The IWP programme has picked up recognition across the South West with Devon and Cornwall asking for architectural details so they can copy the concept and Somerset are currently interested in options to buy into the solution that have been developed.
- Funding is currently the single largest risk this programme faces.
- Process for System Digital Requests within Dorset has been designed, with accompanying mandate and evaluation template. This has been circulated with the Digital Board (Dorset Informatics Group), ready for comments and approval.

5.5 Leading and Working Differently

- Nursing, AHP & Pharmacist coaching faculty fully recruited – training commences June 2019.
- Proactive engagement with partners and maximised usage of the Our Dorset Development Hub

5.6 Integrated Travel Programme

- The TRG have not been meeting so the project has been paused, however a new Programme Manager has been appointed by Dorset Council and will recommence the paused work within the ITP agenda.

5.7 Engagement

- "Stronger Voices" meeting on 13 March 2019. A meeting of over 100 public and voluntary sector representatives was held to update people on the delivery of integrated health and care services across Dorset, in line with both the CSR outcomes and the NHS Long Term Plan.
- Extensive engagement and consultation regarding future models for service provision in Dorset was carried out across Dorset's Clinical Services Review (CSR) (2014-2017). The aspirations of the Long Term Plan (LTP) will be delivered in line with the agreed outcomes of this review.

6. Long Term Plan Development (Appendix D)

The NHS Long Term Plan Implementation Framework was published in July. Each ICS/STP is required to submit a local 5 year plan in draft by September and final version in November.

The Our Dorset LTP Planning Group is coordinating the production of the Our Dorset LTP. A workshop with SPB and SLT members was held in June and from this the a Vision, Outcomes and Themes were drafted. The aspiration is for the Dorset LTP to focus on wider well-being and social determinants of health in recognition that in the long-term creating healthier communities is the best solution to the challenges the health and care system faces. This will require a shift away from medical model focus to a place-based, asset driven approach to health and well-being and a need for the NHS and Local

Authorities (not simply social care) to work much more closely together. It is also DCH's aspiration to ensure that Social Value impact is recognised within the LTP. Currently the two key issues for the Dorset LTP are: • The integration of LAs within the production process; and • The ability to assess the impact of initiatives and interventions to date and to identify the impact of planned initiatives and interventions Public and staff engagement is currently taking place to seek feedback on the proposed themes and focus of the plan.	
Paper Previously Reviewed By Appendices reviewed by System Leadership Team	
Strategic Impact DCH has developed a strategy focused on integration and collaboration and is therefore currently committed to the development of the ICS.	
Risk Evaluation ICS activity and involvement is currently delivering variable benefit to DCH and DCH must balance system focus and transformation with organisational focus and transformation.	
Impact on Care Quality Commission Registration and/or Clinical Quality DCH retains all CQC and quality obligations as an organisation	
Governance Implications (legal, clinical, equality and diversity or other): As the ICS governance matures there will be an increasing expectation for 'decisions' to be made at ICS level and endorsed at the statutory/organisational level.	
Financial Implications DCH retains an individual control total, within a wider system control total.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	It is recommended that Trust Board: a) note and comment on the report b) identify any issues to be raised with the ICS System Leadership Team

Title of Meeting	Board of Directors
Date of Meeting	31 July 2019
Report Title	NHSI Mortality Governance Review and Action Plan
Author	Alastair Hutchison, Medical Director
Responsible Executive	Alastair Hutchison, Medical Director

Purpose of Report (e.g. for decision, information) For information.	
Summary update: The Trust continues to closely monitor mortality indicators in line with the recommendations from NHS Improvement who undertook a Governance Review in March 2019. An action plan has been constructed to address the recommendations outlined in that report.	
Paper Previously Reviewed By Executive Team Quality Committee 23 July 2019	
Strategic Impact It is likely that NHSI and/or CQC will visit DCH again before year end to review progress. Failure to action the recommendations would have a significant negative impact on DCH reputation and credibility.	
Risk Evaluation • The data quality issues related to clinical coding are affecting our ability to make inferences on the quality of care. • Although other indicators of care quality are not causing concern, the high SHMI is the one believed by the public to relate most directly to mortality • Reputation risks due to high SHMI • Potential clinical safety issues could be masked by the issues related to data quality	
Impact on Care Quality Commission Registration and/or Clinical Quality The elevated SHMI has raised concerns from both NHS Improvement and the CQC during recent visits to the Trust. Fortunately a full explanation of our actions to date, including analysis of a wide variety of other care quality indicators, and renewed focus on Structured Judgment Reviews has assured them that care at DCH is safe, and that we understand the problem.	
Governance Implications (legal, clinical, equality and diversity or other): The mortality reports and other metric related to quality of care should be monitored and used as a tool for continuous improvement and assessment of clinical safety. Divisions will be accountable for implementing the action plan.	
Financial Implications Loss of confidence in Trust safety could result in fewer referrals.	
Freedom of Information Implications – can the report be published?	No

Recommendations	For the Board to note and review progress.

Mortality Governance Review

Dorset County Hospital NHS Foundation Trust - Q4 2018-19

NHS England and NHS Improvement

Contents

Background.....**Error! Bookmark not defined.**

National changes to mortality that influence DCH **Error! Bookmark not defined.**

NHS Improvement support .....**Error! Bookmark not defined.**

National mortality statistics 3

Methodology 3

Findings 4

Conclusions 7

Recommendations 8

Appendix A – Potential agenda for Hospital Mortality Group meeting 10

Mortality Governance Review

Background

Dorset County Hospital is the single site acute hospital run by Dorset County Hospital NHS Foundation Trust (DCH). The hospital provides acute and some community services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. Services are also provided for renal patients throughout Dorset and South Somerset to a total population of 850,000.

Dorset County Hospital has approximately 400 beds including 32 maternity beds and eight critical care beds. There are seven main theatres and two theatres used for day surgery. Full emergency department services including critical care (the hospital has trauma unit status) are provided. A full range of services are available including; acute and elective (planned) surgery and medical treatments, outpatients, services for older people, acute stroke care, cancer services and pharmacy services. The hospital has comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal and postnatal care. There is a level one special care baby unit and children's services include emergency assessment, inpatients and outpatients.

For the past four years, the trust has flagged as having higher than expected Summary Hospital-level Mortality Indicator (SHMI). Over a similar time period, the trust has also seen a decline in the Hospital Standardised Mortality Ratio (HSMR), up to December 2017. Since then, there has been a rise in HSMR, culminating in being higher than expected for the 12-month period to September 2018.

The trust has outlined that the reason for the increase in both national mortality indicators is not a deterioration in the quality of care but issues with coding. As Executive Director for mortality, the Medical Director has been keen to demonstrate this and has put in place a number of measures to strengthen the mortality position. In order to support this work, the NHS Improvement (NHSI) sub-regional team, in conjunction with Dorset Clinical Commissioning Group (DCCG) have undertaken a governance review of mortality at the trust.

National changes to mortality that influence DCH

The National Quality Board Learning from Deaths guidance, published in March 2017, sought to improve mortality governance. The upcoming requirement (from April 2019) for acute trusts to begin to introduce Medical Examiners will also support learning from deaths.

NHS Improvement support

The NHSI sub-regional team has provided mortality oversight support to the trust for the past two years. This support has been via targeted meetings with senior management responsible for the management of mortality, to understand the drivers of the increase in both national indicators as well as a review of the trust Hospital Mortality Group (HMG) in August 2018.

National mortality statistics

Both SHMI and HSMR require careful interpretation and should not be taken in isolation as headline figures of trust performance. Both are best treated as a 'smoke alarm'. SHMI and HSMR provide indications of whether individual trusts are conforming to the national baseline of hospital-related mortality. Mortality within a trust is described as either 'as expected', 'lower than expected' or 'higher than expected'.

Trusts who have values 'higher than expected' are required to investigate to identify any underlying causes as to why this may be and action any changes as appropriate.

Methodology

The aim of this review was to:

- review the robustness of the trust governance structure in place to identify any quality of care issues;
- review the corporate governance approach to mortality.

To achieve this, a range of approaches were followed. These were:

- Desktop reviews of both corporate and divisional information;
- Attendance at the trust Hospital Mortality Group meeting on 20 March 2019;
- Meetings with trust staff who are integral to the mortality process, namely:
  - Trust Medical Director;
  - Interim Chief Information Officer;
  - Deputy Director of Nursing;
  - Consultant Nurse responsible for quality improvement;
  - Clinical Coding Manager and members of the clinical coding team;
  - Junior doctors involved in the morbidity and mortality (M&M) meetings;
  - Clinical Chairs of local M&M meetings;
  - Non-Executive Director for Quality.
- Triangulation of the national picture in relation to mortality and how this is reflected by the work the trust has implemented over the past two years.

Findings

The information supplied by the trust describes the mortality governance structure. The NHS has adopted the concept of 'ward to Board' oversight of issues. As no ward-based data is available, mortality governance follows the principle of 'specialty to Board' oversight.

It is for the trust to determine how it governs mortality from speciality to Board. The introduction of the *Learning from Deaths* (LfD) process in 2017 was an attempt by the NHS to standardise casenote reviews (via structured judgement review [SJR]) and subsequent reporting of the findings of these reviews within organisations. Prior to this, trusts undertook local morbidity and mortality (M&M) meetings and followed guidance from Royal Colleges (if available) to establish any learning from those patients who had died. There was no standardised process.

Since the introduction of the SJR process, trusts now have an approved, systematic method to identify and pass on learning from reviews. This can be undertaken in a number of ways, dependant on the culture of an organisation. If a strong quality improvement (QI) culture exists, trusts may wish to discharge their learning from SJRs via well-established QI processes (should the learning warrant this approach). If QI is not as embedded but a trust has a strong governance culture, the trust may wish to follow this route to ensure that learning is disseminated.

The remainder of this report highlights the areas of good practice and areas for improvement that the trust may wish to consider.

Areas of good practice

- The trust Board reviews an LfD report every three months which meets the national standard.
- HMG has good senior management attendance with clear and appropriate engagement from the executive directors.
- Findings from SJRs are shared in the reports to the trust Quality Committee.
- The non-executive director who chairs the Quality Committee is experienced and provides the necessary challenge to the Executive on mortality issues.
- The Medical Director's Audit of Standards of Care (31 January 2019) gives good assurance that overall care and treatment is safe and of a good standard. The report contains a number of recommendations which would support further improvement in the mortality processes within the trust.
- There are early signs at the HMG of triangulation of other quality information for example Intensive Care National Audit & Research Centre (ICNARC) information.
- A pilot is in place to use DATIX to record the findings of SJRs. The effective capture of SJR results is vital to improve the dissemination of learning.
- Mortality is detailed on the Corporate Risk Register and offers a line of sight on the issue and the timeline for improvements.
- A contract has been established with Dr Foster to provide external resource to support mortality monitoring and will include attendance at the HMG.

- Very experienced clinical coding manager who has a clear plan to improve coding throughout the trust. These plans include the introduction of higher graded coding leads to support improvement in coding standards. Training is available through foundation courses, refreshers and workshops.
- The clinical coders attend the in-patient wards each morning to review notes of discharged patients and have opportunities to discuss cases with doctors in training and nursing teams where clarification is required.
- The trust's QI plan has been submitted to the Board and provides an overview of current themes and highlights emerging themes for improvement using a QI approach.
- The Medical Director confirmed there was a training programme for Clinical Directors planned to start in April / May 2019 to support development in the role.
- Overall the Family Services and Surgical Division is further ahead with M&M included as part of the clinical governance meetings or as stand-alone. All deaths are reviewed by the Division. There is a Divisional learning bulletin which is circulated to all staff which has included learning from incidents as well as SJRs. Sepsis related SJRs from the Division are shared with the Sepsis Steering Group.
- The Clinical Director from the Urgent and Integrated Care Division gave an example from the Respiratory Department where there is a multi-disciplinary monthly meeting on the ward to review SJRs and M&M. This feeds into the formal quarterly M&M meeting to discuss cases in more depth. The minutes of these meetings are made available and learning is shared widely within the Division.
- The trust is considering new models of care where specialty consultants are working more closely with primary care clinicians in the community. An underpinning principle of this is a unified strategic approach that would support patients' agreed treatment and escalation plans.
- There are trust and divisional level quality and safety dashboards provided by Business Intelligence (BI) to share relevant information regarding mortality.
- The Clinical Audit Lead gave an example of Heart Failure Nurse Specialists who were working with the coding team to specifically improve the quality of information, to support the information baseline to measure improvement.
- The trust is represented at the pan-Dorset Mortality review meeting by the Medical Director. This meeting brings together the leads for mortality across Dorset to discuss best practice.
- Under the leadership of the Medical Director, the trust has been proactive in preparing for the introduction of the new Medical Examiner roles. This puts the trust in a good position when the role starts to be become operational from 01 April 2019.
- The trust has been actively engaged in the wider regional discussions on improvements to mortality and remains committed to continuing in this way.

Areas for improvement

- Quarterly Board reports should contain a balance of information and narrative which describes the learning from mortality reviews and how this is translated to QI.
- In the current governance structure, SJRs are reported to the Hospital Mortality Group and QI plans to the Quality Committee. There is a need to join these to ensure that learning is fully embedded in improvement at trust wide level.
- Whilst there are early signs of the triangulation of quality and mortality information at the HMG, each meeting would benefit from a tabled sub-set of QI information relating to mortality. This will draw together all the strands of work that relate to mortality.
- The trust Learning from Deaths policy is being reviewed and clinical governance requirements for M&M meetings should be included in the next version. Consideration should be given to the recommendations from the Medical Director's Audit in this document along with a clear link to the overall QI Plan.
- QI as a whole was not as visible as expected. Whilst QI is undertaken across the trust, utilising the Institute of Healthcare Improvement (IHI) methodology, there appears to be a lack of coordination of QI activity.
- Not all the relevant deaths are reviewed in a timely manner by the Urgent and Integrated Care Division. This leads to delays in the implementation of learning from SJRs.
- Local M&M processes are inconsistent. There were some good examples, but no consistent standard is in place across the trust.
- Trust level performance in relation to SHMI and HSMR was not understood at Speciality level. There is a BI analyst working in each Division, however this role appears to need to develop to ensure information from speciality to Board level is shared and used to inform improvement.
- The conclusion from the review of divisional and specialty papers, is that the route from specialty to Board of mortality information is unclear. Specialties are undertaking M&Ms, but these are not always structured and the outputs are not well defined. There was no evidence that this information is then aggregated to divisional level and then on to the Board via the corporate route described in the governance arrangements of the trust.
- Junior Doctors are not receiving consistent induction to the trust. Standards for documentation are not always clarified and there is little or no introduction to the QI plan. The junior doctors we met described clinical audits they were engaged in. The website, with supporting information for clinical audit and QI, was described by the junior doctors as confusing, however the audit team were reported as being very helpful. It is noted that, during feedback from this review to executives, it was confirmed that the trust had identified that there was no trust Clinical Lead for QI and this was being actively discussed.
- There was a clear link between quality of information on electronic discharge summaries, depth of coding and the overall position for the trust in relation to SHMI and HSMR. Coders confirmed that where they are short of staff, they have

concentrated on coding in detail the episodes where a procedure is performed i.e. surgical interventions. The unplanned medical episodes are mainly coded using only the Electronic Discharge Summaries (EDS).

- There is limited opportunity for the coders to give feedback to clinical teams on standards of documentation and irregularities that have been noted. Examples were given where, during a patient episode in orthopaedics, the affected limb of a patient alternated between left and right in the notes and it was not clear to the coder which was the correct side.
- Staff reported inconsistent cultures in different specialty teams in relation to the completion of the EDS. Some teams are diligent and expect that discharge summaries are prioritised in the workload and some are not; quality of this documentation therefore varies hugely.

Conclusions

The causes for higher than expected SHMI and HSMR are multi-factorial and therefore the effective management of mortality is complex.
The remainder of this report details recommendations with the aim of improving mortality governance at the trust. Whilst there are clearly a number of actions in relation to coding that the trust has in hand, there are similar improvements in the governance of specialty level mortality meetings and trustwide QI that will have an equally positive impact on improving both SHMI and HSMR.

Recommendations

The following recommendations are provided in response to the findings of this report:

No.	Recommendation
1	**Setting the corporate expectation on mortality review** The trust should be clear on how it expects improvements in mortality to be managed and reported, at both the corporate level and within divisions. This should be detailed in trust policies and procedures.
2	**Board reporting on Learning from Deaths** As more information becomes available, future reports should contain more detail around the learning from Structured Judgement Reviews (SJRs). The report should also contain the performance measures detailed in the trust policy on Learning from Deaths. This will allow the Board to track and monitor mortality robustly. It should also be recognised that the report is written for the general public and therefore the language used should reflect the lay reader.
3	**Learning from Deaths policy** The policy should be updated to reflect the incoming Medical Examiner requirements.
4	**Hospital Mortality Group** Whilst there are early signs of the triangulation of quality and mortality information, each meeting would benefit from a tabled sub-set of quality improvement (QI) information relating to mortality. This will draw together all the strands of work that relate to mortality. Appendix A offers an example of potential agenda for the HMG that will meet this requirement.
5	**The Coordination of Quality Improvement Activity** QI as a whole was not as visible as expected. Whilst QI is undertaken across the trust, utilising the Institute of Healthcare Improvement (IHI) methodology, there appears to be a lack of coordination of QI activity. The trust should consider appointing a clinical lead for QI and developing a 'hub' to coordinate activity. The benefit of this would be that all QI activity (not just mortality-related) would be clearly visible and easily accessible to clinical teams. One direct benefit is that doctors in training could undertake QI projects as part of their training that align with the trust's QI strategy and priorities.
6	**Divisional, Care Group and Specialty Governance of Mortality** The trust should ensure that mortality is robustly discussed at specialty, care group and divisional governance meetings. The trust should also mandate that Morbidity and Mortality (M&M) meetings are held in each relevant specialty. The corporate mortality team should provide templates for M&M meetings that follow relevant Royal College guidance and include how the outputs from these meetings are progressed through the mortality governance structure. There should be a clear expectation on how learning from the meetings is disseminated throughout the specialty, especially

No.	Recommendation
	to those staff who were not present. Specific, tailored and relevant mortality information should be supplied to each meeting, this should include the specialty position regarding SHMI and HSMR and learning from SJRs.
7	**Assuring the quality of SJRs** The trust should consider its approach to assuring the quality of SJRs. One suggestion is that a group of those staff involved in undertaking SJRs could be convened to discuss specific cases, to ensure that all reviewers concur on the findings.
8	**Clinical coding** The trust Board has shown its commitment to improving clinical coding by significantly increasing the finance available for staff resourcing. The trust now needs to deliver on this investment by investing in the coding team in terms of numbers of coders, team development and integration with specialty teams.
9	**Clinical quality measures** NHSI uses a number of clinical quality measures to assess the effectiveness the quality of care at trusts. The measures closely related to mortality are sepsis, venous thromboembolism (VTE), Acute Kidney Injury (AKI), the deteriorating patient (NEWS2), Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) planning and four-hour wait performance in the Emergency Department. These measures are reported to the Board via the Integrated Performance Report (IPR). The metrics described above should be available at each HMG meeting and then cascaded to the relevant Divisional/Care Group/Specialty meetings to ensure that this sub-set of information is reviewed through the lens of patient care quality concerns and mortality improvement.
10	**Internal Audit** Due to the risks associated with having reported higher than expected mortality, the trust should consider engaging internal audit to review its specialty to Board processes in 2019/20. This should be in the latter half of the financial year to allow the recommendations of this report to be implemented.

Appendix A

Potential agenda for Hospital Mortality Group meeting

Agenda item	Who
1. Welcome and apologies	Chair
2. Minutes of the previous meeting	Chair
3. Actions from the previous meeting	Chair
4. Review of Trustwide mortality metrics – SHMI and HSMR Description of the current position against SHMI & HSMR – high level breakdown of those areas that are alerting (from whichever system the trust uses). Are there any alerts from the CQC and if so what is this telling the trust? The report should cross reference with trust-wide quality metrics that have a bearing on mortality (e.g. VTE, deteriorating patient; DNAR; sepsis AKI etc.) and detail any issues highlighted from other committees of relevance e.g. ELOC; Resus etc. If a national or local clinical audit has an element related to mortality (e.g. ICNARC) how are the results of this audit fed into the overall picture of mortality? Review of the latest trust dashboard or report to Board, which should include a comment on whether those reviews detailed in the trust policy have been undertaken.	Head of Business Intelligence & Head of Quality Governance
5. Coding Review of coding action plan. Report on any issues in relation to coding (staffing, expertise; working processes etc.)	Clinical Coding Manager
6. Feedback from Divisions on death review processes (SJRs) Each Division to give an overview of the following themes: **PROCESS** – position on progress with SJRs. Are all Inpatient deaths being triaged as per policy? Are a random sample of triaged deaths being audited to ensure the quality of onward SJR review? Is there a backlog of SJRs? If so why and what are the plans to remedy? Are there sufficient trained staff? Statement on the Division's position as to the quality of SJR review to include any random checks made. Statement on how this is fed into the Divisional Governance meeting. **OUTCOME** – High level review of the learning from SJRs. What actions have the Division taken considering the findings from SJRs? How are these actions recorded? How confident is the Division that the actions are embedded (to include how they did this)?	Clinical Directors
7. Quality Improvement	Head of QI

	Review of quality improvement activities that have been instigated from the actions highlighted in item 6. Position statement of how the improvement projects are progressing and what support has been offered.	
8.	**Any other business**	Chair

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

ACTION PLAN developed from

NHSI Mortality Governance Review

Inspection Date

13th – 20th March 2019

Reference Key				
	DOMAIN	CORE SERVICES		
MD = Must Do	S = Safe	Med = Medicine	U&E = Urgent and	CYP = Children
SD = Should Do	C = Caring	Inc. Older People	Emergency	and Young People
	E = Effective	MAT = Maternity	SUR = Surgery	OPD = Outpatients
Reg - Regulation	R = Responsive	GYN = Gynaecology	CC = Critical Care	DIAG = Diagnostics
	WL = Well-led	TW = Trustwide	EOL = End of Life	
DD – Divisional Director CD – Care Group Clinical Director				

RAG Key			
Recommendation	Green = Recommendation action complete	Amber = Recommendation action in progress	Red = Recommendation action not fully development
Assurance	Green = Full assurance met	Amber = Partial assurance met	Red = No collated assurance met

TRUST-WIDE

No.	Our Ref	Recommendation	Domain/ Reg	Action required to meet recommendation	Target Completion Date	Lead Manager / Exec Lead	Evidence	Assurance
1		**Corporate expectation on mortality review** DCHFT should be clear how it expects improvements in mortality to be managed and reported at corporate & divisional level. This should be detailed in Trust policies and procedures.	Safe Effective Well-led	Learning from Deaths policy to be updated and amended. Cross reference with other policies as appropriate. The revised policy will incorporate the role of the newly appointed Medical Examiners and stipulate: • SJR targets • Frequency and best practice in conduct of Morbidity & mortality Meetings • Reporting structures and dissemination of findings within Care Groups, Divisions and to Executive team • Provision of Dr Foster data to Care Group and departmental level	**31st July 2019**	Alastair Hutchison	Policy approval at Execs Meeting, Quality Committee and Trust Board	Feedback from Execs and Board

Current status:
In Progress:
1.

Complete: 1.								
2		**Board reporting on Learning from Deaths** Future reports should contain more detail on learning from SJRs. Report should contain performance measures detailed in the Trust policy on Learning from Deaths. Board to track and monitor mortality robustly. Language used should reflect the lay reader.	Safe Caring Effective Responsive Well led	Future Board reports to incorporate appropriate narrative and metrics, suitable for the lay reader for publication on DCH internet site Presentation to Quality Committee and Board every quarter, then publication.	**Next Board report 31st July 2019**	Alastair Hutchison	On-line publication every quarter, with readability feedback sought from Trust Governors and specific Trust staff groups.	Identification of themes and production of QI projects to address these
Current status: **In Progress:** 1. **Complete:** 1.								
3		**Learning from Deaths policy** The policy should be updated to reflect the incoming Medical Examiner requirements.	Safe Effective	Learning from Deaths policy to be updated and amended	**31st July 2019**	Alastair Hutchison	Policy approval at Execs Meeting, Quality Committee and Trust Board	Revised "Learning from Deaths" policy approved by Board
Current status: **In Progress:** 1. **Complete:** 1.								
4		**Hospital Mortality Group** Each meeting would benefit from a tabled sub-set of QI information relating to mortality. This will	Safe Effective Well led	Future HMG agendas to follow template provided in Appendix A, including a tabled subset of	**30th June 2019**	Alastair Hutchison	Publication of agenda in suggested format	Agenda regularly includes links to QI projects, and CEIG Committee agendas

		draw together all the strands of work that relate to mortality. Appendix A - potential agenda for the HMG that meets this requirement.		QI information relating to mortality.			Divisional Directors and Managers to draw together QI projects related to mortality	include links to mortality/learning from deaths
Current status: **In Progress:** 1. Template adopted March 2019, QI information awaited **Complete:** 1.								
5		**Coordination of Quality Improvement Activity** QI as a whole was not as visible as expected. There appears to be a lack of coordination of QI activity. Consider appointing a clinical lead for QI and developing a 'hub' to coordinate activity. All QI activity (not just mortality-related) would be clearly visible and accessible to clinical teams. Doctors in training could undertake QI projects as part of their training that align with the trust's QI strategy and priorities.	Effective Responsive Well led	QI Training to be redeveloped QI Lead to be appointed QI reporting to be incorporated in Clinical Effectiveness +Information Governance Committee (CEIG)	**31st Aug 2019** **31st Aug 2019** **31st Aug 2019**	Alastair Hutchison Julie Doherty	Appointment of QI Lead CEIG Committee to advertise and appoint	Report from QI Lead to Board Number/grade of staff actively involved in QI projects.
Current status: **In Progress:** 1. Change of Trust 'Audit Lead' to QI Lead already discussed at CEIG Nov 2018 **Complete:** 1.								
6		**Divisional/Care Group/Specialty Governance** Trust should ensure that mortality is robustly discussed at specialty/care group/divisional governance meetings.	Safe Well led	Learning from Deaths to be incorporated into Governance agendas at all Specialty/Care Group/Divisional meetings	**31st July 2019**	Div. Directors	Minutes of meetings from departments and Care Groups reviewed by Divisions.	Minutes to include attendance record and anonymised outline of discussions

		Trust should mandate that M&M meetings are held in each relevant specialty. Corporate mortality team should provide templates for M&M meetings that follow relevant Royal College guidance and include how the outputs from these meetings are progressed through the mortality governance structure. Should be a clear expectation on dissemination of learning throughout the specialty, including staff who were not present. Specific, relevant mortality information to be supplied to each meeting, including specialty position regarding SHMI and HSMR and learning from SJRs.		Divisional Directors to ensure that M&M meetings are taking place in each relevant specialty, with brief minutes produced and learning documented, reporting to Care Group Each Care Group Clinical Director to ensure that learning is disseminated to all appropriate staff and that QI projects are implemented where required Divisional Quality Leads/Clinical Leads to be provided with appropriate mortality data from IT/Dr Foster	**31st July 2019**	Clinical Directors Dr. Foster Clinical Leads	Template for M&M meetings produced and circulated as standard Newsletters and other learning events recorded by Divisions Minutes of specialty meetings recorded by Care Groups	Minutes to included specific learning points Audit of staff recollection of newsletters Minutes of specialty meetings recorded by Care Groups
Current status: **In Progress:** 1. Royal College of Surgeons template circulated to Divisional and Care Group leads February 2019 **Complete:** 1.								
7		**Assuring the quality of SJRs** The trust should consider its approach to assuring the quality of SJRs. One suggestion is that a group of those staff involved in undertaking SJRs could be convened to discuss specific cases, to ensure that all reviewers concur on the findings.	Safe Effective	Hospital Mortality Group to discuss and develop a method of Quality Assurance for SJRs. To involve DCH Internal Audit team and report at Year End	**27th Nov 2019** **31st Mar 2020**	Alastair Hutchison	Method agreed by HMG	Report to Board on quality assurance

Current status: **In Progress:** 1. **Complete:** 1.								
8		**Clinical coding** Trust needs to deliver on its investment in terms of number of coders, team development and integration with specialty teams.	Well led	Progress with Clinical Coding Action Plan to be reviewed at each Hospital Mortality Group meeting	**31st Oct 2019**	Sue Eve-Jones	Coding team fully staffed	Audit of coding accuracy
Current status: **In Progress:** 1. Recruitment to these posts already underway with 2 appointments made May 2019 **Complete:** 1.								
9		**Clinical quality measures** NHSI uses a number of clinical quality measures to assess the effectiveness the quality of care at trusts. The measures closely related to mortality are sepsis, VTE, AKI, deteriorating patient (NEWS2), DNACPR planning and four-hour wait performance in the Emergency Department. These metrics should be available at each HMG meeting and cascaded to the relevant Divisional/Care Group/Specialty meetings to ensure that this sub-set of information is reviewed through the lens of patient care quality concerns and mortality improvement.	Safe Effective Well led	Metrics as described will be routinely reported at each Hospital Mortality Group meeting. Also to include ICNARC data every 3 months, and other relevant national audit data. Data to be cascaded to Divisions for discussion and distribution	**17th July 2019** **17th July 2019**	Alastair Hutchison Alastair Hutchison	HMG minutes Divisional, Care Group and Departmental clinical effectiveness meeting minutes	HMG minutes 17/7/19 Divisional, Care Group and Departmental clinical effectiveness meeting minutes

Current status: **In Progress:** 1. Some of this data is already incorporated as of 1st April 2019 **Complete:** 1.								
10		**Internal Audit** Due to the risks associated with having reported higher than expected mortality, the trust should consider engaging internal audit to review its specialty to Board processes in 2019/20. This should be in the latter half of the financial year to allow the recommendations of this report to be implemented.	Safe	Audit of mortality to be discussed at future Execs meeting – either Internal or PWC.	**31st May 2019**	Patricia Miller		
Current status: **In Progress:** 1. **Complete:** 1.								

Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 2019**
Report Title	**Board Assurance Framework**
Author	Paul Goddard, Director of Finance and Resources
Responsible Executive	Paul Goddard, Director of Finance and Resources

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

Summary

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

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

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

4. The attached Board Assurance Framework has been through a comprehensive refresh with each Executive Director to consider the current risk rating and whether the controls and assurances are still current and relevant. A target risk score has also been applied to each principle risk, which was a recommendation made in a recent Internal Audit.

5. During the meeting there will be the opportunity to go through the BAF in more detail.

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

1. **Outstanding: Delivering outstanding services every day.**
   New risk highlighting the Mortality index risk which threatens the reputation of the Trust in terms of outstanding services (risk 6).
   Removal of the previous principle risk related to the reliance on temporary clinical staff as it is duplicated in the risk in not having the appropriate staff to meet our patient's needs.
   Some additional gaps in controls and positive assurances have been added.
2. **Integrated: Joining up our Services.**
   No material changes other than some refreshes to some controls and positive assurances.
3. **Collaborative: Working with our patients and partners.**
   Removal of the principle risk in achieving >96% in the friends and family test.

New risk included highlighting the wider system wide workforce planning risk if there is a lack of collaboration between organisations. 4. **Enabling: Empowering Staff.** New risk added reflecting the gap in medical leadership in senior management positions. 5. **Sustainable: Productive, effective and efficient.** Some changes to consequence and likelihood scores of some of the principle risks.
Paper Previously Reviewed By Executive Management Team Risk and Audit Committee 23 July 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: July 2019

Summary Narrative

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

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

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

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

Objective	Range of Risk Scores	Strength of Controls	Strength of assurance
1. Outstanding: Delivering outstanding services every day. We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	**6-20**	**A**	**G**
2. Integrated: Joining up our Services. We will drive forward more joined up patient pathways, particularly working more closely with and supporting GP's.	**2-12**	**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.	**6-9**	**G**	**G**
4. Enabling: Empowering Staff. We will engage with our staff to ensure our workforce is empowered and fit for the future.	**4-12**	**G**	**A**
5. Sustainable: Productive, effective and efficient. We will ensure we are productive, effective and efficient in all that we do to achieve long term financial sustainability.	**9-16**	**A**	**R**

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

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

REF	STRATEGIC OBJECTIVE	Risk		Rating
1	**Outstanding: Delivering outstanding services everyday.** We will be one of the very best performing Trusts in the country delivering outstanding services for our patients.	Strength of controls		A
		Strength of assurance		G

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not achieving an outstanding rating from the Care Quality Commission within next two years	NL	3	3	**9**	6
R2	Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality	NL	3	3	**9**	6
R3	Not achieving national and constitutional performance and access standards	IR	4	4	**16**	12
R4	Not having effective Emergency Preparedness, Resilience and business continuity plans	IR	3	2	**6**	6
R5	Not having the appropriate worforce in place to deliver our patient needs	MW	4	5	**20**	12
R6	Failing to improve the Trust SHMI index	AH	4	4	**16**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits). ICS quality surveillance Group monitors and scrutinises safety and quality with the system and the regulator. (R1)	G	Quality Committee reports on CQC, CQC Provider Information Collection & Insight data, CQC quarterly meetings. Dorset Quality Surveillance meeting in place that reviews hard and soft intelligence	G
C2	Performance monitoring and management of key priorities for improvement in quality and safe care (R2)	G	Divisional exception reporting and monitoring of quality improvement plans 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 Quality Committee	G
C4	Performance Framework - triggers for intervention/support (R3)	A	Performance monitoring via weekly PTL meetings and monthly Divisional Performance Meetings (through to Sub-Board and Board). Divisional Performance Framework to be presented at July 2019 Trust Board.	G
C5	Emergency Preparedeness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE (R4)	G	Reporting from EPRR Committee to Audit Committee and via assigned NED to Board. Yearly self assessment aginst EPRR core standards ratified by Local Health Resiliance Partnership.	G
C6	Establishment of a Resourcing Operations Group. Monthly review of vacancies at Workforce Committee and SMT and tracking of junior doctor exception reports. (R5)	A	We review safe staffing through Board reports; junior doctor workforce issues through the GOSW reports; vacancy levels through the Workforce Committee and Board workforce reports; develop strategic solutions through the Resourcing Operations Group.	A
C7	People Strategy published May 2018. (R5)	G	Board sign off of 2018-2021 people Strategy in May 2018.	G
C6	Weekly review of medical workforce recruitment activity (R5 &6), Review of nursing vacancies and recruitment plans at the Resource Strategy Group.	A	Recruitment update report provided by recruitment team on a weekly basis. Workforce Planning capacity and capability gap - plan to address with increased resources. Dorset Workforce Action Board partner and	A
C7	Scrutinising other care quality indicators to assure standards of care (R6)	A	Regular reports to Hospital Mortality group , Quality Committee and Board	G
C8	Poor data capture drives patient coding which effects SHMI (R6)	A	Internal audit of sample of 1000 patient notes and national benchmarking undertaken by PWC	G
Overall Strength		A		G

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

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

CONTROL	ASSURANCE	EVIDENCE
C1	Internal Audit of CQC action plan and assurances. November 2018 CQC rating as 'Good'.	KPMG audit report and published CQC report
C2	Internal Audit of Medicines management	KPMG audit report
C3	CCG assurance visits and contract monitoring	CCG assurance reports
C4	Internal performance reports	Board and FPC reports
C2	External auditors - Quality Account (transparency and accuracy of reporting)	Board and QC reports
C5	Internal Audit of systems and processes; and CCG assurance of the EPRR standards	Audit Committee and Board
C1	External review of Divisional Governance Structures and the PWC Well Led Review	Quality Committee and Board
C6	Monthly workforce reports detailing vacancies and trajectories.	Strategic Resourcing Group, Workforce
C8	NHSI regular scrutiny and support (R6)	NHSI visit and report April 2019

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

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

ISSUE 1		ACTION
C1	CQC inspection process being redefined as it progresses, which may result in some services not being reviewed to enable an 'outstanding' rating	Work with the CQC during the year through quarterly meetings and monitoring (as per the new methodology) to actively promote reviews of services where possible.
ISSUE 2		**ACTION**
	Significant resource constraints to deal with increased demand for both Elective and Emergency services.	System wide working on changes to care models and capacity and demand analysis to identify areas for additional investment. Escalation via Elective Care Board, Urgent Emergency Care Board, OFRG and SLT.
ISSUE 3		**ACTION**
C5	Uncertainty over no deal Brexit and associated impact on procurement, staffing and charging of overseas patients.	Receiving regular briefings from regional team, participation in national data submissions, task and finish group reporting to Audit Committee.
ISSUE 4		**ACTION**
	Inconsistent application of the Performance framework within the Divisions leading to failure to pick up early warnings of deteriorating performance	
ISSUE 5		**ACTION**
	Late visibility in junior doctor gaps from Deanery rotations	Regular communications with the Deanery, and profiling of historic gaps. "At risk" recruitment in anticipation of gaps.
ISSUE 6		

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

REF	STRATEGIC OBJECTIVE	Risk		Rating
2	**Integrated: Joining up our services.** We will drive forward more joined up patient pathways particularly working more closely with and supporting GPs.			
		Strength of controls		A
		Strength of assurance		G

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Emergency Department admissions continuing to increase per 100,000 population	IR	3	4	**12**	9
R2	Occupied hospital beds days continue to increase per 100,000 population	IR	3	4	**12**	9
R3	Having delayed discharges	IR	3	4	**12**	9
R4	Not achieving an integrated community health care hub based on the DCH site	IR	3	2	**6**	6
R5	Not achieving a minimum of 35% of our outpatient activity being delivered away from the DCH site	IR	2	1	**2**	6

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Reframed Urgent and Emergency care Boards objectives linked to the Boards delivery plan. (R1,2,&3)	A	Upward reporting and escalation from UECB to SLT.	A
C2	Performance Framework reporting - triggers for intervention/support (R1,2&3)	G	Ward to Board reporting	G
C3	Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management (R3)	A	Patient flow project as part of operational efficiency strand of Transformation strategy.	G
C4	Integrated Community and Primary care Portfolio, West integrated Health and Care partnership, and Primary care networks all focused on delivery (R4)	G	Transformation (SMT) Reporting and Strategic updates to Board and ICPCS portfolio Board to SLT.	G
C5	Outpatient Improvements (within Elective Care Board Programme) (R5)	A	Reports to SMT and through to Board via Strategy updates	G
Overall Strength		A		G

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

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

CONTROL	ASSURANCE	EVIDENCE
C1	Continuous high performance against national Emergency access standard (R1)	Performance reporting
C2	Primary Care engagement with Locality Projects - Cardiology, Dermatology, Ophthalmology, Diabetes and Paediatrics (R1).	SMT (Transformation) reporting and updates to Board
C3	Full community and primary care engagement (R2&3)	SMT (Transformation) reporting and updates to Board
C4	Dorset designated as a wave one ICS (R1-5)	ICS Memorandum of Understanding and shared collaborative agreement

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

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

ISSUE 1		ACTION
C3	Delayed Discharges - above national ambition (R3)	Implementation of national template for weekly reporting of delayed PTL. Executive challenge panel established July 2019
ISSUE 2		**ACTION**
C1	Emergency Department capacity (R1)	Business case development for investment in progress.
ISSUE 3		**ACTION**

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

REF	STRATEGIC OBJECTIVE	Risk		Rating
3	**Collaborative:** We will work with all our partners across Dorset to co-design and deliver efficient and sustainable patient centred outcome focussed services.	Strength of controls		G
		Strength of assurance		G

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Failing to deliver services which have been co-designed with patients and partners	NL	3	3	**9**	6
R2	Not being at the centre of an integrated care system, commissioned to achieve the best outcomes for our patients and communities	PM	3	3	**9**	6
R3	Failing to be an integral part of full system multi-disciplinary teams to contribute to the system collaborative working	IR	3	2	**6**	6
R4	Workforce planning consequences across the system are not fully considered which de-stabilises individual organisation's workforce	MW	3	2	**6**	4

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Patient and Public engagement as part of transformation framework, with Trust Transformation lead and team trained in service improvement; plus Patient Experience lead in place; Communications team link with CCG for public consultations and engagement events where relevant (R1)	A	Senior Management Team (SMT), Executive Management Team (EMT), Patient Experience Group (PEG) - via CCG , Health Oversight and Scrutiny Committee, Healthwatch, special interest groups	A
C2	CEO Leadership role in SPB and broader membership of SLT meetings including leading on the Dorset Clinical Networks and LMS (R2)	A	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	A
C3	Locality Projects (Elective Care Recovery and Sustainability Programme) (R2)	G	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	G
C4	Divisions supported by the Transformation Team (DCH) integral part of Locality and service redesign meetings (R3)	G	SMT Meeting updates and escalation to Execs and Board where pplicable	G
C5	Investment in DCH workforce planning team. DWAB resourced Dorset wide workforce planning capacity to co-ordinate (R4).	G	Regular reports considered at DWAB and escalated to Workforce Committee	G
Overall Strength		A		A

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

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

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

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

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

ISSUE 1		ACTION
C1	Public engagement in all elements of developments is not embedded and requires strengthening strategies to deliver this	Communciaiton Team, Head of PALS/Complaints and Transformation team to build and embed processes to deliver patient and public engagement
ISSUE 2		**ACTION**
ISSUE 3		**ACTION**

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

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

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not achieving a staff engagement score in the top 20% nationally	MW	2	4	**8**	6
R2	Not benefitting from the successful delivery of our People Strategy	MW	4	2	**8**	6
R3	Failure to deliver flexible and appropriate support service models	NJ	3	4	**12**	9
R4	Not achieving a Dorset wide integrated electronic shared care record	SS	3	4	**12**	9
R5	Not being an exemplar site for clinical research and innovation	AH	2	2	**4**	9
R6	Loss of training status for junior doctors	MW	4	1	**4**	4
R7	Lack of medical leadership in senior management positions	AH	3	4	**12**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Appointment of OD Manager to focus on Organisational Culture. Diversity and Inclusion/ Wellbeing Manager appointed to provide a dedicated resource to this agenda. Divisional champions to be identifed to ensure local action plans developed and discussed. (R1)	A	Quarterly Family & Friends test results reported to the Workforce Committee. Staff Survey action plan presented to Board. Review of Equality & Diversity associated issues at Equality & Diversity Steering Board.	A
C2	People Strategy approved at May 2018 Trust Board. (R2)	G	Workforce committee formed October 2018 to consider and report progress against people Strategy.	G
C3	Better Value Better Care Group provides model hospital overview. Proposal to establish SLAs and performance measures for support services. (R3)	A	Proposal to establish SLAs and performance measures for support services	A
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 (R5)	G	Reports to the Quality Committee	G
C6	Medical training activity and issues reviewed by the Director of Medical Education at the Medical Education Committee. Escalation through to the Resourcing Operations Group, and FPC as necessary. (R6)	G	Medical Education update provided at Workforce Commitee. GMC junior doctor survey presented to board annually.	G
Overall Strength		G		A

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

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

CONTROL	ASSURANCE	EVIDENCE
C1	Appointment now in place. Staff survey promoted appropriately and launch of staff recognition scheme (R1).	Confirmation of appointment
C2	Assurance provided through Board agreement of the refreshed People Strategy. Progress updates to be provided regularly to the Workforce Committee (R2).	Trust Board approved People Strategy in May 2018. Updates to be reported to Workforce Committee on a regular basis.
C3	Wide ranging risk. Model hospital and corporate benchmarking information will assist with assurance (R3).	Benchmarking information
C5	Recognition via nominations and awards within Research networks (R5)	Wessex CRN awards 2019

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

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

ISSUE 1		**ACTION**
C1	Poor responses to the quarterly Staff Family and Friends test do not provide assurance of staff engagement (R1).	Focus on annual staff survey action plans. Review current people strategy.
ISSUE 2		**ACTION**
C2	Medical engagement continues to be hard to guage. Recently formed Medical Engagament Forum too early to assess impact (R2).	Review effectivement of Medical Engagement Forum in 6 months. Consider engagement as part of the communication strategy review.
ISSUE 3		**ACTION**
C3	No clear metrics to determine appropriateness of support services, meaning assurance is limited (R3).	n/a
ISSUE 4		**ACTION**
C4	No independent assurance on controls in place for the Dorset Care Record (R4)	Progress reported through the Dorset Informatics Group. DCH input is progressing well but other partners are behind their milestones.
ISSUE 5		
C6	Gap in workforce reporting to highlight medical leadership vacancies (R6)	Include clinical leadership as part of talent management review

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

REF	STRATEGIC OBJECTIVE	Risk		Rating
5	**Sustainable: Productive, effective and efficient.** We will ensure we are productive, effective and efficient in all that we do to achieve long-term financial sustainability			
		Strength of controls		A
		Strength of assurance		R

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Not returning to financial sustainability, with an operating surplus of 1% and self sufficient in terms of cash	PG	4	4	16	12
R2	Failing to be efficient as outlined in the Model Hospital	PG	3	3	9	9
R3	Not generating 25% more commercial income with an average gross profit of 20%	NJ	2	5	10	8
R4	Not using our estate efficiently and flexibly to deliver safe services	PG	4	3	12	12
R5	Failure to secure sufficient funding to ensure financial sustainability	PG	4	4	16	12

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	The 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)	A	The Better Value Better Care Group oversee the implementation of the financial savings. The Senior Management Team receive regular updates on the Transformation Programme. Regular reports received by the Finance and Performance Committee and the Board.	A
C2	Model hospital metrics accessible to service areas. Regular reports and opportunities identified by the Better Value Better Care Group (R2)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	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
C3	Model hospital will provide information on the efficient use of our estate. (R4)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	A
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	A	The Authorising Engineers which the Trust appoint, are independent and ensure that safe systems of work and inspection regimes are in place and carried out in accordance with the legislative requirements	G
C6	Six facet survey due to be undertaken in Q2 of 19/20 to identify backlog maintenance levels and investment requirements. (R4)	A	Capital Planning Group review the 6 facet survey and capital investment required. This is reported to the Senior Management Team, Finance and Performance Committee and Board of Directors for approval.	A
C7	The Trust is part of the Dorset Finance Colloborative Agreement to ensure that funds and control totals are amended across the system (R5)	A	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	A
Overall Strength		A		R

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

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

CONTROL	ASSURANCE	EVIDENCE
C1	Internal audit report 17/18 gave significant assurance with minor improvements. (R1) and (R2).	KPMG audit report
C2	Model hospital information provides the information on our level of efficiency. (R2)	Model Hospital
C3	Estates Benchmarking (ERIC) return confirms efficient use of estate with opportunities in waste management (R2)	Estates Benchmarking (Eric) Return

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

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

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

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

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

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

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

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

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

Identifying Risks

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

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

Scoring & Grading

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

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

DOMAIN C1: SAFETY, QUALITY & WELFARE

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

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) Local resolution	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Inadequate/performance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 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)
To review

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

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

The most significant risks which could prevent us from achieving our strategic objectives are detailed in the tables within the report.

All current active risks continue to be reviewed monthly with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.

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

CHANGES TO RISK REGISTER:
As reported in the May report, we were looking to consolidate all of the risk entries relevant to failing to achieve our Constitutional standards in relation to elective care, such as 18 Weeks RTT, Diagnostics standard 6 week, Cancer standards (2 week wait and 62 day standard) and ED, which previously were all siting on the Corporate Risk Register separately have now been amalgamated in to an overarching Corporate risk. The same has happened with the follow up waiting list backlog.

Again as reported in the May report, we agreed to split the Mortality and Coding risks, which has now been agreed and actioned.

INCREASE IN RISK RATING:

- **Financial Sustainability**

This risk has been reviewed in light of the commencement of a new financial year.
There is a gap of £2m from the full year CIP target and current agency spend levels, whilst affordable currently given non recurrent benefits, it is not expected that this will continue. Remedial actions are being considered.

NEW RISKS TO NOTE:
After meeting with the Director of Organisational Development and Workforce, the risks have been reviewed and reframed to be more reflective of the Trust position. One new additional risk has been added to the Corporate Risk Register by this Director. Details of the changes are below:

Recruitment and retention of Medical staff across specialities
To mitigate this we have:

- *We have proactively recruited F3 posts, and WAST posts to mitigate risk of gaps in*

Foundation Doctors.

- *We now provide training for undergraduate physician associates which we hope will provide a source of future recruitment.*

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

Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff

To mitigate this we have:

- *We have contracted with a new supplier to deliver international registered nurses.*
- *We have increased resources for temporary staff and bank team*
- *We have increased recruitment events, participating and arranging.*
- *Developed different recruitment marketing tools including a Trust micro site and greater use of social media.*
- *Reviewed employer branding.*
- *We have invested in a workforce planning capability to consider longer term actions to mitigate staff shortages, actions.*

NEW:
Personnel files (Non Medical) not being stored centrally

- *There is a risk that the personnel files for non medical staff are not being maintained and stored centrally. There is a risk to the files being lost or misplaced when staff or managers move or being stored securely which is a risk to confidentiality.*
- *There are potential inconsistent standards to which the files are being maintained.*
- *There is a risk that the files may not be available or contain the required contents to support the Trust in defence of any employment or legal claims and also evidence of required NHS background and recruitment checks.*

EMERGING:

- Availability of medical workforce resulting from pension taxation pressure

Mark Warner is reviewing the risk statement currently.

DIVISIONAL LEVEL EMERGING RISKS

Urgent and Integrated Care Division

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

Details of Risk:

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

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

We are seeing an increasing number of incidents reported, and investigations via the Corporate Learning from Incident Panels to evidence that the space issue and patients being seen in inappropriate spaces is impacting on patient and staff safety. One of the incidents heard at Panel 11.07.19 sited the root cause as 'Patient treated in wrong location'.

There are a number of incidents to substantiate the risk rating of EXTREME. The service is

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

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

- Ilchester – staffing and capacity (Currently rated as HIGH on the Divisional risk register).

Details of Risk:
Ongoing use of Ilchester Escalation Capacity (planned and unplanned), leading to insufficient nursing cover particularly if opened at short notice, contributing to increased risks and having an impact on staff wellbeing.

This was also reported in the May report and remains a risk for the Division.
Ilchester has been opened to above 100% bed occupancy since late 2018. Some of this has been planned for, with staffing pre-booked; in cases where this has not been pre-planned staff have had to work at higher nurse:patient ratios, come off of required admin/supervisory shifts, and have been under increasing pressure to support flow from ED. ***We have had an increased number of incidents reported in regards to staffing and we have had an increased some serious incidents reported in the last month.***

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

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

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

Paper Previously Reviewed By
SMT
Audit and Risk Committee 23 July 2019

Strategic Impact
The Risk Register outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.

Risk Evaluation
Each risk item is individually evaluated using the current Trust Risk Matrix.

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

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

Financial Implications
The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.

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

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

Corporate Risk Register

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

TARGET DATE TO MEET TARGET RISK LEVEL:	RISK LEVEL (CURRENT)	PREVIOUS RISK LEVEL	RISK LEVEL (TARGET)	ID	TITLE	RISK STATEMENT	REVIEW DATE	LAST UPDATED	CARE GROUPS	PRINCIPLE RISK - COLLABORATIVE: JOINING UP OUR SERVICES
31/03/2020 	Extreme (20)	Extreme (20)	Low risk (6)	641	Clinical coding	Poor clinical coding can result in:- - failure to optimize legitimate income - lack of adequate information to support resource management and business planning - inaccurate reflection of trust performance and quality of care (e.g. Shmi)	31/08/2019	MANDY FORD 12/07/2019 16:16:57	FINANCE	**Strategic objective 1: outstanding** failing to be in the top quartle of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **MITIGATING ACTIONS:** Recruitment of new coders has taken place and they are currently receiving their training which is due to be completed by September 2020. The longer term plan is for coders to sit with clinicians to complete the coding to ensure that the coding is correct and that we can maximise legitimate income to assist with the financial sustainability.

TARGET DATE TO MEET TARGET RISK LEVEL:	RISK LEVEL (CURRENT)	PREVIOUS RISK LEVEL	RISK LEVEL (TARGET)	ID	TITLE	RISK STATEMENT	REVIEW DATE	LAST UPDATED	CARE GROUPS	PRINCIPLE RISK - COLLABORATIVE: JOINING UP OUR SERVICES
31/03/2020	Extreme (20)	Extreme (20)	Very low (2)	474	Review of co-tag system and management of issuing/retrieving tags to staff	The door access system is unstable and due to its age and condition is at the end of its useful life. The trust is experiencing regular failures of the system causing operational disruption to users and information governance concerns.	30/08/2019	PAUL DANIELL 04/07/2019 11:12:48	FINANCE	**Strategic objective 5: sustainable** not using our estate efficiently and flexibly to deliver safe services. **MITIGATING ACTIONS:** User feedback sought to inform design philosophy. This will be used to determine scope and desired capabilities of the replacement system. 50+ feedback received, assessed and added to tender document specification . Tender due by end of July 2019.
31.03.2025	Extreme (20)	Extreme (20)	Low risk (9)	709	Failure to achieve constitutional standards (elective care)	The Trust is current not achieving constitutional standards in : • 18 week • Rtt • diagnostic standards - 6 weeks • cancer standards (2 week wait and 62 day standard) • ED standards	31/10/2019	MANDY FORD 12/07/2019 15:34:49	DIRECTOR OF OPERATIONS	**Strategic objective 1: outstanding** failing to be in the top quartle of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards strategic objective 3: collaborative not achieving a 96% score on our friends and family test, not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities. **Strategic objective 5: sustainable** not generating 25% more commercial income with an average gross profit of 20% **MITIGATING ACTIONS:** The relevant service have individualised management plans to mitigate the risks for meeting standards, however, without appropriate staffing and service capacity to

TARGET DATE TO MEET TARGET RISK LEVEL:	RISK LEVEL (CURRENT)	PREVIOUS RISK LEVEL	RISK LEVEL (TARGET)	ID	TITLE	RISK STATEMENT	REVIEW DATE	LAST UPDATED	CARE GROUPS	PRINCIPLE RISK - COLLABORATIVE: JOINING UP OUR SERVICES
										deliver these, it will be difficult to achieve in all areas. These are being monitored by service, caregroup and divisions.
31.03.2025	Extreme (20)	Extreme (20)	Low risk (9)	710	Follow up waiting list backlog	Failure to ensure that patient's are followed up according to their clinical needs and presentation.	31/10/2019	MANDY FORD 12/07/2019 15:37:31	DIRECTOR OF OPERATIONS	**Strategic objective 1: outstanding** failing to be in the top quartle of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **MITIGATING ACTIONS:** The relevant service have individualised management plans to mitigate the risks for meeting standards, however, without appropriate staffing and service capacity to deliver these, it will be difficult to achieve in all areas. These are being monitored by service, caregroup and divisions.
31/03/2025	High risk (15)	High risk (15)	Moderate risk (12)	463	Workforce planning & capacity for nursing and allied health professional and health sciences staff	Inability to source appropriately skilled and competent staff to meet requirements for nursing, allied health professional and health science staffing	31/10/2019	MANDY FORD 12/07/2019 15:46:33	WORKFORCE AND HUMAN RESOURCES	**Strategic objective 1: outstanding** not having the appropriate workforce in place to deliver our patient needs **MITIGATING ACTIONS:** Risk reframed. Update to progress. We have contracted with a new supplier to deliver international registered nurses. We have increased resources for temporary staff and bank team We have increased recruitment events, participating and arranging.

TARGET DATE TO MEET TARGET RISK LEVEL:	RISK LEVEL (CURRENT)	PREVIOUS RISK LEVEL	RISK LEVEL (TARGET)	ID	TITLE	RISK STATEMENT	REVIEW DATE	LAST UPDATED	CARE GROUPS	PRINCIPLE RISK - COLLABORATIVE: JOINING UP OUR SERVICES
										We have developed different recruitment marketing tools including a trust micro site and greater use of social media. We have reviewed employer branding. We have invested in a workforce planning capability to consider longer term actions to mitigate staff shortages, actions.
31.03.2025	Extreme (20)	Moderate risk (16)	Low risk (9)	449	Financial sustainability	An unsustainable financial position could result in a reduced quality of both clinical and support services and reduce the autonomy the trust has in providing high quality services to its population.	10/07/2019	MANDY FORD 10/07/2019 14:12:02	FINANCE	**Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital, failure to secure sufficient funding to ensure financial sustainability, not generating 25% more commercial income with an average gross profit of 20%, not returning to financial sustainability, with an operating surplus of 1% and self-sufficient in terms of cash, not using our estate efficiently and flexibly to deliver safe services **MITIGATING ACTIONS:** There is a gap of £2m from the full year CIP target and current agency spend levels, whilst affordable currently given non recurrent benefits, it is not expected that this will continue. Remedial actions are being considered.

TARGET DATE TO MEET TARGET RISK LEVEL:	RISK LEVEL (CURRENT)	PREVIOUS RISK LEVEL	RISK LEVEL (TARGET)	ID	TITLE	RISK STATEMENT	REVIEW DATE	LAST UPDATED	CARE GROUPS	PRINCIPLE RISK - COLLABORATIVE: JOINING UP OUR SERVICES
31/03/2020 	Moderate risk (10)	Very low (4)	Very Low (4)	682	Personnel files (non medical) not being stored centrally	There is a risk that the personnel files for non medical staff are not being maintained and stored centrally. There is a risk to the files being lost or misplaced when staff or managers move or being stored securely which is a risk to confidentiality. There are potential inconsistent standards to which the files are being maintained.	31/10/2019	MANDY FORD 12/07/2019 16:41:38	WORKFORCE AND HUMAN RESOURCES	**Strategic objective 4 :enabling** failure to deliver flexible and appropriate support service models. **MITIGATING ACTIONS:** There is guidance available on how to maintain a personal file. The alternatives are to centrally store personal files which would require space and facilities. The preferred option would be to move to electronic personal records. We will include this in the business planning process as it was hoped this could be covered through the DPR project, however this is now not possible.

Safe Staff Return May

Ward name	Day				Night				Day		Night		Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)				
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
Abbotsbury Short Stay Surgical Unit	1753.3	1600.8	1112	1373.5	682	979	682	715	91.3%	123.5%	143.5%	104.8%	696	3.7	3.0	6.7
Barnes	1281.5	1228.6	1567	1479.3	682	671	869	1023	95.9%	94.4%	98.4%	117.7%	698	2.7	3.6	6.3
Critical Care Unit	2305	2212	347	338.5	2138.5	2090	0	0	96.0%	97.6%	97.7%	-	198	21.7	1.7	23.4
Day Lewis	1484.5	1329	1139	1353	682	682	682	682	89.5%	118.8%	100.0%	100.0%	692	2.9	2.9	5.8
Fortuneswell	917.5	1086.25	749	797.5	682	685	341	451	118.4%	106.5%	100.4%	132.3%	431	4.1	2.9	7.0
Ilchester Intergrated Assessment Unit	1428.25	1649.25	1474.25	1658.42	1068.5	1380	1067.5	1308.5	115.5%	112.5%	129.2%	122.6%	690	4.4	4.3	8.7
Kingfisher	1484	1474	603.5	663.75	1069.5	1045	356	343.5	99.3%	110.0%	97.7%	96.5%	197	12.8	5.1	17.9
Lulworth	1871.25	1791	1508	1495.5	1023	1024.5	1023	1034	95.7%	99.2%	100.1%	101.1%	888	3.2	2.8	6.0
Maternity	3063	2782	1563	1255.25	2418	2338	682	658	90.8%	80.3%	96.7%	96.5%	389	13.2	4.9	18.1
Maud Alex	1239	1248.75	805.75	831.5	1069.5	1071.5	356.5	380.5	100.8%	103.2%	100.2%	106.7%	419	5.5	2.9	8.4
Moreton	1403	1319.5	1504	1611.5	682	679	1023	1056	94.0%	107.1%	99.6%	103.2%	691	2.9	3.9	6.8
Prince of Wales	1458.5	1346.5	764.5	661	682	689.5	341	341	92.3%	86.5%	101.1%	100.0%	382	5.3	2.6	8.0
Purbeck	1678	1560	1529.75	1491	682	704	682	682	93.0%	97.5%	103.2%	100.0%	779	2.9	2.8	5.7
Ridgeway	1287	1262.8	1101.5	1549.75	682	682	682	693	98.1%	140.7%	100.0%	101.6%	717	2.7	3.1	5.8
SCBU	751.5	892.3	350	205	683.5	706	341	319	118.7%	58.6%	103.3%	93.5%	245	6.5	2.1	8.7
Stroke Unit	1509	1474.2	1122	1476.5	682	697	682	972.5	97.7%	131.6%	102.2%	142.6%	543	4.0	4.5	8.5

Exception report: Day Lewis day shifts were all supported by the supervisory ward leader. There were 2 shifts with only 1 RN on duty during this reporting period (Elderly Care and Renal); these were supported by adjacent ward areas and night sister presence on all occasions.

Note- Many areas are showing as greater than 100% due to additional staff required for extra capacity beds due to demand and activity which have been open consistently throughout June. Therefore staffing for this capacity have relied on temporary staffing.

Title of Meeting	**Trust Board**
Date of Meeting	**31 July 2019**
Report Title	**Annual Equality, Diversity and Inclusion Report**
Author	**Sarah Stickland, HR Manager Engagement & Wellbeing**
Responsible Executive	**Mark Warner, Director of Workforce and Organisational Development**

Purpose of Report (e.g. for decision, information) The report is intended to provide assurance on work undertaken during 2018/19 to ensure compliance with current legislation and NHS standards and to progress the Trust's equality and diversity agenda.
Summary c Under the Equality Act (2010), public bodies have very specific duties and in particular, the Trust has a duty to promote equality and diversity and to publish information on compliance and to demonstrate how it is delivering improvement. The report details the work undertaken by the Trust during 2018/19 to demonstrate its commitment to promoting equality, diversity and human rights. An analysis of the workforce and the 2018/19 recruitment cycle are also included. Data contained within this report refers to the April 2018 – March 2019 reporting cycle.
Paper Previously Reviewed By Workforce Committee
Strategic Impact Actions undertaken in response to findings from equality and diversity monitoring have the potential to provide direct benefits for the workforce and improve access and quality of service for patients.
Risk Evaluation Low, although breaches in duty could have an impact on the Trust's reputation and significant financial implications.
Impact on Care Quality Commission Registration and/or Clinical Quality Embedding good equality practice has impacts on patient satisfaction and patient experience.
Governance Implications (legal, clinical, equality and diversity or other): In accordance with the Equality Act Public Sector Equality Duty, the Trust has a legal obligation to promote equality and diversity and to produce and publish information on compliance.
Financial Implications There are no direct financial implications although failure to comply with legislation could result in fines being levied on the Trust and successful discrimination claims brought against the Trust at employment tribunal.

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

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

Annual Equality and Diversity Report

1.0 DCH approach

The Trust is part of the Dorset NHS E&D cluster with other local Dorset trusts, including Royal Bournemouth and Christchurch Hospital Foundation Trust, Poole Hospital Foundation Trust, Dorset HealthCare University NHS Foundation Trust and Dorset Clinical Commissioning Group. As part of this partnership a Dorset wide engagement exercise was undertaken and the outputs of this work have been used to build the equality objectives and action plan contained in Appendix 2.

2.0 Promoting Equality and Celebrating Diversity

The Equality Act (Equality Act) came into effect in 2010, replacing previous anti-discrimination laws with a single act, this and other Legislative and Compliance Framework is detailed within Appendix 1. The Trust continually reviews its policy framework to ensure that it is meeting its legal obligations and providing a supportive workplace environment for staff and a supportive care provision environment for patients. All Trust policies, strategies, services and business plans are assessed prior to implementation to ensure equality issues are considered by means of an Equality Impact Assessment (EIA). Whilst the Equality Act does not impose a legal requirement to conduct EIAs, this process helps managers identify areas for a potential claim and to take corrective action.

In 2016 the Two Ticks Disability Symbol scheme changed to the Disability Confident Employer scheme, for which the Trust retained its accreditation this year.

The trust has its own Equality, Diversity and Inclusion Steering Group which was established in 2016, with responsibility for the equality and diversity agenda. This group is attended by staff from across the Trust representing all staff groups and works with Dorset diversity networks to promote equality and diversity and provide accessible staff support groups. The Steering Group will monitor progress against the Trust Equality and Diversity Action Plan (Appendix 2).

3.0 Our Patients

The West Dorset area has a total population of 102,064*; the table below shows the age demographics of this population compared to the national average.

	Aged 0-15	Aged 16-64	Aged 65+
West Dorset*	15%	54%	30%
England & Wales*	19%	63%	18%
Our patients	17.5%	46.7%	35.8%

*Source: 2017 Mid-year Estimates, Office of National Statistics

The percentage of the West Dorset population who are white is 98% while the total percentage of the population who are from BME communities is 1.9%. The table below shows the race/ethnic origin split of the West Dorset population compared to the national average.

	White *(British, Irish, other white)*	**Mixed** *(White and Black Caribbean, White and Black African, White and Asian, Other mixed)*	**Asian** *(Indian, Pakistani, Bangladeshi, other Asian)*	**Black** *(Black Caribbean, Black African, other Black)*	**Chinese/ Other** *(Chinese, other ethnic group)*
West Dorset	98.0%	0.8%	0.9%	0.1%	0.1%
England & Wales	85.9%	2.2%	7.5%	3.4%	0.1%
Our patients*	71.68%	0.44%	0.38%	0.10%	0.15%

* 27.25% of patients' ethnicity data was not recorded

The table below shows the gender split of the West Dorset population compared to the national average.

	Men	**Women**
West Dorset	48%	52%
England & Wales	49%	51%
Our patients	46.8%	53.2%

Detailed charts showing the demographic split of patients by characteristic can be found at Appendix 3.

4.0 Our Staff

Although the Trust's monitoring systems support the collection of data across all the 'protected characteristics', the limited number of individuals within some categories is too small to support statistical analysis and to protect the confidentiality of individuals and may therefore not be included within the present report. It must also be noted that the number of people disclosing their status varies by protected characteristic, which means that in some instances there are a high number of staff members whose status is undisclosed or undefined. Detailed charts showing the demographic split of staff by characteristic can be found at Appendix 4.

4.1 Workforce Demographics

88.2% of staff in the Trust are white; a decrease of 0.5% from the previous year. While there is a high percentage of staff within the Trust from white backgrounds, this figure is more ethnically diverse than the Dorset population and only slightly higher than the UK population.

Just 2.7% of staff reported that they have a disability within the Trust. However, 24.25% of staff have either not declared their status or are recorded as 'undefined' and it is therefore likely that the true proportion of disabled employees is much higher.

75.86% of staff are women in the Trust, which is representative of the gender split within the NHS more generally.

48.48% of our staff has recorded Christianity as their religious belief, with this being the dominant belief. However, 26.22% of staff did not disclose their religious belief.

77.14% of staff reported their sexual orientation as heterosexual, with other sexual preferences less well represented. However, 21.41% of staff did not declare their sexual orientation.

The largest age cohort of Trust staff is between 46 and 55 years old, with 28.31% of staff being between these ages; an increase of 2.23% from the previous year. The generally older population within the Trust is anticipated to be as a result of the type of roles which are prevalent within the NHS, which typically require longer periods of training, often meaning that workers are older when they qualify than in other sectors.

The earlier rate of retirement in clinical roles is representative of trends within the wider NHS and is reflective of the increased requirement for physical effort within clinical roles when compared to non-clinical roles; we are seeing an increase in staff retiring and then returning to the trust which enables us to continue to benefit from their knowledge and skills. This figure also illustrates the relatively low turnover rates in the Trust.

4.2 Employee Relations Cases and Employment Tribunals

The Trust analyses data from grievance, disciplinary and other related procedures by the protected characteristics outlined in the Equality Act as well as the number of cases that proceed to an Employment Tribunal (ET).

ER Cases 2018/19	Gender		Ethnicity				
	Male	Female	White	Asian	Black	Other	Not Stated
Disciplinary	8	23	26	3	0	1	1
Grievance	3	1	3	1	0	0	0
Performance	3	11	13	0	0	0	1
Sickness Capability	42	231	234	4	1	6	28

74% of our disciplinary cases, 25% of our grievance cases, 79% of our performance cases and 85% of our sickness capability cases are with Females. (Females represent 76% of the workforce). We will undertake sampled quality assurance checks in relation to sickness capability and grievances to ensure fairness.

Type of Employment Tribunal Claim	Gender	
	Male	Female
Unfair dismissal (including constructive dismissal)	1*	1*
Race discrimination	0	0
Sex discrimination	0	0
Religion/belief discrimination	0	0
Disability discrimination	0	0
Breach of contract	0	1
Detriment of whistleblowing	0	**0**
County Court Claim	1	**0**
Total	2	2

**These claims are currently ongoing so no outcome is yet available.*

This analysis provides an indication of the Trust not discriminating against any employees with a protected characteristic.

4.3 Learning and Development

The Trust is committed to promoting equal and fair access to learning opportunities for all staff and providing appropriate learning and development interventions that suit different learning styles and work patterns. All staff members receive training in a number of key areas which form Trust mandatory requirements. Additional training funding is decided as a result of completion of study application forms that assess learners' applications based on the relevance of training to Trust business and service plans, delivering improved quality to patients and increased productivity and innovation within the workplace.

The Trust takes a structured approach to ensuring that all staff members understand the importance of reducing discrimination and valuing inclusion and diversity. This is achieved through the provision of equality and diversity training, which is regularly reviewed and updated to ensure that it stays current. Messages on equality and diversity are communicated to staff as follows:

- All new staff are signposted to equality and diversity training as a key component of their Essential Skills Training at Trust Induction

- We are currently creating recruitment training; a key component of this will be reminding those who are required as part of their role to chair and/or participate in recruitment activity including selection panels have their knowledge updated in respect of any changes in legislation or best practice.

- Our leadership programme is being developed to include a module on Inclusion and Diversity.

4.4 Recruitment and Resourcing

The Trust monitors equality data for all applicants for posts across conversion rates from application to appointment. The on-line application form used by NHS Jobs and TRAC addresses all of the protected characteristics covered by the Equality Act, including marriage and civil partnership, with the exception of pregnancy and maternity. Managers are not made aware of applicants' age, sex, race, religion, marital status or sexual orientation. This information is only used for monitoring purposes and managers complete shortlisting based on the strength of the application in relation to the person specification.

Statistically, applicants applying from ethnic backgrounds other than white British remain low, although higher than the average make-up of the local population. Statistically, candidates from BAME backgrounds advance better than white British candidates.

Christianity accounted for 48.11% of all applications received. 11.48% of appointed candidates did not disclose their religion or belief. Twelve candidates were appointed from four different declared faith groups other than Christianity or Atheism and thirty nine declared their religion was "other".

Applications by candidates indicating their sexual orientation as heterosexual represent 90% of all those received while 4.58% of respondents did not disclose their sexual orientation. The data shows no significant change in the proportion of applicants indicating their sexual orientation and applicants are now able to declare as being transgender or undecided.

Male applicant numbers remain lower than those for female candidates when compared to the relatively even gender split of the local population. This trend is representative of the NHS staffing population generally, in which women are over represented. Detailed charts showing the demographic split of recruitment stages by characteristic can be found at Appendix 5.

Despite having the Disability Confident Employer accreditation, the Trust receives relatively few applicants from disabled candidates. However, applicants who declare a disability do not report any disadvantage at interview or appointment stage (4.26% of applications were from candidates with declared disability compared to 3.64% of appointments).

4.5 National Staff Survey

As part of the Trust's participation in the 2018 National Staff Survey, the views of staff were sought on a number of equality and diversity related issues. There was little change in the Trust's scores from 2017, demonstrating that the Trust's performance in this area remains generally positive.

The following table shows the Trust's position in relation to key questions from the Survey as compared to the Trust position in 2016 and 2017 and also the ranking relevant to all other acute trusts that participated.

Key Question from National Staff Survey	2016	2017	2018	Ranking, compared with all acute trusts in 2018
Staff believing the Trust provides equal opportunities for career progression or promotion	91%	92%	91%	Above (better than) average
BAME Staff believing the Trust provides equal opportunities for career progression or promotion	96%	92%	92%	Above (better than) average
Staff experiencing discrimination from patients/members of the public in the last 12 months	5.3%	4.2%	3.7%	Below (better than) average
BAME Staff experiencing discrimination from patients/members of the public in the last 12 months	23%	18%	23%	Below (better than) average
Staff experiencing discrimination from managers/team leaders in the last 12 months	6.0%	6.7%	6.1%	Below (better than) average
BAME Staff experiencing discrimination from managers/team leaders in the last 12 months	6%	19%	14%	Equal to the average

We will be working with our BAME staff network to explore the reasons behind the differences between the overall responses and those of the BAME respondents. We are really conscious of the difference between the reported experiences of our BAME staff and will use this when refreshing our training. We will also increase the publicity

of the freedom to speak up guardians (FTSUG's). We are in the process of exploring the possibility of cultural interventions which we hope will improve these results.

5.0 Workforce Race Equality Scheme (WRES)

The NHS Equality & Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

All health service providers are expected to show progress against nine indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

The WRES will continue to work to evidence the outcomes of the work that is done, publishing data intelligence and supporting the system by sharing replicable good practice.

A table detailing our WRES results can be found at Appendix 6. Our results in comparison to last year are encouraging. Key findings from the results are:

- Positive increase in BAME staff numbers in VSM and non-consultant career grades
- Significant positive increase in the likely appointment of BAME staff
- 13% more BAME staff responding favourably when asked about training learning and development
- Negative increase in BAME staff (+5%) reporting they have suffered bullying harassment or abuse from patients, relatives or members of the public
- Positive significant decrease in BAME staff (-13%) reporting they have suffered bullying harassment or abuse from staff members
- Significant positive decrease in BAME staff (-5%) reporting they have suffered bullying harassment or abuse from managers
- Significant negative decrease (-7%) in BAME staff believing the trust provides equal opportunities for career progression or promotion

6.0 Workforce Disability Equality Scheme (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.

The implementation of the WDES will enable NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It will support positive change for existing employees, and enable a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard on which the WDES is in part modelled, it will also allow us to identify good practice and compare performance regionally and by type of trust.

A table detailing our WDES results can be found at Appendix 7. This is the first year we have reported against the WDES Metrics, so no comparison of the data is yet possible. 3% of our workforce has declared they have a disability. It should be noted that 699 staff (24%) have a disability status recorded as unknown or NULL.

Key findings from the results are:

- 4.64% of shortlisted applicants and 4.32% of all staff appointed had declared a disability.
- Disabled staff have 24% chance of being appointed in comparison to 26% of non-disabled staff
- 89% of disabled respondents for the 2018 Staff Survey felt the trust acts fairly with regards to career progression and promotion compared to 92% of not disabled respondents
- 27% of disabled respondents for the 2018 Staff Survey reported they have experienced bullying harassment or abuse from patients, relatives or members of the public in comparison to 23% of not disabled respondents
- 20% of disabled respondents for the 2018 Staff Survey reported they had experienced bullying harassment or abuse from managers compared to 8% of not disabled respondents
- 46% of disabled respondents for the 2018 Staff Survey reported that after experiencing harassment, bullying or abuse at work say they or a colleague reported it compared to 57% of not disabled staff
- 31% of disabled respondents for the 2018 Staff Survey reported feeling pressure their line manager to come to work despite not feeling well enough to do so compared to 21% of not disabled respondents
- 34% of disabled staff respondents for the 2018 Staff Survey said they were satisfied with the extent the organisation valued their work compared to 50 of not disabled respondents

7.0 Conclusions

The report shows that statistics of our staff and patients from a demographic perspective remain consistent with last year in all areas. The demographic split of DCH staff continues to be more diverse than that of the local population, and the demographics of our patients mirror those of the local population.

Listening events have been held with our BAME and Disabled staff and networks are in the process of being established. These networks will provide staff from minority groups assurance they have a way to raise concerns and a forum to share both positive and negative experiences. The learnings from these events will also inform our training and development interventions. However engagement beyond the event has been limited.

Our staff survey results indicate our BAME and disabled staff are being treated differently to their colleagues; specifically in relation to experiencing discrimination. We have no apparent areas of discrimination in relation to the protected characteristics within our policies and processes and our analysis of formal HR processes does not highlight any. We will be discussing the differences and areas of concern with our staff networks to enable us to tackle these moving forwards.

We are particularly mindful of the increase in the percentage (+5%) of BAME staff experiencing discrimination from patients/members of the public in the last 12 months; whilst below the national average this is still of concern and indicate an area requiring further action. Likewise, staff experiencing discrimination from managers/ team leaders stands at 14% of respondents. Although this has reduced by 5% since the 2017 survey it still remains an area of concern.

We are investing in board development sessions with an equality specialist in October 2019 and January 2010; after those sessions our areas of priority will be finalised and our action plans updated accordingly. The Workforce Committee is scheduled to receive an update on this area in December 2019; this timescale will be reviewed following the October board session.

More legislation is expected to provide further guidance relating to the other protected groups going forward. It is the intention of the Equality, Diversity and Inclusion Steering Group to strengthen our focus on staff and patient diversity needs and further develop relationships within the Dorset network.

Appendix 1 – Background Information

Legislative and Compliance Framework

Equality Act (2010)

The Equality Act (Equality Act) came into effect in 2010, replacing previous anti-discrimination laws with a single act. The duties contained within the Equality Act cover the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief (including atheist)
- Gender
- Sexual orientation

Contained within the Equality Act is the Public Sector Equality Duty (PSED), which established a general duty for all public bodies to demonstrate due regard for enhancing equality by:

- Eliminating unlawful discrimination, harassment and victimisation
- Advancing equality of opportunity between different groups
- Fostering good relations between different groups

Also contained within the Equality Act and imposed by secondary legislation are specific duties, which require public bodies to:

- Publish relevant, proportionate information demonstrating their compliance with the general equality duty at least annually
- Set and publish specific, measurable equality objectives

NHS Equality Delivery System 2 (EDS2)

As a result of a consultation by NHS England, EDS2 was developed and launched in November 2013, as a refreshed delivery system for equality within the NHS. EDS2 is a generic tool designed for use by both NHS commissioners and NHS providers, at the heart of which are 18 core outcomes. These outcomes are grouped under 4 goals relating to the issues that matter to those who use and work within the NHS. The implementation of EDS2 locally was mandated in 2015 and the system affords trusts a good deal of flexibility with regard to language and approach used, in order to ensure that the system can be bespoke to meet the requirements of individual trusts.

Workforce Race Equality Standard (WRES)

In 2015 the WRES was mandated for all trusts to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This report contains the Trust's annual WRES results for 2018/19.

Workforce Disability Equality Standard (WDES)

The NHS Equality and Diversity Council has recommended that a Workforce Disability Equality Standard (WDES) should be mandated in England from April 2019. This report contains DCH's first return.

Gender Pay Gap (GPG)

Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG).

Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

Our Gender Pay Gap Report is published separately.

Appendix 2 – Equality Objectives and Action Plan

EQUALITY, DIVERSITY & INCLUSION ACTION PLAN 2019 – 2021 FROM EDS2 PUBLIC/STAKEHOLDER CONSULTATION MAY-JUNE 2018						
EDS GOAL 1 – BETTER HEALTH OUTCOMES FOR ALL						
Objective **	**Action**	**Measures of Success**	**Lead**	**Date Added**	**Timescale**	**Progress Update**
1.3 (Developing) Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Ensure that patient leaflets are available in a variety of formats and work with parties across the health community	• Availability of resources in several different formats • Improvement of questionnaire scores next year	Patient and Public Experience Lead	March 2019	Ongoing	Reviewing leaflet process and formats available
	Publicise the use of patient care passports to staff, patients, carers and local interest groups	• Increased use of patient care plan passports	Patient and Public Experience Lead	March 2019	Ongoing	LD passports Dementia 'This is me' Carers Awareness – John's Campaign
	Seek engagement opportunities with Patient Engagement Groups. To establish a Public & Youth Forum (Volunteers) Utilise Health Watch. Link with small local groups	• Patient survey responses relating to accessibility of services • Feedback from Carers, patient forums and HealthWatch reports	Patient and Public Experience Lead	March 2019	Ongoing	HealthWatch Dorset Discharge project Pan Dorset Carers Groups Engagement with local LD Speak Up groups Attendance at Dorset Carer Hub
	Creation of Patient & Public Engagement Strategy	• Implementation of Patient & Public Engagement Strategy in line	Patient and Public Experience Lead	March 2019	Ongoing	Ongoing piece of work

		with Trust aims & objectives				
	Ensure compliance with the accessible information standard	• Increase awareness of patient communication needs • Evidence of information accessible in other format	Patient and Public Experience Lead	March 2019	Dec 2019	PPE lead to work with Head of Access to develop policy and implementation Interpretation policy reviewed to confirm that the Trust can access other formats of information via K International.
EDS GOAL 2 IMPROVED PATIENT ACCESS AND EXPERIENCE						
Objective	**Action**	**Measures of Success**	**Lead**	**Date Added**	**Timescale**	**Progress Update**
2.1 (Achieved) Patients' carers and communities can readily access services and should not be denied access on unreasonable grounds	Include patient representatives in the development of Trust travel plans	• Development of inclusive travel plan	AM	March 2019	Ongoing	Green Travel Plan – G Troop
	Accessibility audits relating to protected groups to be completed with local patient forums	• Audit outcomes and related action plans • PLACE inspections	AM	March 2019	Ongoing	
	Communication methods with patients to be reviewed	• Accessible Information Standard	AS	March 2019	Ongoing	Hearing Loop – A Savin
	Site signage to be reviewed	• Audit outcomes and related action plans • PLACE Inspection • Estates Master	AM / Estates	March 2019	Ongoing	

		Plan				
2.4 (Achieved) Patients and carers complaints about services and subsequent claims for redress should be handled respectfully and efficiently	Review of Complaints Policy	• Complaints Survey	AM	March 2019	December 2019	Complaints Policy currently being updated
2.2 (Developing) People are informed and supported to be as involved as they wish to be in decisions about their care	Develop co-production opportunities as part of the Engagement Strategy.	Service improvements made with the involvement of patients/service users.	AM	March 2019	December 2019	OPD Listening event to inform the OPD transformation project Co-design training for staff PPE Lead working with Transformation team to ensure that patients part of improvement projects.
2.3 (Developing) People report positive experiences of the NHS	Patient Experience Team to share positive feedback	Compliments recorded FFT comments Care Opinion & NHS Choice	AM	March 2019	Ongoing	

EDS GOAL 3 – EMPOWERED, ENGAGED AND WELL SUPPORTED STAFF						
Objective **	**Action**	**Measures of Success**	**Lead**	**Date Added**	**Timescale**	**Progress Update**
3.2 (Achieving) The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil legal obligations	Undertake Gender Pay Gap audits as part of workforce planning processes Repeat annually GPG in line with statutory requirements Analyse areas of significant variance and identify key actions	• Communicate variances in GPG data • Communicate action plan to address variances • Regular communication of progress against	SS	March 2019	July 2019 Annual requirement	

		action plan				
3.4 (Achieving) When at work, staff are free from abuse, harassment, bullying and violence from any source	Promotion of the whistleblowing process and policy Publicise whistleblowing process by using leaflets, posters, communication updates, team brief, FTSUG's and focus groups Analyse annual Staff Survey Data	• Staff surveys • Feedback through staff side forums • Staff survey outcomes are published • Whistleblowing process updates are publicised in communications updates/team brief quarterly • Evidence of leaflets/posters in the organisation	SS	March 2019	Ongoing	
	Analysed anonymised summary of disciplinary cases relating to dignity & respect to be provided to the HRD to ensure all cases were appropriately implemented and managed. Identify any actions required to address (WRES)	• Present analysis at ED&I steering group and review actions	SS	March 2019	July 2019	Detail included within annual ED&I report
	Engage with trade union representatives to inform staff engagement and equality initiatives	• Staff Side involvement in planning and delivery of equality and engagement initiatives	SS/CG/JK	March 2019	Ongoing	
	Engage with staff to ensure	• Staff feedback	SS/CG/JK	March 2019	Ongoing	

	initiatives are having desired effect	received				
	Analyse Staff Survey results for incidences and trends	• Staff survey outcome will identify reducing trend in incidences of B&H	SS	March 2019	Sept 19	
3.1 (Achieving) Fair NHS Recruitment & Selection processes lead to a more representative workforce at all levels	Promote schemes that support underrepresented groups securing placements and/or employment at DCH	• Supported Internship • Accredited as a Disability Confident employer	SS / HH / Education	March 2019	Ongoing	
	Provide options for different recruitment methods	• Evidence that methods other than face to face are offered for recruitment activities (skype/assessments)	HH	March 2019	Ongoing	
	Delivery of Recruitment Training for 95% of recruiting staff which will include D&I module	• Evidence of training records • Staff being signed off by manager as competent fair recruiter • Updates on progress will be reported to the workforce committee	HH	March 2019	May 2019	
3.5 (Achieving) Flexible working options are available	To review and refresh flexible working policy Promote policy to all staff	• Local staff survey to be carried out to ascertain views	SS	March 2019	Sept 19	

to all staff consistent with the needs of the service and the way people lead their lives		• Evidence of policy promotion in communications following review • Carry out in year audit of requests and policy application				
3.3 (Achieving) Training & Development opportunities are taken up and positively evaluated by all staff	Develop process pre-education centre involvements to allow collection of anonymised summary of training refusal. (informal and formal requests) (WRES)	• Data published in WRES/WDES	SS / Education	March 2019	Ongoing	
3.6 (Achieving) Staff report positive experiences of their membership of the workforce	Staff Survey results disseminated to departments and action plans developed	• Evidence of analysis and trends in comms	SS	March 2019	May 2019	Completed
	Develop support networks for minority groups	• Details of groups published to all staff	SS	March 2019	Ongoing	
	Staff Engagement Event to be held annually	• Event to be publicised and reviewed in trust communications	SS	March 2019	April 2020	
EDS GOAL 4 INCLUSIVE LEADERSHIP AT ALL LEVELS						
Objective **	**Action**	**Measures of Success**	**Lead**	**Date Added**	**Timescale**	**Progress Update**
4.3 (Achieving) Middle managers and other line managers support their staff to work in culturally competent ways	D&I training to form part of recruitment training (see objective 3.1 above)	• Monitor attendance	HH	March 2019		
	Create and deliver Diversity Awareness sessions for staff of all levels	• Monitor attendance • Review impact and	SS	March 2019	September 2019	

within a work environment free from discrimination		content with minority groups				
	Staff Cultural Appreciation Event to be held annually	• Event to be publicised and reviewed in Trust Communications	SS / HH	March 2019	Ongoing	Annual event – starting September 2019
	Deliver bullying and harassment training for line managers	• Monitor attendance	HR Team	March 2019	Ongoing	Part of HR Training
	Support staff from minority groups to have a voice and to share experiences	• Membership of staff networks	All	June 2019	Ongoing	BAME and Disabled listening events held
	Ensure representative from each of the divisions is in attendance at the D&I steering group Strengthen "reporting up" and feedback from divisions relating to D&I	• Membership of D&I Steering group • Minutes of D&I steering group published on intranet	MW / SS	March 2019	Ongoing	
4.1 (Achieving) Boards and senior leaders routinely demonstrate their commitment	D&I updates to be provided at workforce committee monthly – deep dive twice per year.	• Meeting minutes • Attendance at board development days	MW / SS	March 2019	July 2019 October 2019 March 2020	
	Development opportunities to be provided to board member and senior leaders	• Meeting minutes • Attendance at board development days	MW / SS	March 2019	August 2019	
	Senior Leaders to support an annual listening/engagement event for staff partnership / BAME / Disability Network	• Meeting minutes	MW / SS	March 2019	March 2020	
4.2 (Achieving) Papers that come before board and other major	Review trust reporting template to ensure D&I is adequately addressed	• Updated template and review minutes in D&I meeting	MW / SS	March 2019	August 2019	

committees identify equality related impacts including risks, and say how these risks should be managed						
OTHER ACTIONS						
Objective	**Action**	**Measures of Success**	**Lead**	**Date Added**	**Timescale**	**Progress Update**
N/A	To work with BAME and Disabled staff networks to explore differences in SoS responses	• Improvement in response in 2019 survey	MW / SS	June 2019	December 2019	
N/A	To undertake sampled quality assurance checks in relation to sickness capability and grievances	• Improvement in data	SS	June 2019	December 2019	

Appendix 3 – Patient Demographic Data

Any patient who has had activity between 1 April 2018 – 31 March 2019 is included (but counted only once)
This includes inpatients, outpatients and ED

Gender	No of Patients
Female	60703
Male	53411
INDETERMINATE/OTHER	2
UNKNOWN/NOT STATED	1

Ethnic Group	No of Patients
ASIAN/ASIAN BRITISH - ANY OTHER	210
ASIAN/ASIAN BRITISH - BANGLADESHI	76
ASIAN/ASIAN BRITISH - INDIAN	120
ASIAN/ASIAN BRITISH - PAKISTANI	30
BLACK/BLACK BRITISH - AFRICAN	48
BLACK/BLACK BRITISH - ANY OTHER BACKGROUND	24
BLACK/BLACK BRITISH - CARIBBEAN	46
MIXED - ANY OTHER	154
MIXED - WHITE AND ASIAN	157
MIXED - WHITE/BLACK AFRICAN	65
MIXED - WHITE/BLACK CARIBBEAN	123
NOT STATED	6828
NULL	24271
OTHER - ANY OTHER	85
OTHER - CHINESE	86
WHITE - ANY OTHER BACKGROUND	6358
WHITE - BRITISH	75174
WHITE - IRISH	262

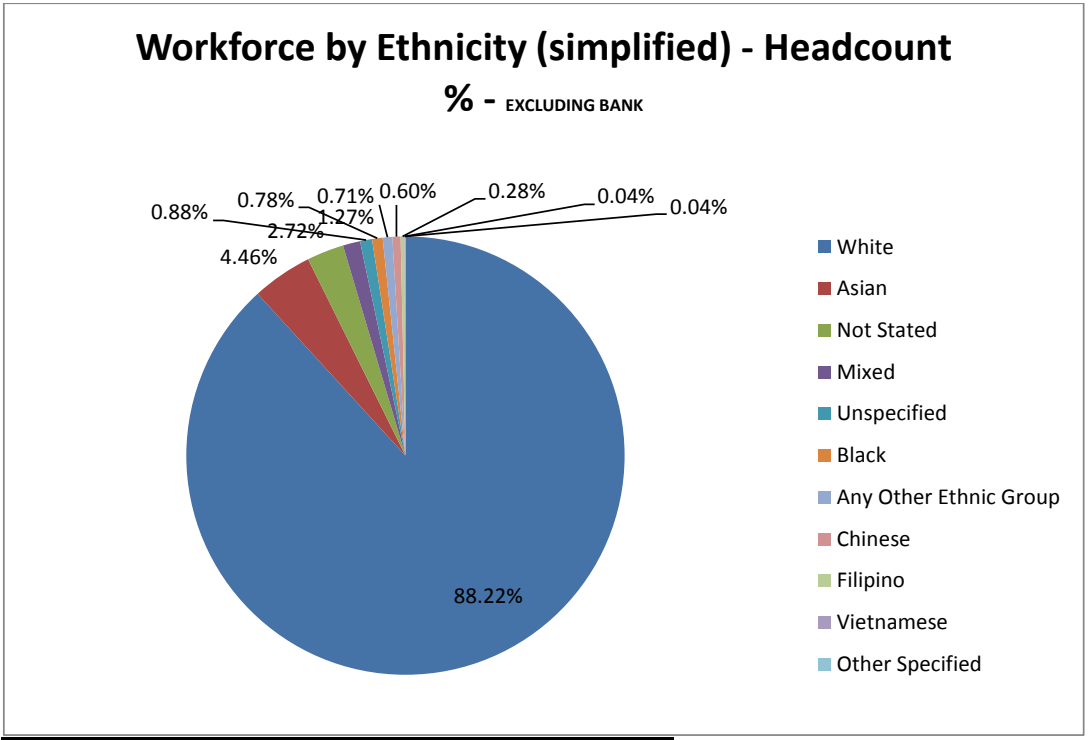
Marital Status	No of Patient
Divorced	919
Married/Separated	15341
Not Applicable	246
Not Known	10005
NULL	72640
Single	14402
Widowed	563
Separated	1

Religion	No of Patients
Armenian Catholic	7
Baptist	114
Buddhist	19
Christian Scientist	6
Chritadelphian	5
Church of England	11866
Church of Ireland	2
Church of Scotland	37
Church of Wales	2
Hindu	10
Jehovah's Witness	88
Jewish	19
Methodist	408
Mormon	9
Muslim	51
Nonconformist	11
None	4808
Not Known	14483
NULL	80646
Orthodox	14
Other	162
Other Free Church	52
Pentecostal	6
Presbyterian	4
Quaker	11
Roman Catholic	1229
Salvation Army	16
Sikh	1
United Reformed	29
Unitarian	2

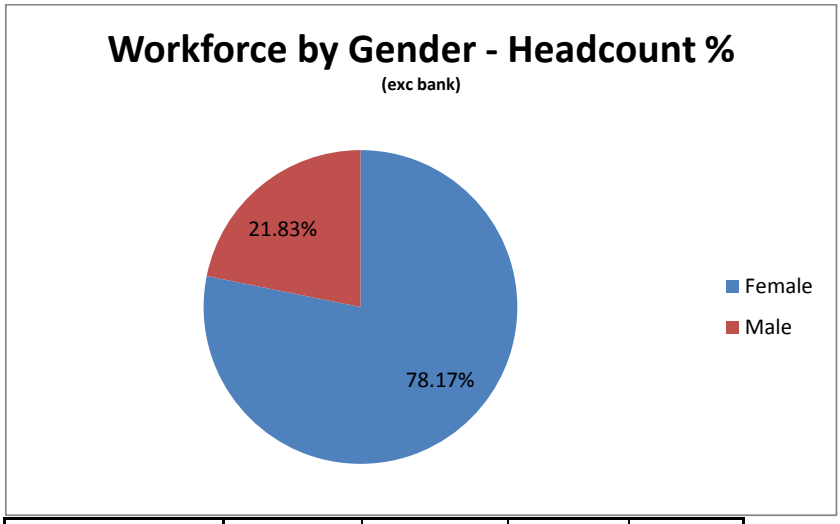
Age	No of Patient
NULL	3
0-18	19937
19-35	14995
36-50	14807
51-65	23486
66+	40889

Appendix 4 – Workforce Demographics Data

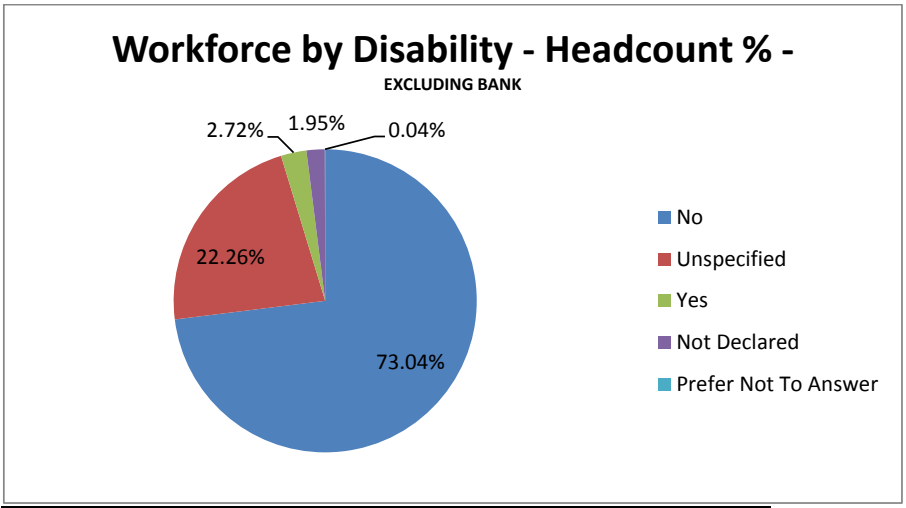
All Measures are %



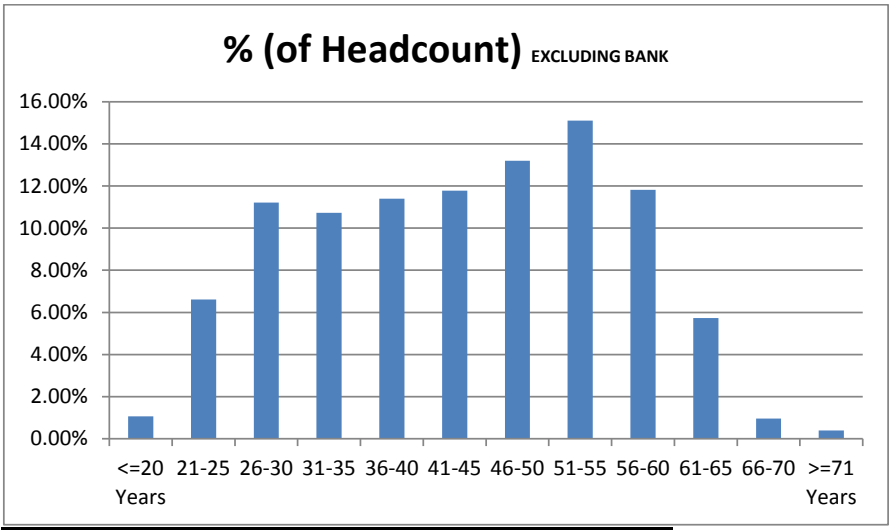
ETHNICITY	HEADCOUNT	% (of headcount)	FTE
White	2493	88.22%	2089.7
Asian	126	4.46%	117.1
Not Stated	77	2.72%	66.187
Mixed	36	1.27%	32.36
Unspecified	25	0.88%	20.71
Black	22	0.78%	20.92
Any Other Ethnic Group	20	0.71%	17.297
Chinese	17	0.60%	14.895
Filipino	8	0.28%	7.4
Vietnamese	1	0.04%	1
Other Specified	1	0.04%	0.8
GRAND TOTAL	**2826**	**100.00%**	**2388.3**



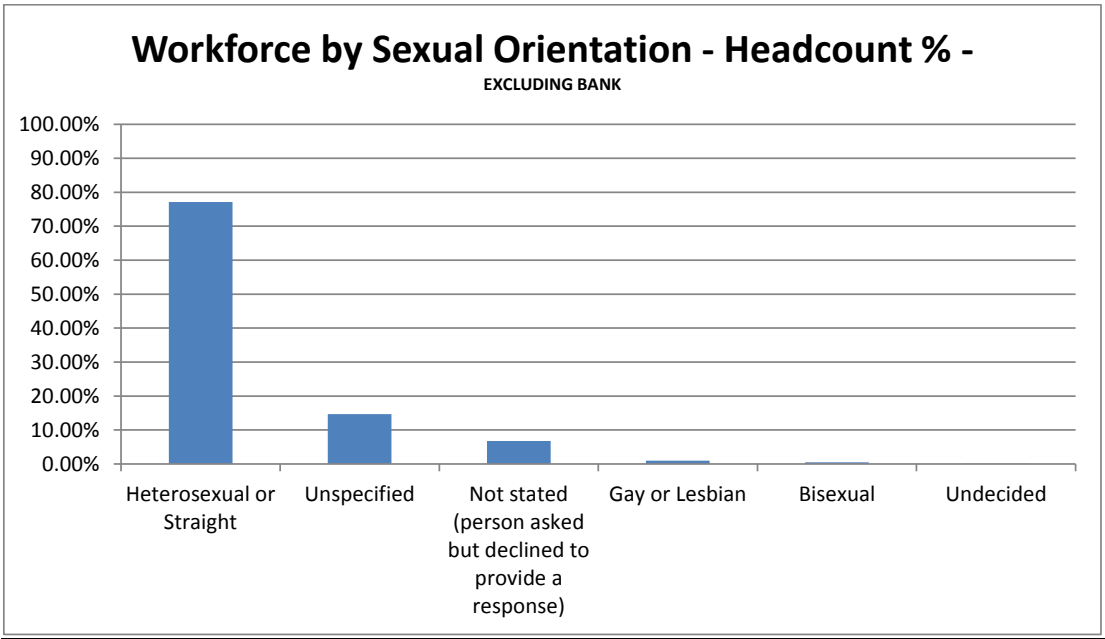
Gender	Headcount	% (of Headcount)	FTE	% (of FTE)
Female	2209	78.17%	1811.698	75.86%
Male	617	21.83%	576.6332	24.14%
GRAND TOTAL	2826	100.00%	2388.331	100.00%



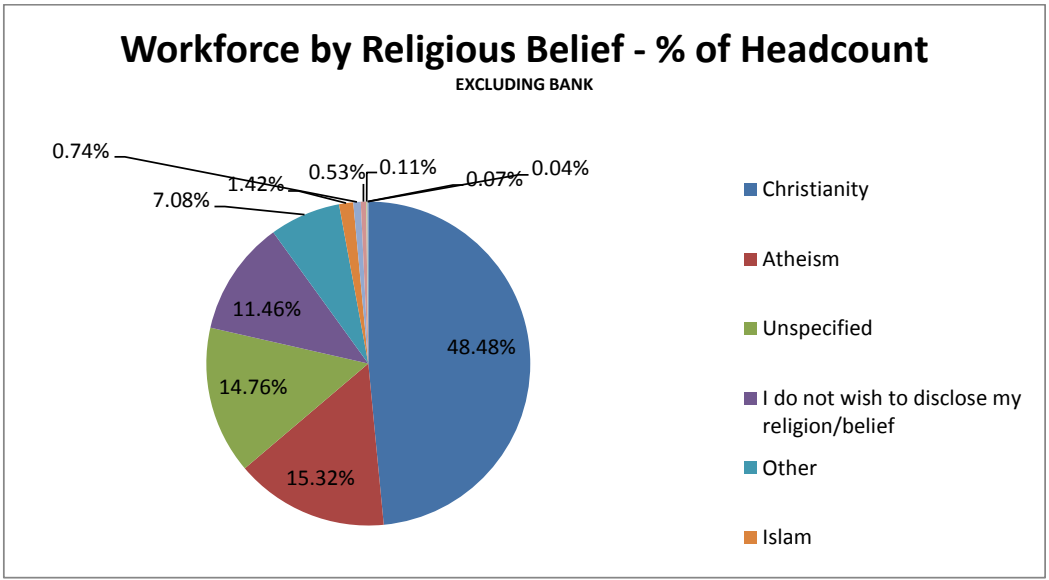
Disability Flag	Headcount	% (of Headcount)	FTE
No	2064	73.04%	1765.5592
Unspecified	629	22.26%	514.13828
Yes	77	2.72%	63.45999
Not Declared	55	1.95%	44.17333
Prefer Not To Answer	1	0.04%	1
GRAND TOTAL	2826	100.00%	2388.3308



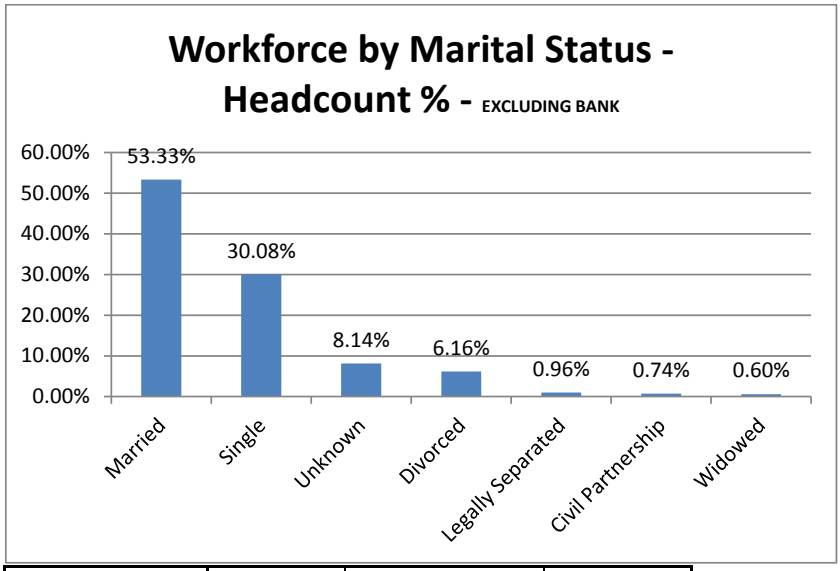
Age Band	Headcount	% (of Headcount)	FTE
<=20 Years	30	1.06%	29.8
21-25	187	6.62%	180.64665
26-30	317	11.22%	289.72264
31-35	303	10.72%	247.69965
36-40	322	11.39%	264.36766
41-45	333	11.78%	280.06842
46-50	373	13.20%	310.99085
51-55	427	15.11%	369.27467
56-60	334	11.82%	274.68256
61-65	162	5.73%	116.57921
66-70	27	0.96%	17.52862
>=71 Years	11	0.39%	6.96987
GRAND TOTAL	2826	100.00%	2388.3308



Sexual Orientation	Headcount	% (of Headcount)	FTE
Heterosexual or Straight	2180	77.14%	1860.66284
Unspecified	414	14.65%	332.18354
Not stated (person asked but declined to provide a response)	191	6.76%	155.86192
Gay or Lesbian	27	0.96%	26.46
Bisexual	13	0.46%	12.1625
Undecided	1	0.04%	1
GRAND TOTAL	2826	100.00%	2388.3308



Religious Belief	Headcount	% (of Headcount)	FTE
Christianity	1370	48.48%	1151.14677
Atheism	433	15.32%	381.33571
Unspecified	417	14.76%	334.98354
I do not wish to disclose my religion/belief	324	11.46%	272.78575
Other	200	7.08%	170.33303
Islam	40	1.42%	38.95
Hinduism	21	0.74%	20.2
Buddhism	15	0.53%	12.596
Judaism	3	0.11%	3
Sikhism	2	0.07%	2
Jainism	1	0.04%	1
GRAND TOTAL	2826	100.00%	2388.3308



Marital Status	Headcount	% (of Headcount)	FTE
Married	1507	53.33%	1218.38115
Single	850	30.08%	767.78629
Unknown	230	8.14%	196.99673
Divorced	174	6.16%	150.4333
Legally Separated	27	0.96%	22.86666
Civil Partnership	21	0.74%	17.81334
Widowed	17	0.60%	14.05333

Appendix 5 – Recruitment Demographics Data

		Non-medical						Medical					
	Answer	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Age	Under 20	132	62	30	3.38%	46.97%	48.39%	0	0	0	0.00%	0.00%	0.00%
	20 - 24	554	193	50	14.20%	34.84%	25.91%	32	1	0	4.42%	3.13%	0.00%
	25 - 29	710	229	64	18.20%	32.25%	27.95%	286	39	19	39.50%	13.64%	48.72%
	30 - 34	592	185	49	15.18%	31.25%	26.49%	146	43	18	20.17%	29.45%	41.86%
	35 - 39	410	153	51	10.51%	37.32%	33.33%	109	49	22	15.06%	44.95%	44.90%
	40 - 44	314	136	32	8.05%	43.31%	23.53%	57	23	8	7.87%	40.35%	34.78%
	45 - 49	388	179	45	9.95%	46.13%	25.14%	37	14	3	5.11%	37.84%	21.43%
	50 - 54	393	199	49	10.07%	50.64%	24.62%	23	13	3	3.18%	56.52%	23.08%
	55 - 59	259	118	26	6.64%	45.56%	22.03%	20	5	2	2.76%	25.00%	40.00%
	60 - 64	129	62	19	3.31%	48.06%	30.65%	3	0	0	0.41%	0.00%	0.00%
	65+	19	5	2	0.49%	26.32%	40.00%	8	4	3	1.10%	50.00%	75.00%
	Not stated	1	0	0	0.03%	0.00%	0.00%	3	3	0	0.41%	100.00%	0.00%
	Total	3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

% shortlisted is the % of applications in each category shortlisted - so, for example, for Under 20s non medical, there were 132 applications; of which 62 were shortlisted. 62 is 46.97% of 132. (cells highlighted in yellow above).

% appointed is the percentage of those shortlisted who were appointed - for example 30 of the 62 non medical applicants who were shortlisted were then appointed (48.39%) – These are the figures in **bold red** text

	Non-	Medical

	Answer	medical Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Ethnic Origin	White	3153	1375	370	80.83%	43.61%	26.91%	97	39	15	13.40%	40.21%	38.46%
	Black	297	20	1	7.61%	6.73%	5.00%	110	13	2	15.19%	11.82%	15.38%
	Asian	245	57	11	6.28%	23.27%	19.30%	324	57	3	44.75%	17.59%	5.26%
	Other	83	20	5	2.13%	24.10%	25.00%	74	13	1	10.22%	17.57%	7.69%
	Mixed	77	21	8	1.97%	27.27%	38.10%	31	5	3	4.28%	16.13%	60.00%
	Not disclosed	27	9	3	0.69%	33.33%	33.33%	22	2	0	3.04%	9.09%	0.00%
	Not stated	19	19	19	0.49%	100.00%	100.00%	66	65	54	9.12%	98.48%	83.08%
Total		3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

	Answer	Non-medical Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Medical Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Disability	Not stated	21	21	21	0.54%	100.00%	100.00%	65	64	53	8.98%	98.46%	82.81%
	I do not wish to disclose	83	35	4	2.13%	42.17%	11.43%	3	0	0	0.41%	0.00%	0.00%
	No	3601	1392	375	92.31%	38.66%	26.94%	655	129	24	90.47%	19.69%	18.60%
	Yes	196	73	17	5.02%	37.24%	23.29%	1	1	1	0.14%	100.00%	100.00%
Total		3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

	Answer	Non-medical						Medical					
		Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Gender	Male	1015	290	76	26.02%	28.57%	26.21%	461	120	42	63.67%	26.03%	35.00%
	Female	2884	1230	341	73.93%	42.65%	27.72%	261	74	36	36.05%	28.35%	48.65%
	I do not wish to disclose	2	1	0	0.05%	50.00%	0.00%	2	0	0	0.28%	0.00%	0.00%
Total		3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

	Answer	Non-medical						Medical					
		Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Sexual Orientation	Not stated	19	19	19	0.49%	100.00%	100.00%	66	65	54	9.12%	98.48%	83.08%
	Heterosexual or Straight	3562	1392	373	91.31%	39.08%	26.80%	618	118	22	85.36%	19.09%	18.64%
	Gay	10	2	1	0.26%	20.00%	50.00%	0	0	0	0.00%	0.00%	0.00%
	Lesbian	12	6	2	0.31%	50.00%	33.33%	0	0	0	0.00%	0.00%	0.00%
	Bisexual	71	23	4	1.82%	32.39%	17.39%	2	1	1	0.28%	50.00%	100.00%
	I do not wish to describe	182	64	16	4.67%	35.16%	25.00%	30	9	1	4.14%	30.00%	11.11%
	Gay or Lesbian	37	13	1	0.95%	35.14%	7.69%	4	1	0	0.55%	25.00%	0.00%
	Other sexual orientation	2	0	0	0.05%	0.00%	0.00%	0	0	0	0.00%	0.00%	0.00%
	Undecided	6	2	1	0.15%	33.33%	50.00%	4	0	0	0.55%	0.00%	0.00%
Total		3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

	Answer	Non-medical						Medical					
		Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Religion	Not stated	19	19	19	0.49%	100.00%	100.00%	64	63	53	8.84%	98.44%	84.13%
	Atheism	739	336	103	18.94%	45.47%	30.65%	31	13	6	4.28%	41.94%	46.15%
	Buddhism	32	14	6	0.82%	43.75%	42.86%	41	9	1	5.66%	21.95%	11.11%
	Christianity	2061	774	207	52.83%	37.55%	26.74%	164	41	11	22.65%	25.00%	26.83%
	Hinduism	69	12	0	1.77%	17.39%	0.00%	77	15	1	10.64%	19.48%	6.67%
	Islam	87	12	0	2.23%	13.79%	0.00%	282	37	3	38.95%	13.12%	8.11%
	Jainism	1	1	0	0.03%	100.00%	0.00%	1	1	0	0.14%	100.00%	0.00%
	Judaism	2	1	1	0.05%	50.00%	100.00%	0	0	0	0.00%	#DIV/0!	0.00%
	Sikhism	0	0	0	0.00%	#DIV/0!	0.00%	3	2	0	0.41%	66.67%	0.00%
	Other	410	167	39	10.51%	40.73%	23.35%	11	2	0	1.52%	18.18%	0.00%
	I do not wish to disclose	481	185	42	12.33%	38.46%	22.70%	50	11	3	6.91%	22.00%	27.27%
Total		3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

	Answer	Non-medical						Medical					
		Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
Transgender	Not stated	2510	1029	251	64.34%	41.00%	24.39%	665	176	72	91.85%	26.47%	40.91%
	No	1358	474	161	34.81%	34.90%	33.97%	56	16	5	7.73%	28.57%	31.25%
	Yes	2	0	0	0.05%	0.00%	0.00%	1	0	0	0.14%	0.00%	0.00%
	I do not wish to answer	31	18	5	0.79%	58.06%	27.78%	2	2	1	0.28%	100.00%	50.00%
Total		3901	1521	417	100.00%	38.99%	27.42%	724	194	78	100.00%	26.80%	40.21%

Appendix 6 – WRES Detailed Data

<table>
<tr><th colspan="2">WRES Indicator</th><th>Data for Reporting year (up to 31 March 2019)</th><th>Data for previous year (up to 31 March 2018)</th><th>Implications for the data and any additional background narrative</th></tr>
<tr><td colspan="5">Workforce Metrics – For each of these four workforce indicators the standard compares the metrics for white and BME Staff</td></tr>
<tr><td>1</td><td>Percentage of BAME staff in bands 1-9 and VSM compared with the percentage of BAME staff in the overall workforce</td><td>
<table>
<tr><th></th><th>White</th><th>BAME</th></tr>
<tr><td>Band 8a</td><td>96%</td><td>4%</td></tr>
<tr><td>Band 8b</td><td>96%</td><td>4%</td></tr>
<tr><td>Band 8c</td><td>100%</td><td>0%</td></tr>
<tr><td>Band 8d</td><td>100%</td><td>0%</td></tr>
<tr><td>Band 9</td><td>100%</td><td>0%</td></tr>
<tr><td>VSM</td><td>83%</td><td>17%</td></tr>
<tr><td>Junior Doctor</td><td>63%</td><td>32%</td></tr>
<tr><td>Non Consultant Career Grades</td><td>42%</td><td>43%</td></tr>
<tr><td>Consultant</td><td>4%</td><td>51%</td></tr>
<tr><td>Other Medical Staff</td><td>76%</td><td>5%</td></tr>
<tr><td>Board</td><td>93%</td><td>7%</td></tr>
</table>
</td><td>
<table>
<tr><th></th><th>White</th><th>BAME</th></tr>
<tr><td>Band 8a</td><td>95%</td><td>5%</td></tr>
<tr><td>Band 8b</td><td>84%</td><td>13%</td></tr>
<tr><td>Band 8c</td><td>100%</td><td>0%</td></tr>
<tr><td>Band 8d</td><td>100%</td><td>0%</td></tr>
<tr><td>Band 9</td><td>100%</td><td>0%</td></tr>
<tr><td>VSM</td><td>89%</td><td>11%</td></tr>
<tr><td>Junior Doctor</td><td>0%</td><td>90%</td></tr>
<tr><td>Non Consultant Career Grades</td><td>51%</td><td>33%</td></tr>
<tr><td>Consultant</td><td>59%</td><td>17%</td></tr>
<tr><td>Other Medical Staff</td><td>0%</td><td>63%</td></tr>
<tr><td>Board</td><td>93%</td><td>7%</td></tr>
</table>
</td><td>There was an overall increase in BAME VSM staff and non- consultant career grades.

Across the trust the total number of BAME staff employed fell from 248 to 234.</td></tr>
<tr><td>2</td><td>Relative Likelihood of BAME Staff being recruited from shortlisting compared to that of white staff being recruited from shortlisting across all posts</td><td>Number of Shortlisted applicants
White 1375
BAME 118
Number appointed from shortlisting
White 370
BAME 25
Likelihood of appointment
White 27%</td><td>Number of Shortlisted applicants
White 1508
BAME 504
Number appointed from shortlisting
White 400
BAME 26
Likelihood of appointment
White 27%</td><td>This data has shown a significant increase (16%) in the likely appointment of BAME candidates from the previous year. This is a positive indicator for the Trust.</td></tr>
</table>

		• BAME 21%	• BAME 5%	
3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process	Number of staff entering the formal disciplinary process • White 26 (1.09%) • BAME 4 (1.71%)	Number of staff entering the formal disciplinary process • White 23 (0.77%) • BAME 3 (1.21%)	There was an increase in disciplinary processes involving both white and BAME staff in 2018/19.
4	Relative likelihood of BAME staff accessing non-mandatory training and CPD as compared to white staff	Information relating to non-mandatory training participation and CPD is not recorded centrally by the trust	Information relating to non-mandatory training participation and CPD is not recorded centrally by the trust	2018 National Staff Survey finding showed that BAME staff responded 13% more favourably when asked if they received training, learning or development in the previous 12 months (not including mandatory training)
National NHS Staff Survey Findings – For each of the below indicators the standard compares the metrics for each survey question response for white and BME Staff				
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the previous 12 months	29% of BAME respondents reported experiencing bullying, harassment or abuse from patients, relatives or the public in the previous 12 months compared to 23% of white respondents	18% of BAME respondents reported experiencing bullying, harassment or abuse from patients, relatives or the public in the previous 12 months compared to 25% of white respondents	Incidences of bullying, harassment or abuse from patients, relatives or the public have increased significantly (+11%) for BAME staff
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the previous 12 months	28% of BAME respondents reported experiencing bullying, harassment or abuse from staff in the previous 12 months compared to 18% of white respondents	31% of BAME respondents reported experiencing bullying, harassment or abuse from staff in the previous 12 months compared to 24% of white respondents	A small decrease in the number of BAME staff reporting they had experienced bullying, harassment or abuse from staff members, but the percentage is still higher than that reported by their white colleagues.

7	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	85% of BAME respondents feel the Trust acts fairly with regard to career progression and promotion, compared to 92% of white respondents	92% of BAME respondents feel the Trust acts fairly with regard to career progression and promotion, compared to 92% of white respondents	A significant negative decrease in the percentage of BAME staff who believe the trust provides equal opportunities for career progression or promotion.
8	Percentage of staff experiencing discrimination at work from managers in the previous 12 months	14% of BAME respondents experienced discrimination from managers in the previous 12 months compared to 10% of white respondents	19% of BAME respondents experienced discrimination from managers in the previous 12 months compared to 6% of white respondents	A significant and positive decrease occurred in the number of BAME staff experiencing discrimination at work from their managers
Board Composition – Does the board meet the requirement on Board membership				
9	Percentage difference between the organisations Board voting membership and its workforce overall	Board members • White 13 (92.9%) • BAME 1 (7.1%) Voting Board members • White (85.7%) • BAME (14.3%) Overall Workforce by ethnicity • White (87.8%) • BAME (8.7%)	Board members • White 14 (93.3%) • BAME 1 (6.7%) Voting Board members • White (85.7%) • BAME (14.3%) Overall Workforce by ethnicity • White (88.5%) • BAME (7.4%)	A marginal change has occurred in this indicator due to there being 1 less non-executive director in post.

Appendix 7 – WDES Detailed Data

<table>
<tr><th colspan="2">WDES Indicator</th><th>Data for Reporting year
(up to 31 March 2019)</th></tr>
<tr><td colspan="3">Workforce Metrics – For each of these four workforce indicators the standard compares the metrics for disabled and not disabled staff</td></tr>
<tr><td>1</td><td>Percentage of Disabled Staff in bands 1-9 and VSM compared with the percentage of Disabled Staff in the overall workforce

*699 Staff have their disability status recorded as unknown or null</td><td>
<table>
<tr><th></th><th>Disabled</th><th>Not Disabled</th><th>Not declared / prefer not to say*</th></tr>
<tr><td colspan="4">Non – Clinical Staff</td></tr>
<tr><td>Band 1-4</td><td>3%</td><td>70%</td><td>26%</td></tr>
<tr><td>Band 5-7</td><td>2%</td><td>71%</td><td>26%</td></tr>
<tr><td>Band 8a-8b</td><td>3%</td><td>81%</td><td>17%</td></tr>
<tr><td>Band 8c-9 and VSM</td><td>0%</td><td>89%</td><td>11%</td></tr>
<tr><td>Other Staff</td><td>0%</td><td>43%</td><td>57%</td></tr>
<tr><td colspan="4">Clinical Staff</td></tr>
<tr><td>Band 1-4</td><td>2%</td><td>80%</td><td>17%</td></tr>
<tr><td>Band 5-7</td><td>3%</td><td>74%</td><td>23%</td></tr>
<tr><td>Band 8a-8b</td><td>0%</td><td>77%</td><td>23%</td></tr>
<tr><td>Band 8c-9 and VSM</td><td>0%</td><td>100%</td><td>0%</td></tr>
<tr><td>Consultant</td><td>1%</td><td>60%</td><td>39%</td></tr>
<tr><td>Non Consultant Career Grades</td><td>5%</td><td>60%</td><td>35%</td></tr>
<tr><td>Medical & Dental Trainee Grades</td><td>2%</td><td>64%</td><td>34%</td></tr>
<tr><td>Other Staff</td><td>0%</td><td>83%</td><td>17%</td></tr>
</table>
</td></tr>
<tr><td>2</td><td>Relative Likelihood of Disabled Staff being recruited from shortlisting compared to that of white staff being recruited from shortlisting across all posts</td><td>Number of Shortlisted applicants
74 Disabled
1521 Not Disabled
Number appointed from shortlisting
18 Disabled
399 Not Disabled
Likelihood of appointment
24% Disabled
26% Not Disabled</td></tr>
<tr><td>3</td><td>Relative likelihood of Disabled staff entering the formal capability process, compared to that of Not Disabled Staff entering the formal capability process</td><td>Number of staff entering the formal capability process
Disabled 3 (4%)
Not Disabled 165 (8%)</td></tr>
<tr><td colspan="3">National NHS Staff Survey Findings – For each of the below indicators the standard compares the metrics for each survey question response for disabled and not disabled staff</td></tr>
<tr><td>4a</td><td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the previous 12 months</td><td>27% of Disabled respondents reported experiencing bullying, harassment or abuse from patients, relatives or the public in the previous 12 months compared to</td></tr>
</table>

		23% of Not Disabled respondents
	Percentage of staff experiencing harassment, bullying or abuse from managers in the previous 12 months	20% of Disabled respondents reported experiencing bullying, harassment or abuse from managers in the previous 12 months compared to 8% of Not Disabled respondents
	Percentage of staff experiencing harassment, bullying or abuse from colleagues in the previous 12 months	24% of Disabled respondents reported experiencing bullying, harassment or abuse from staff in the previous 12 months compared to 17% of Not Disabled respondents
4b	Percentage of staff who after experiencing harassment, bullying or abuse at work say they or a colleague reported it	46% of Disabled respondents reported that after experiencing harassment, bullying or abuse at work say they or a colleague reported it compared to 57% of Not Disabled Staff
5	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	89% of Disabled respondents feel the Trust acts fairly with regard to career progression and promotion, compared to 92% of Not Disabled respondents
6	Percentage of staff saying they had felt pressure from their line manger to come to work despite not feeling well enough to perform their duties in the previous 12 months	31% of Disabled respondents felt pressure from their line manger to come to work despite not feeling well enough to perform their duties in the previous 12 months compared to 21% of Not Disabled respondents.
7	Percentage of staff saying they are satisfied with the extent to which their organisation values their work	34% of Disabled respondents said they were satisfied with the extent to which their organisation values their work compared to 50% of Not Disabled respondents
8	Percentage of staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	78% of Disabled respondents reported their employer has made adequate adjustment(s) to enable them to carry out their work compared to 0% of Not Disabled respondents
9a	Staff Engagement score	Staff engagement score is 6.7 for Disabled Staff compared to 7.3 for Not Disabled staff. The overall staff engagement score is 7.2
9b	Has the Trust taken action to facilitate the voices of disabled staff to be heard	Yes - A Disabled Staff listening Event was held and we are in the process of scoping and establishing a more regular forum for this group.
Board Composition		
10	Percentage difference between the organisations Board voting membership and its workforce overall	Board members • Disabled 0% • Not Disabled 100% Voting Board members • Disabled 0% • Not Disabled 0% Overall Workforce by disability • Disabled 3% • Not Disabled 73% • Unknown / Null 24%

Title of Meeting	**Trust Board**
Date of Meeting	**31 July 2019**
Report Title	**2019 Gender Pay Gap Findings**
Author	**Sarah Stickland, HR Manager**
Responsible Executive	**Mark Warner, Director of Workforce and Organisational Development**

Purpose of Report (e.g. for decision, information)
For information and to note actions set out in the Action Plan.

Summary
The Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force in September 2011, placing a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG).

This report provides an analysis of the workforce with an effective date of 31 March 2019.

Paper Previously Reviewed By
Workforce Committee

Strategic Impact
Data received through the gender pay gap analysis provides a source to inform improvements to leadership and management practices and changes to the working environment. Research suggests that there is a gender pay gap even before the arrival of a first child. Unequal sharing of care responsibilities contributes to a higher proportion of women taking part-time work, which is generally lower paid. Consequently the gender pay gap widens, particularly for those employees over 40.

Risk Evaluation
The analysis of the gender pay gap results has assisted in identifying key areas of concern and potential risk and these were incorporated into the action plan.

Impact on Care Quality Commission Registration and/or Clinical Quality
No specific implications relating to the contents of the action plan.

Governance Implications (legal, clinical, equality and diversity or other):
The gender pay gap results show the difference in the average pay between all men and women in the Trust**.**

Financial Implications
No specific implications relating to the contents of the action plan.

Freedom of Information Implications – can the report be published?	Yes
Recommendations	Trust Board are asked to note the contents of this paper and the actions in response to the 2019 Gender Pay Gap analysis.

1.0 CONTEXT

1.1 Gender pay gap obligations have been introduced alongside the existing requirements for specified public bodies, including publishing annual information to demonstrate compliance under the Public Sector Equality Duties (PSED) and publishing equality objectives every four years. The deadline for publishing requirements has now been streamlined to 30 March each year. We will refresh our report in July of each year; using data from 31 March; this will enable us to see if the actions we are taking are having an impact on the overall picture.

1.2 All organisations with over 250 employees must follow the methodology set out in the regulations and accompanying guidance, regardless of how this data may have been previously calculated. The gender pay gap differs from equal pay. Equal pay deals with the **pay difference between men and women who carry out the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the difference between the **average hourly pay between all men and women** in a workforce.

1.3 There are six basic calculations the Trust is required to report:

- mean gender pay gap;
- median gender pay gap;
- mean bonus gender pay gap;
- median bonus gender pay gap;
- proportion of males and females receiving a bonus payment;
- proportion of males and females in each quartile band.

1.4 As with any data analysis, the most critical aspect of the process is not just about reviewing the results but being clear about what needs to be done differently in future.

2.0 PURPOSE OF THE REPORT

2.1 This report will help the Trust to understand any underlying causes for their gender pay gap and take suitable steps to minimise it. Taking these steps will help us to continue to develop a reputation for being a fair and progressive employer, attracting a wider pool of potential recruits for vacancies and the enhanced productivity that can come from a workforce that feels valued and engaged in a culture committed to tackling inequality.

3.0 METHODOLOGY

3.1 Colleagues from the Electronic Staff Record (ESR) team have developed reports which will help organisations calculate their GPG data. These are available via ESR and accessible via the dashboard of ESR Business Intelligence.

4.0 FINDINGS

All staff who were classed as "Full Pay Employees" as at the snapshot date of 31 March 2019 are included in the analysis. Any members of staff who had a reduced pay rate because of absence for example have been excluded.
The mean (average of numbers in the data range) gender pay gap for the Trust is 29.09%; and the median (middle value) gender pay gap is 10.74%

Mean (Average) & Median Hourly Rates						
Gender	**2018/19**				**2017/18**	
	Avg. Hourly Rate 2018/19	**Movement in Year**	**Median Hourly Rate 2018/19**	**Movement in Year**	**Avg. Hourly Rate 2017/18**	**Median Hourly Rate 2017/18**
Male	21.77	↑	15.38	↑	21.69	14.70
Female	15.43	↑	13.73	↑	15.15	13.55
Difference	6.33	↓	1.65	↑	6.54	1.15
Pay Gap %	29.09%	↓	10.74%	↑	30.15%	7.85%

The above table shows that the average hourly rate and median hourly rate have both increased in year; much of this is attributed to the pay award. Appendix B shows we have seen a switch from a male to female dominance in bands 4, 7 and ad-hoc salaries. Only the category of Band 8c, d and 9 showed a change from a female dominance to a male dominance. This has been due to staff leaving the organisation and interim structures being put into place.

The below table shows the proportion of males and females in each of the quartile bands. To calculate this proportion all employees are sorted by hourly rate of pay, that list is then divided into four equal quarters and the proportion of males and females is calculated.

Number of employees | Q1 = Low, Q4 = High								
	2018/19				**2017/18**			
Quartile	**Female**	**Male**	**Female %**	**Male %**	**Female**	**Male**	**Female %**	**Male %**
1	590	170	77.63	22.37	552	158	77.75	22.25
2	649	130	83.31	16.69	576	134	81.13	18.87
3	657	112	85.44	14.56	607	103	85.49	14.51
4	504	266	65.45	34.55	461	250	64.84	35.16

The below table shows the summary of males and females receiving a bonus payment. For GPG calculations our bonus payments relate to Clinical Excellence Awards only, Clinical excellence awards are designed to reward medical practice that goes above and beyond the norm and can be awarded for truly outstanding work or research. There has not been an award round since the last report.

Bonus Pay Summary				
	2018/19		2017/18	
Gender	Avg. Pay	Median Pay	Avg. Pay	Median Pay
Male	12629.26	9048.00	12616.45	9040.5
Female	9704.59	3015.96	11592.55	5315.28
Difference	2924.67	6032.04	1023.91	3725.23
Pay Gap %	23.16%	66.67%	8.12	41.21

The below table shows the proportion of males and females receiving a bonus payment

Bonus ratio						
	2018/19			2017/18		
Gender	Employees Paid Bonus	Total Relevant Employees	%	Employees Paid Bonus	Total Relevant Employees	%
Female	15	2796	0.54	14	2626	0.53
Male	55	830	0.63	55	743	7.4

Gender Pay Gap calculations by band group (Appendix B) are expressed as a percentage in relation to the male salary. All values recorded as a negative (-) indicate that the Gender Pay Gap is in favour of the female workforce.

It is noted that although the Gender Pay Gap is small in most of these instances, this bias toward the female workforce is greater in the lower pay bandings. The GPG increases toward the male employees in the medical workforce. and is also noticeable in the Non-Medical and Dental ad hoc group which consists of apprentices and directors.

5.0 Next Steps

5.1 Enabling Progression

To tackle underrepresentation at the top and remove barriers to progression for all staff who possess a protected characteristic, we are implementing a number of actions. Our leadership development programme is undergoing further development to provide a range of options to develop within the workplace that are as accessible as possible to all employees irrespective of gender, ethnicity or other protected characteristic.

5.2 Early Career Support

We invest heavily in the quality of our preceptorship programmes, focusing on providing opportunities to learn new skills, to work with talented and experienced colleagues and to make a positive impact on patients near and far. The fresh perspectives and ideas Preceptees bring to our diverse and evolving business are invaluable.

5.3 Recruitment

We aim to recruit from the widest possible talent pool. Our recruitment training is about to be re-launched; it is anticipated this will help our hiring managers ensure that the language in the job advert is both gender neutral and inclusive; so we encourage diverse applications for all jobs; and to understand the importance of interviewing people with diverse panels in order to mitigate unconscious biases. As an example of our commitment to ensuring equality of opportunity our applications are anonymised with no biometric data visible at the time of screening and shortlisting.

5.4 Manage family-friendly leave successfully

We will continue to actively encourage the use of family friendly policies with all employees. This will include simple steps, such as encouraging male employees to consider taking shared parental leave.

5.5 Make the most of flexible working

Flexible working is used increasingly by both male and female employees. However, flexible working uptake varies significantly by employee gender, as do certain types of flexible working arrangements (such as condensed hours or job shares). Employees may also feel that flexible working arrangements may sometimes be an obstacle to career development for certain roles, particularly at senior levels of employment. As a Trust we will ensure we look at all flexible working requests equally whether they are submitted by male or female employees at any level across the organisation. In our most recent staff opinion survey we have seen an increase in the percentage of staff (from 51.5% to 54.3%) satisfied with opportunities for flexible working patterns.

We want to ensure that male employees are aware of the options that are available to them being able to work flexibly or taking leave for domestic and caring responsibilities. We will continue to promote our flexible working policy and hope that by raising awareness and encouraging such practices we will see a positive increase in this.

As a Trust we have a high proportion of female employees on flexible working or part time contracts. If there is an opportunity to be involved in a career-developing project that requires full-time resource, we consider job-sharing proposals from employees and challenge the full-time requirement.

6.0 Conclusions

The vast majority of employees are part of NHS pay grade structures that are nationally set tariffs. Progression through pay increments (where applicable) is applied in line with policy for all staff, therefore the Gender Pay Gap when calculated in this manner should be negligible. The only exception to this is Very Senior Managers – Contracted Directors and Apprentices.
Analysis of the data has shown that the workforce is predominantly female (75.86%, a decrease of 2.31% since last year).

We have a gender pay gap (median) of 10.74% an increase of 2.89% over the past year. In common with most NHS organisations, the primary reason for our gender pay gap is an imbalance of male and female colleagues at different levels across the organisation. Although we are making progress, Medical and Dental grade employees represent the highest pay grade and there are a greater proportion of males in this category than females. Conversely at the lower bands there is a higher proportion of female staff. This has resulted in the gender pay gap, and suggests there is no obvious discrimination based on gender at our senior grades

In every grade other than medical and dental there is a greater proportion of female to males. Historically medicine has been a male dominated profession, although in recent years this position has changed and predictions suggest that in time females will become the higher proportion rather than males. This reflects societal change, equal access to opportunities and commitment to flexible working patterns. In time we should expect the gender pay gap for this workgroup to shift.

Our bonus pay gap reflects lower female representation across senior medical and dental staff; 30% of our Consultants are female, this is a 2.6% increase from last year. This staff group is where bonus is a larger component of overall pay and Clinical Excellence Awards (CEA's) account for all our bonus payments. At our most recent CEA Award panel (held in June 2019, which will be reflected in next year's report) we were encouraged to see an increase in the number of female clinicians who had applied for and were awarded a CEA.

As we adhere to structured national incremental pay scales there is no evidence to suggest there is gender discrimination in relation to pay awards and setting of salaries. The GPG identified appears to be as a result of the gender mix of different workgroups.

7.0 RECOMMENDATION

This report has identified a number of areas for action and these are detailed in Appendix A. Progress against these actions will also be monitored through the Equality, Diversity and Inclusion Steering group at their quarterly meetings.

APPENDIX A

Action	Owner	Timescale	Notes
Relaunch Recruitment process / Training	Workforce Resourcing Team	September 2019	To ensure equality in language used in adverts and prevent unconscious bias during process
Continue to promote links with local schools and colleges. To include career taster days and encourage all young people to consider health as a career irrespective of gender	Education	Ongoing	To provide information and inspiration regarding career options
Continue to develop and utilise the leadership programme, to ensure all staff irrespective of gender have opportunities for career progression	Education	Ongoing	To provide employees with the skills to enable them to be promoted to band 7, 8a, 8b roles
To review Gender Pay Gap data on an annual basis	Operational HR	Ongoing	Data to be published in July each year
Produce an easy to read infographic summarising results	Operational HR	Annually	To be shared with all staff within the organisation, the CCG and local press as appropriate

APPENDIX B

SPLIT BY GRADE – Based on Spinal value						
	2018/19			2017/18		
GRADE	**MEAN AVG SALARY**		**2018/19 GAP**	**MEAN AVG SALARY**		**2018/19 GAP**
	FEMALE	**MALE**		**FEMALE**	**MALE**	
Band 1	**£17,460.00**	**£17,460.00**	0.00% equal	**£15,641.56**	**£15,632.76**	-0.06% in favour of female employees.
Band 2	**£17,965.19**	**£17,790.22**	-0.98%(in favour of female employees)	**£17,021.12**	**£16,824.38**	-1.17% in favour of female employees.
Band 3	**£19,315.11**	**£19,493.36**	0.91% (in favour of male employees)	**£18,828.09**	**£18,904.58**	0.41% in favour of male employees.
Band 4	**£22,131.48**	**£22,112.23**	-0.09% (in favour of female employees)	**£21,435.91**	**£21,518.96**	0.39% in favour of male employees.
Band 5	**£27,034.77**	**£26,430.90**	-2.28% (in favour of female employees)	**£26,627.02**	**£25,809.75**	-3.17% in favour of female employees.
Band 6	**£33,211.89**	**£33,201.30**	-0.03% (in favour of female employees)	**£32,633.01**	**£32,127.29**	-1.57% in favour of female employees.
Band 7	**£40,073.14**	**£39,631.24**	-1.12% (in favour of female employees)	**£39,094.25**	**£39,539.81**	1.14% in favour of male employees.
Band 8a	**£47,377.91**	**£47,506.18**	0.27% (in favour of male employees)	**£44,908.29**	**£45,294.72**	0.86% in favour of male employees.
Band 8b	**£56,098.39**	**£57,001.30**	1.58% (in favour of male employees)	**£55,496.12**	**£57,773.57**	4.1% in favour of male employees.
Band 8c, 8d, 9	**£73,323.38**	**£75,601.86**	3.01% (in favour of male employees)	**£76,077.67**	**£69,048.67**	-10.18% in favour of female employees.
Ad- Hoc	**£85,142.96**	**£58,645.27**	-45.18% (in favour of female employees)	**£53,744.57**	**£65,633.08**	22.12% in favour of male employees.
Medical & Dental	**£57,083.20**	**£71,614.48**	20.29% (in favour of male employees)	**£54,437.55**	**£70,529.31**	29.56% in favour of male employees.

Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 2019**
Report Title	**Guardian of Safe Working Annual Report**
Author	**Dr Jonathan Chambers, Guardian of Safe Working**
Responsible Executive	**Alastair Hutchison, Medical Director**

Purpose of Report (e.g. for decision, information) For information	
Summary The Guardian is required to report to the Board on a quarterly basis and this report adheres to the nationally agreed Board report template and that of the Lead Employer template. This report is the quarterly report covering the period March 2019 and April 2019 – June 2019; the additional month will allow future reports to be aligned to the financial year.	
Paper Previously Reviewed By SMT – 17 July 2019	
Strategic Impact Junior Doctors are central to the Trust being able to achieve its key strategic objectives. Their service provision enables DCHFT to deliver its core functions. The 2016 contract is essential to help maintain their training requirements and the safety of their working environment	
Risk Evaluation Analysis of the data summarised within this report will assist in identifying key areas of concern and potential risk.	
Impact on Care Quality Commission Registration and/or Clinical Quality The Guardian of Safe Working role is one of the mechanisms within the 2016 contract introduced to provide assurance of safety and clinical quality.	
Governance Implications (legal, clinical, equality and diversity or other): No specific implications relating to the contents of the paper.	
Financial Implications Potential risk associated with payment due to excess hours worked. The divisions need to implement a robust system for administering time back in lieu to prevent the risk of fines.	
Freedom of Information Implications – can the report be published?	Yes

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

Title of Meeting	**Trust Board**
Date of Meeting	**31 July 2019**
Report Title	**Quarterly Guardian Report on Safe Working House: Doctors in Training (April 2019 – June 2019 and to include March 2019)**
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 report is the quarterly report covering the period March 2019 and April 2019 – June 2019; the additional month will allow future reports to be aligned to the financial year.

2 Overview

- Number of training post (total): 156 training posts in total
- Number of doctors sat in training post (total): 139.8 in total (the 16.2 posts equivalent of vacancies and LTFT trainees sat in a WTE post)
- Number of doctors in training on the new 2016 contract (total): 139.8 (All DiT in post at DCH have now transitioned to the 2016 T&C).
- Admin support provided to the guardian: Support from the Workforce department but set amount not stipulated.
- Amount of job-planned time for educational supervisors: 0.125 PA per week

3 Exception reports (with regard to working hours)

During the period covered by this report 37 exception reports were submitted. On closer scrutiny these exception reports are related to additional hours worked 39%), service support available (35%), missed educational opportunities (21%), and pattern of work undertaken (5%). Of the additional hours worked the majority were returned as time in lieu. Of the 37 exception reports, 34 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

Six 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 period there was an average of 11.28 training grade vacancies, this is lower than the previous quarter (15). 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 remains 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) Negotiated changes to the Contract for Doctors in Training 2016
A number of changes to the original contract have been agreed between the BMA and NHSE in 2019. The agreed deal between the BMA, NHS Employers and the Department of Health and Social Care brings a £90 million investment for junior doctors over the next four years. The deal includes:

- Increases to weekend and night shift pay
- £1,000 a year extra for all less than full time trainees
- A fifth nodal point on the payscale at the level of ST6
- 'Section 2' transitional pay protection extended until 2025
- Improved GP trainee mileage and confirmed supernumerary status
- Improvements in rest and safety entitlements, with no more pay-to-stay when too tired to drive
- Contractualised Non-Resident On-Call (NROC)/LTFT rostering guidance
- Exception reporting for all ARCP/portfolio requirements
- Guaranteed annual pay uplift of 2 per cent each year for the next four years.

These changes will need to be reviewed by HR and the divisions to ensure that they are delivered in the coming months.

B) Fatigue and Facilities Charter – Monetary Award to DCH

Funding has been made available to NHS trusts in England for improving working conditions for junior doctors. The £10 million funding, outlined by the Secretary of State in September 2018, will be available to enhance facilities and the working environment for junior doctors. information on how the funding will be made available to NHS trusts in England. All NHS trusts in England who employ junior doctors, will receive £30,000, and the remaining balance will be shared between 120 trusts defined as having a greater need, using data from a number of different sources. These 120 trusts will each receive £60,833 in total. DCH has been allocated £30,000. The BMA Fatigue and Facilities Charter can be used as a guide to inform the use of the funding, there is some flexibility in how this is used to improve junior doctors working conditions, providing it is agreed through the junior doctor forum.

C) Interim Guardian of Safe Working

My term of office is now complete and I have stepped down from the role. A new Guardian of Safe Working is yet to be appointed. In the interim, Dr Julie Doherty will be covering the role. I would like to take this opportunity to thank the SMT and Trust Board for their support during my time as GoSW. It has been encouraging to see the progress made in supporting and improving the working lives of Doctors in Training at DCH over the past 3 years.

10 Other Information:

The GoSW will continue to reiterate the importance, and value, of Exception Reporting at DCH. They will be looking to reinforce the necessity of doctors in training at DCH raising concerns 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 are being dealt with in line with the T&Cs of the junior doctor contract. With the ongoing support of the SMT, Trust Board and working alongside the DME and BMA reps, the aim of the GoSW is to continue to work to improve the working lives of, and training environment experienced by, doctors in training at DCH.

APPENDICES - TRUST BOARD PAPER JULY 2019

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

Appendix 1 – Exception Reports by department, grade and rota

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Paediatrics	0	0	0	0
Obstetrics & Gynaecology	0	0	0	0
ENT	0	0	0	0
Urology	0	0	0	0
Colorectal/Breast	0	0	0	0
Upper GI/Vascular	0	6	6	0
Orthopaedics	0	15	13	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	0	0	0
Acute Medicine	0	9	8	1
Elderly Care	0	4	4	0
Stroke	0	0	0	0
Clinical Oncology	0	0	0	0
Cardiology	0	1	1	0
Respiratory	0	1	1	0
Renal	0	0	0	0
Gastroenterology	0	1	1	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**	**37**	**34**	**3**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	28	25	3
F2	0	2	2	0
CT1-2/ST1-2	0	5	5	0
ST3-8	0	2	2	0
Total	**0**	**37**	**34**	**3**

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

FY1 CAMHS (Gen Adult)	0	0	0	0
FY1 Geriatric/Stroke	0	3	3	0
FY1 Respiratory	0	0	0	0
FY1 Renal	0	0	0	0
FY1 Acute Internal Medicine	0	5	4	1
FY1 Cardiology	0	1	1	0
FY1 Gastroenterology	0	0	0	0
FY1 Colorectal/UGI	0	5	5	0
FY1Urology	0	0	0	0
FY1 ENT	0	0	0	0
FY1 Breast/Vascular	0	0	0	0
FY1Orthopaedic	0	14	12	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**	**37**	**37**	**3**

Standard Exception Reports - response time			
	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	26	2	3
F2	2	0	0
CT1-2 / ST1-2	4	1	0
ST3-8	1	1	0
Total	**33**	**4**	**3**

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

Appendix 2 – Work schedule reviews by grade and department

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

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

Appendix 3 - Locum agency bookings and bank usage

Please see separate spreadsheets entitled:

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

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

	Mar-19	Apr-19	May-19
DIVISION A	**£101,443.25**	**£54,631.72**	**£104,986.12**
CONSULTANT BANK	**£19,510.72**	**£26,031.01**	**£21,000.60**
EMERGENCY MEDICINE	£1,861.66	-£23.94	£2,833.84
HISTOPATHOLOGY	£12,989.32	£21,397.56	£13,509.37
LOCUM GERIATRIC MEDICINE	£4,659.74	£4,657.39	£4,657.39
FOUNDATION YEAR 2 BANK	**-£944.55**	**£1,014.59**	**£425.00**
GENERAL (INTERNAL) MEDICINE	£0.00	£1,014.59	£425.00
UROLOGY	-£944.55	£0.00	£0.00
GENERAL PRACTITIONERS BANK	**£5,311.26**	**£3,809.05**	**£77,649.32**
GENERAL MEDICAL PRACTITIONER	£5,311.26	£3,809.05	£22,569.34
GP DOCTORS IN TRAINING	£0.00	£0.00	£55,079.98
SPECIALTY DOCTOR BANK	**£77,031.55**	**£20,999.05**	**£3,374.39**
EMERGENCY MEDICINE	£75,824.42	£18,761.14	£2,169.60
PALLIATIVE MEDICINE	£1,207.13	£2,237.91	£1,204.79
SPECIALTY TRAINEE BANK	**£534.27**	**£3,471.20**	**£2,536.81**
ACUTE INTERNAL MEDICINE	-£677.00	-£7,978.00	£0.00
EMERGENCY MEDICINE	£0.00	£640.57	£409.67
GENERAL (INTERNAL) MEDICINE	£3,481.58	£10,808.63	£2,127.14
LOCUM TRAUMA AND ORTHOPAEDIC	-£2,270.31	£0.00	£0.00
STAFF GRADE BANK	**£0.00**	**-£693.18**	**£0.00**
GENERAL MEDICAL PRACTITIONER	£0.00	-£693.18	£0.00
DIVISION B	**£15,223.63**	**£81,920.66**	**£65,438.48**
ASSOCIATE SPECIALIST BANK	**£0.00**	**£319.32**	**-£319.32**
GENITIO-URINARY MEDICINE	£0.00	£319.32	-£319.32
CONSULTANT BANK	**£20,883.03**	**£61,084.93**	**£44,714.61**
CLINICAL NEUROPHYSIOLOGY	£0.00	£0.00	£5,363.17
CLINICAL RADIOLOGY	£3,132.81	£3,049.38	-£146.74
DERMATOLOGY	-£2,322.00	£3,807.75	£0.00
LOCUM CLINICAL RADIOLOGY	£7,420.13	£10,488.38	£9,709.47
LOCUM DERMATOLOGY	£12,909.21	£6,078.06	£9,269.28
LOCUM GENERAL SURGERY	£0.00	£569.00	-£569.00
LOCUM PAEDIATRICS	£0.00	£6,599.78	£5,607.33
LOCUM TRAUMA AND ORTHOPAEDIC	£10,592.88	£8,639.60	£8,640.18
PAEDIATRICS	-£14,000.00	£18,706.98	£793.02
YEOVIL DISTRICT HOSP NHS FT	£3,150.00	£3,146.00	£6,047.90

FOUNDATION YEAR 2 BANK	**£8,008.01**	**£7,325.72**	**£0.00**
PAEDIATRICS	£1,339.51	£0.00	£0.00
TRAUMA AND ORTHOPAEDIC SURGERY	£6,668.50	£7,325.72	£0.00
SPECIALTY DOCTOR BANK	**£2,809.56**	**£6,563.63**	**£12,762.33**
ANAESTHETICS	-£4,030.11	-£1,510.70	£6,689.49
LOCUM ANAESTHETICS	£6,839.67	£6,072.84	£6,072.84
OTOLARYNGOLOGY	£0.00	£2,001.49	£0.00
SPECIALTY TRAINEE BANK	**-£19,047.64**	**£4,056.39**	**£5,710.20**
LOCUM TRAUMA AND ORTHOPAEDIC	£2,270.31	£0.00	£0.00
OBSTETRICS AND GYNAECOLOGY	-£2,212.74	£2,941.86	£0.00
PAEDIATRICS	-£4,105.21	£1,114.53	£5,710.20
TRAUMA AND ORTHOPAEDIC SURGERY	-£15,000.00	£0.00	£0.00
STAFF GRADE BANK	**£2,570.67**	**£2,570.67**	**£2,570.66**
YEOVIL DISTRICT HOSP NHS FT	£2,570.67	£2,570.67	£2,570.66

Appendix 4 – Medical training grade vacancies

Department	Grade	Rotation Dates	April	May	June	Average Q1
Paediatrics	ST3	Sept 18 to Sept 19	1	1	1	1
Paediatrics	ST4+	Sept 18 to Sept 19	0.4	0.4	0.4	0.4
O&G	ST1	Oct 18 to Oct 19	0	0	0	0
O&G	ST3+	Oct 18 to Oct 19	1	1	1	1
Surgery	CT1	Aug 18 to Aug 19	0	0	0	0
Surgery	CT2	Aug 18 to Aug 19	0	0	0	0
Surgery	ST3+	Oct 18 to Oct 19	0	0	0	0
Orthopaedics	ST3+	Sept 18 to Sept 19	0	0	0	0
Anaesthetics	CT1/2	Aug 18 to Aug 19	0.4	0.4	0.4	0.4
Anaesthetics	ST3+	Aug 18 to Aug 19/Feb19 to Feb 20	0.2	0.2	0.2	0.2
Medicine	CT1/2	Aug 18 to Aug 19	0	0	0	0
Medicine COE	ST3+	Mar 19 to Mar 20	1	1	1	1
Medicine Diab/Endo	ST3+	Aug 18 to Aug 19	0	0	1	0.33
Medicine Gastro	ST3+	Sept 18 to Sept 19	0	0	0	0
Medicine Resp	ST3+	Aug 18 to Aug 19	0	0	0	0
Medicine Cardio	ST3+	Feb 19 to Feb 20	0	0	0	0
Medicine Renal	ST3+	Aug 18 to Aug 19	2	2	2	2
Heamatology	ST3+	Sept 18 to Sept 19	0	0	0	0
Med/Surg	FY1	Aug 18 to Aug 19	0	0	0	0
Med/Surg	FY2	Aug 18 to Aug 19	0	0	0	0
GPVTS	ST1	Aug 18 to Aug 21	2	2	2	2
GPVTS	ST2	Aug 17 to Aug 20	0.4	0.4	0.4	0.4
GPVTS	ST3	Aug 18 to Aug 19	2.55	2.55	2.55	2.55
			10.95	10.95	11.95	11.28

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

Enc _

Title of Meeting	**TRUST BOARD**
Date of Meeting	**31 July 2019**
Report Title	**Annual Reports and Accounts period ended 31/03/19**
Author	James Claypole, Senior Financial Accountant
Responsible Executive	Paul Goddard, Director of Finance

Purpose of Report (e.g. for decision, information)
Approval of 2018/19 Annual Report and Accounts for the Charity following review by Charitable Funds committee and final Audit review meeting on 02/07/19.

Summary
The Annual Accounts and Annual Report:

- Have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- Have been prepared in accordance with the requirements of the Charities Act 2011.

The Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard Applicable in the UK and Republic of Ireland (FRS 102) has been use for preparing this set of Charity Accounts.

The Annual Report and Accounts were audited by Edwards and Keeping during May 2019 with the follow up meeting between Ian Carrington from Edwards and Keeping and Paul Goddard (Director of Finance & Resources) taking place during July 2019.

There were no changes requested by External Audit to the 2018/19 Annual Report and Accounts.

Paper Previously Reviewed By
Charitable Funds Committee.

Strategic Impact
The Annual Report and Accounts summarises the activity of the charity for 2018/19 and demonstrates compliance with the objects of the Charity in preparation for completing the Final Annual Report and Accounts in April 2019.

Risk Evaluation
The Annual Report and Accounts were independently audited using a risk based audit approach. The Charity Auditors met with the Director of Finance & Resources to report on the conduct and outcome of the audit, after the audit had been completed, with no issues arising.

Impact on Care Quality Commission Registration and/or Clinical Quality
N/A

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

The Annual Report and Accounts of the Charitable fund for the year ended 31 March 2019 have been prepared by the Corporate Trustee in accordance with the accounting policies set out in Note 1 to the accounts and comply with the Charity's trust deed, the Charities Act 2011 and Accounting and Reporting by Charities Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland published on 16 July 2014.

In preparing the annual report, the Corporate Trustee has complied with its duty to have due regard to guidance on the public benefit published by the Charity Commission.

Financial Implications
The Fund Balances as at 31 March 2019 are: £1,082,000. The Charity spent £721,000 in 2018/19. £825,000 of the Fund Balances are held within restricted funds.

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

Recommendations

a) Review the 2018/19 Charity Annual Report and Accounts.
b) Approve the Annual Report and Accounts as Corporate Trustee

Dorset County Hospital NHS Foundation Trust Charitable Fund

Annual Report and Accounts

for the year ended 31 March 2019

Registered Charity No. 1056479

Dorset County Hospital NHS Foundation Trust Charitable Fund

Annual Report and Accounts for the year ended 31 March 2019

Contents

Trustee's Annual Report	1
Independent Auditor's Report to the Corporate Trustee	16
Statement of Financial Activities for the year ended 31 March 2019	19
Balance Sheet as at 31 March 2019	20
Statement of Cash Flows for the year ended 31 March 2019	21
Notes to the Accounts	22 - 34

Principal Office
The principal office for the Charity is:
Trust Headquarters
Dorset County Hospital NHS Foundation Trust
Dorset County Hospital
Williams Avenue
Dorchester
Dorset DT1 2JY

Bankers
The Royal Bank of Scotland
Government Banking CST
2nd Floor, 280 Bishopsgate
London EC2M 4RB

Auditors
Edwards & Keeping
Unity Chambers
34 High East Street
Dorchester
Dorset DT1 1HA

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019

Dorset County Hospital NHS Foundation Trust, as Corporate Trustee, presents the Annual Report for the Dorset County Hospital NHS Foundation Trust Charitable Fund (Dorset County Hospital Charity) together with the audited financial statements for the year ended 31 March 2019.

The financial statements have been prepared by the Corporate Trustee in accordance with the accounting policies set out in note 1 to the accounts and comply with the Charity's trust deed, the Charities Act 2011 and Statement of Recommended Practice: *Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102)* published on 16 July 2014.

In preparing this annual report, the Corporate Trustee has complied with its duty to have due regard to the guidance on public benefit published by the Charity Commission. The Charity Annual Report and Accounts include all the separately established funds of which Dorset County Hospital NHS Foundation Trust (DCHFT) is the primary beneficiary.

Forward by the Chair of Charitable Funds Committee

Welcome to our annual report for the year ended 31 March 2019. Dorset County Hospital NHS Foundation Trust is a Corporate Trustee of Dorset County Hospital Charity which works in partnership with the Trust for the benefit of patients of Dorset County Hospital.

The Charity's purpose is to raise and receive funds to enhance patient care at Dorset County Hospital; providing support that is above and beyond the NHS budget.

In this, my fourth and last report as Chair, I would like to thank all the individuals, organisations, businesses and community groups who have donated and fundraised in support Dorset County Hospital (examples of how the funds have been spent can be seen on page 8). I would also like to thank my fellow Charitable Fund Committee Members and the volunteers who assist the Dorset County Hospital Charity staff. It is the commitment and generosity of our supporters, many of whom are patients, their families and friends who have been treated by our dedicated staff, which enables our Charity to help enhance patient care at Dorset County Hospital.

Key highlights of the year for Dorset County Hospital Charity were:

- Successful completion of our £1.75M Cancer Appeal to build a new Cancer Outpatients department as part of a new cancer centre bringing the provision of Radiotherapy services to the West of Dorset for the first time.
- Increasing the Charity's profile and awareness throughout our community.
- Securing major grants from local trusts and charities.
- Building our supporter base of individual donors.
- Chosen charity for major events in our region and increased support from community fundraising.
- Building our presence and support from the local business sector.
- Positive staff engagement through fundraising and volunteering in support of Dorset County Hospital Charity.
- Continuing to support a broad range of projects across our hospital to enhance patient care.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

The new cancer centre, now known as The Robert White Centre, was opened in December 2018 by actor and supporter Martin Clunes OBE. We are especially grateful to everyone who has contributed such valuable support to help fund this vital cancer treatment centre.

Each year Dorset County Hospital cares for 116,000 inpatients, sees 285,000 outpatients and our Emergency Department cares for 45,000 people who attend. The hospital cares for a residential population of nearly 215,000 people plus any tourists who become ill. Demand for services at Dorset County Hospital continues to increase but as you will have heard in the media the NHS resources are stretched. DCH Charity raises funds to enhance patient care at the hospital so any support you can give the Charity is most welcome.

If you would like to support Dorset County Hospital Charity please contact a member of the Charity team on 01305 253470 or send an email to: charity@dchft.nhs.uk

Peter Greensmith, Chair

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Objectives and Activities

Objectives and strategy

Nearly 446,000 patients are cared for by the Foundation Trust each year. Good healthcare is priceless, but it requires significant investment. The charitable contributions help to enhance the quality of services, over and above that which the NHS provides; and make a difference and touch the lives of our community for the public benefit. Dorset County Hospital NHS Foundation Trust Charitable Fund aims to help fund the important extras: making patient care better, by raising funds for the latest technology and equipment and enhancing patient comfort by improving the hospital environment and facilities.

When deciding upon the most beneficial way to use charitable funds, the Corporate Trustee has regard to the main activities, objectives, strategies and plans of the Trust.

"The Charitable Fund enhances the provision of healthcare services that are provided to the population served by Dorset County Hospital NHS Foundation Trust. This encompasses the provision of medical equipment, furniture and fittings, improvement of the environment and facilities, enhancement of staff and patient education and the welfare of staff and patients".

The Charity's profile has been raised through improved promotion, and exposure on the Dorset County Hospital NHS Foundation Trust intranet and web sites. The profile of the Charity has been further enhanced through the launch of a major fundraising appeal, planned media/PR campaign and targeted promotion of fundraising to staff, local community groups, companies and the wider public.

The Charity is operated with a small team lead by Simon Pearson, Head of Fundraising; together with Rachel Cole, Fundraising and Communications Manager, Kitz Gulliford, Fundraising Officer and Damian Chandler, Finance and Fundraising Administrator.

If you would like more information about supporting the Charity, please contact Simon Pearson, Head of Fundraising at Dorset County Hospital on 01305 253470 or send an email to: Simon.Pearson@dchft.nhs.uk.

Grant making policy

Grants are made from the Charity's funds to the Dorset County Hospital NHS Foundation Trust based on funding applications – the funds comprise of three elements:

- ***special purpose funds,*** which are registered with the Charity Commission; and are funds that are restricted through the definition of their "objects," which can be viewed on the Charity Commission website. These funds are managed by named managers of the Foundation Trust. The fund designation is binding on the Corporate Trustee.

- ***designated unrestricted funds,*** which comprise a proportion of the unrestricted funds that are earmarked, but not through a binding designation, for specific elements of the Trust's work. These often result from donations received, where the donor nominated a particular part of the hospital or activity at the time their donation was made. Whilst their nomination is not binding on the Corporate Trustee, the designated funds reflect these nominations. These funds are overseen by directorate managers who can make recommendations on how to spend the money within their designated area. Fund advisers' recommendations are generally accepted and the funds can be spent at any time.

Trustee's Annual Report for the year ended 31 March 2019 (continued)

- ***the general fund,*** which benefits from gifts received by the Charity where donors have not expressed where they want their donations to be spent. Applications for money from this fund are invited from any member of the hospital. Based on the applications received and their knowledge of the hospital, the Charitable Fund Committee agrees funding and priorities based on quality and value for money. Grants are targeted on projects in areas of the hospital that do not have available designated funds.

The Charity seeks to promote the use of the general funds and designates donation receipts to the general fund, by default, rather than to service, or department specific funds. In addition, the Charity now identifies twenty four designated, unrestricted funds: Cardiac, Stroke, Urology, Diabetes, Critical Care, Emergency Department, Ophthalmology, Endoscopy, Kingfisher Ward, Purbeck Ward, DCH Research, Ridgeway Ward, Dementia Fund, Forget-me-not Suite, Go Girls Fund, Maud Alexander Ward, Colorectal and Lower GI, Breast Care, Lulworth Ward, Hinton Ward, Prince of Wales Ward, DCH Therapies, Haemodialysis and Barnes Ward. Whilst, these funds are not registered individually with the Charity Commission, they are important specific purpose funds managed by the Charity.

This approach has reduced the bureaucracy of management of the funds and improved the flexibility and effectiveness of the Charity's use of its available resources.

Achievements and Performance

Annual review: Our activities
During the year, the Charity's main focus was the major £1.75million Cancer Appeal raising funds for a new Cancer Outpatients Department and refurbishment of the hospital's existing Chemotherapy Unit; part of a wider project with Poole Hospital building a new Cancer Centre bringing radiotherapy services to Dorchester for the first time. Ward and speciality charitable funds received a number of donations specifically for charitable activities within those areas.

Development of the Charity
It has been a significant year in the development and growth of the Charity. The Charity has undertaken the following key activities:

a) Successful completion of the £1.75 million Cancer Appeal including a significant uplift in individual donations and community and events fundraising; as well as major grants and local corporate support.

b) This included providing £10,000 funding for Arts in Hospital for the design and installation of specially designed art vinyls for the Cancer Outpatients department windows to improve the environment for patients.

c) Providing £54,000 funding for a specialist optical camera for the Royal Eye Infirmary to diagnose and treat eye disease.

d) Securing £75,000 funding for development of a Youth Volunteering programme for the hospital, funded by the Pears Foundation.

e) The Charity also continued to support a wide range of projects and activities benefiting both patients and staff.

f) Continuing to build engagement and support from the hospital's dedicated staff and volunteers.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

g) Building our presence and visibility in the community as we work towards becoming one of the leading charities in our region.

Significant Projects
Our Cancer Appeal is part of a partnership project with Poole Hospital to bring radiotherapy services to Dorchester for the first time. Our £1.75 million appeal has funded the building of a new Cancer Outpatients Department above the new Radiotherapy Unit at Dorset County Hospital. The new cancer treatment facility was opened in December 2018 by Martin Clunes OBE. We received significant support from major trusts, individuals local charities, community groups, local businesses and staff fundraising events.

In addition, other funds donated to the Charity's funds have been used to provide a variety of additional equipment and services, above and beyond NHS budgets, to help enhance patient care.

Thanking our Supporters
Dorset County Hospital NHS Foundation Trust is extremely grateful to all supporters whose generosity, in supporting Dorset County Hospital Charity, ensures we are able to enhance the care and services we provide for patients.

In particular, we extend heartfelt thanks to everyone who has donated and raised funds for the DCH Cancer Appeal. This has been the Charity's major appeal and during this year with your support we achieved our target.

We remain indebted for the support of so many individuals, groups, trusts, businesses and charitable organisations across Dorset, and nationally, who provide many thousands of pounds each year in support of Dorset County Hospital NHS Foundation Trust

Our Cancer Appeal has received significant support from major contributors and events during 2018/19 including the following:

- Fortuneswell Cancer Trust
- Garfield Weston Foundation
- Dorset Health Trust
- Buckham Fair
- Friends of Dorset County Hospital
- GO Girls Support Group
- District 1200 Rotary Clubs
- Dorset Agricultural Society
- Sutton Poyntz Fayre
- Marshwood Vale Young Farmers
- Lions Clubs
- Cerne Abbas Open Gardens
- NHS70 70K Challenge
- Dorchester Chamber for Business
- DCH Staff fundraising

We would also like to thank all the organisations that have helped raise the profile of the Charity and supported our fundraising efforts. These include the following:

- Dorset Echo
- Wessex FM
- BBC Solent

Trustee's Annual Report for the year ended 31 March 2019 (continued)

- Dorset Life
- Dorset Magazine
- Poundbury Magazine
- Jordan's Jewellers
- Air FM
- Keep FM
- And many other publications and organisations.

We are most appreciative of the many individuals whose fundraising efforts gained valuable publicity in the press and on social media, helping to increase the community's awareness of Dorset County Hospital Charity and the valuable support provided to our hospital.

We would like to express our sincere thanks to all our supporters including staff, community fundraisers, trusts, local businesses, volunteers and the many organisations who donate money, fundraise and offer their time and services in support of the Charity. Donations continue to be received from individuals, trusts, community fundraising events, companies, in memoriam donations and legacies. The growth in support for Dorset County Hospital Charity is so important to us and our patients, as we aim to increase the contribution charitable support provides to enhance patient care at Dorset County Hospital.

Dorset County Hospital NHS Foundation Trust Charitable Fund

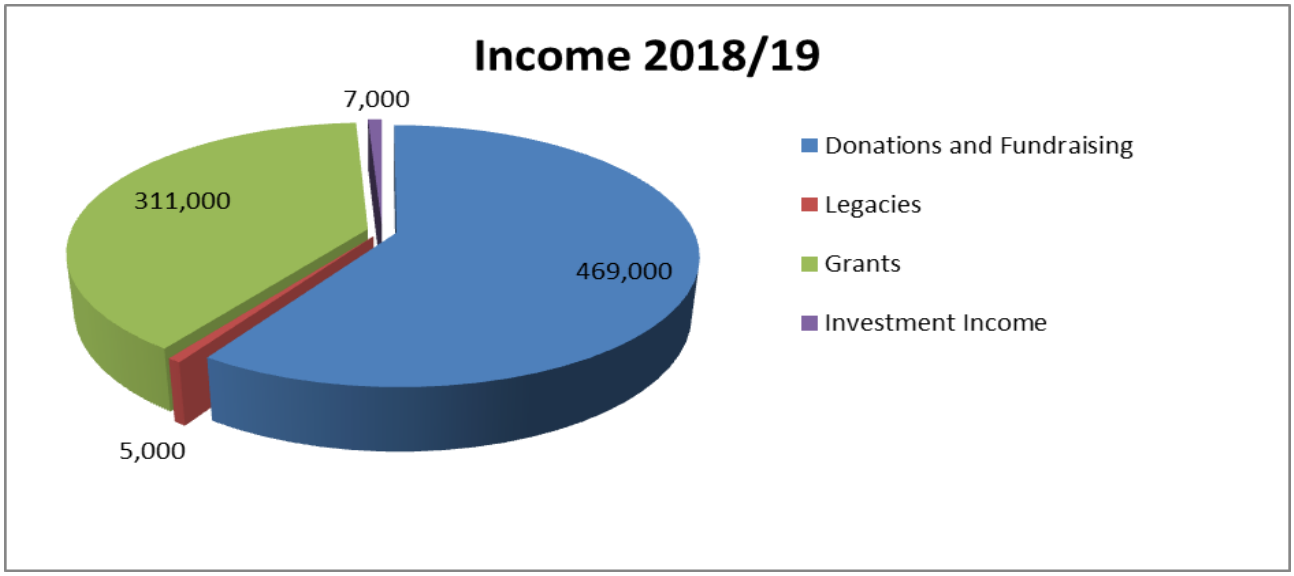
Trustee's Annual Report for the year ended 31 March 2019 (continued)

Financial Review

A review of our finances, achievements and performance
The net assets of the Charitable Fund as at 31 March 2019 were £1,082,000 (2018: £1,011,000).

The Charity continues to rely on donations, grants, fundraising and legacies as the main sources of income.

Income
Total income was £792,000 (2018: £1,086,000) which was a decrease of £294,000 compared to the previous year. The pie chart below shows the main sources of income. The largest income category is donations and fundraising followed by grant income representing donations from other charities supporting Dorset County Hospital.



Donations and Legacies £785,000 (2018: £1,084,000) – the Charity's largest source of income is given by the public and other charities keen to support Dorset County Hospital NHS Foundation Trust Charitable Fund.

- Grant Income £311,000 (2018: £304,000) – The Charity is most grateful to the charities that have given grant income to support the Dorset County Hospital Charity's Cancer Appeal, as well as the purchase of equipment which will make a real difference to the patients at Dorset County Hospital.

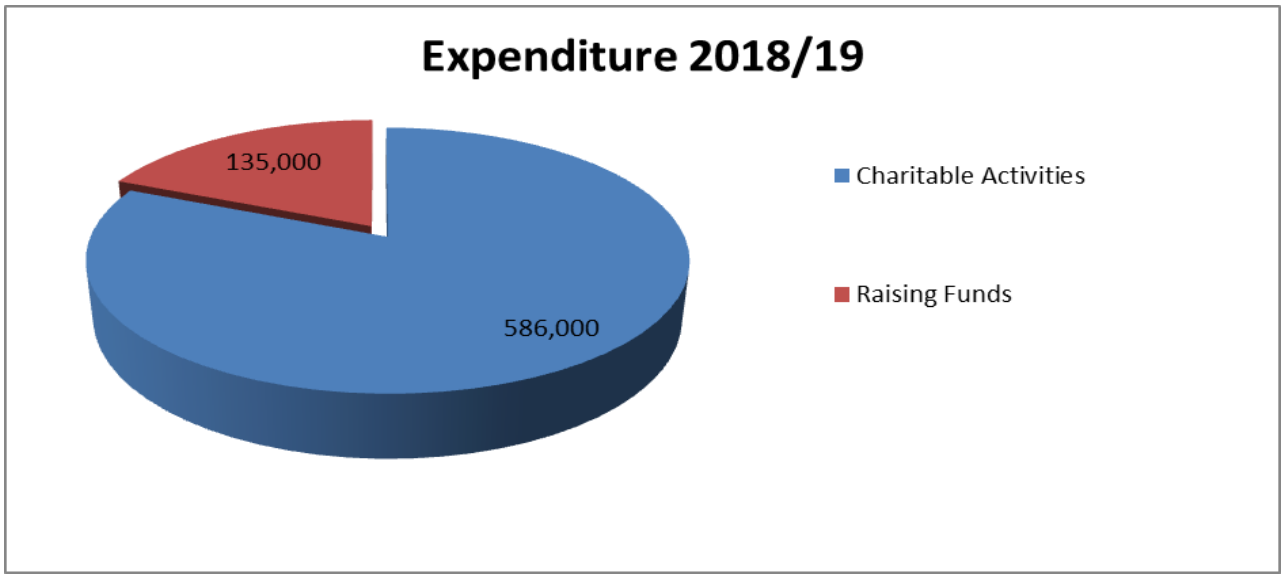
- Legacies £5,000 (2018: £490,000) – The Charity values the major support it receives from those who remember our work through their wills. Legacies make a lasting difference, benefiting future generations of patients.

- Donations and fundraising £469,000 (2018: £290,000) from collecting boxes and personal donations to fundraising events in the community. We are fortunate to receive generous donations for the benefit of the patients at Dorset County Hospital.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Expenditure
Of the total resources expended of £721,000 (2018: £1,181,000), expenditure on direct charitable activity was £586,000 (2018: £1,048,000) across a range of programmes. The pie chart shows that our largest area of spend was on charitable activities:



Raising funds expenditure of £135,000 (2018: £133,000) related to the cost of the fundraising office (including fundraising staff) and fundraising events.

Charitable activities expenditure of £586,000 included the Charity donating to Dorset County Hospital NHS Foundation Trust assets of £623,000 (2018: £786,000). These covered contributions to building schemes (primarily the Cancer Outpatient Building) and medical and surgical equipment. It also donated furniture and fittings of £4,000 (2018: £50,000), artwork expenses of £nil (2018: £11,000) and staff welfare and amenities of £3,000 (2018: £2,000). Patients' welfare and amenities were (£44,000) which was due to the reversal of the prior year commitment for Home Dialysis Equipment, with the actual expenditure relating to this now being recognised in contributions to building schemes and medical and surgical equipment above in 2018/19 (2018: £199,000). Support costs for charitable activities totalled £31,000 (2018: £28,000) and this relates to the support and governance charge to support compliance requirements and these charitable activities.

The last of the staged build payments, along with the fit out costs, associated with the Cancer Outpatients Building were incurred in 2018/19. The Cancer Outpatients building was completed during 2018/19.

Performance management
The Charity relies on the Foundation Trust to identify the appropriateness of funding requests initially through its divisional managers.

All funding applications must advise and justify:

- What difference the proposal will make and what benefit it will provide and its priority.
- The recurring costs that might arise from such a purchase, such as consumables and maintenance which have to be funded by Exchequer funding.
- Why the application cannot be funded from the Foundation Trust's Exchequer funds.
- How the application is in the interest of public benefit.

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Each of the funds is monitored by staff of the Foundation Trust's finance department and the Charitable Funds Committee on a quarterly basis.

Investments
The Corporate Trustee does not rely significantly on income from investments, since its policy is to spend the donated income in line with the purpose of the donation, whilst ensuring the financial sustainability of the Charity, in line with Charity Commission expectations. The Corporate Trustee does not invest its charitable funds in equity-based investments. The Charity's Investment Policy 2018 states clearly that the Corporate Trustee should 'not place the funds at risk by speculative investment'. Due to the relatively small level of funds held, the Charitable Funds Committee has chosen not to invest the surplus above reserve levels during the year; and surplus funds are not invested with fund managers. Consequently, though the return on deposits and interest earned remains low as a result of reduced bank deposit interest rates, the fund value has not been put at risk.

Bank and cash balances at the year-end totalled £1,215,000 (2018: £1,214,000) of which £1,214,000 (2018: £1,213,000) was held in an interest earning account with the Government Banking Service. £800 was held as Petty Cash at the end of March 2019.

The Corporate Trustee will constantly review the investment of funds based on the balances available at the time.

Risk management
The Charity's Risk Register identifies the major risks to which the Charity is exposed. They have been reviewed and systems established to mitigate those risks.

The Charitable Fund Committee will maintain a regular review of the investment policy to ensure that both spending and firm financial commitments remain in line with available resources.

Income and expenditure and commitments are monitored on a monthly basis to avoid unforeseen overspending.

Dorset County Hospital Charity is reliant on donations to allow it to make grants to the Dorset County Hospital NHS Foundation Trust. If income falls then the Charity would not be able to make as many grants or enter into long term commitments with Dorset County Hospital NHS Foundation Trust. The Corporate Trustee mitigates the risk that income will fall by requiring a comprehensive fundraising strategy providing a planned approach to raising funds.

The Corporate Trustee has identified that the NHS, by its very nature, is subject to national changes in government policy as well as local politically driven decisions. This risk may mean initiatives or healthcare activities supported by Dorset County Hospital Charity are no longer delivered in the Dorset area. The Board Members of the Corporate Trustee benefit from attending board meetings at the Foundation Trust where they are able to understand the changes that they are facing at an early stage and are able to review strategic plans of partner NHS organisations when developing future plans.

Reserves policy
As permitted by the establishing declarations of trust, all of the funds are available to be spent at the discretion of the Corporate Trustee. However, under the Accounting and Reporting by Charities: Statement of Recommended Practice 2015 (FRS 102), all charities are required to prepare and publish a reserves policy.

Trustee's Annual Report for the year ended 31 March 2019 (continued)

The Corporate Trustee reviewed its policy on setting a reserve balance for the charitable funds; and adopted a revised policy at its meeting in February 2019. This policy sets a target for reserves to ensure that the charitable funds are not over committed. The level of reserves is based on a realistic assessment of need; and takes account of the following:

- the forecast level of income in future years;
- the level of commitments that the Charity has; and
- an analysis of future needs

The policy recognises that, other than restricted funds, charitable donations are given for spending on charitable purposes; and not for investing for an uncertain future. Achievement of actual reserves against the target is modified by the needs of grant applicants, and whilst the overriding object of the Charity is to distribute, rather than accumulate, funds the Trustees recognise the need to accumulate an agreed level of funds to ensure the long term operational sustainability of the Charity. The results are reviewed quarterly by the Charitable Funds Committee. The Charitable Funds Committee agreed, at its meeting in February 2019, to set the target reserves balance at £225,000 to cover costs of administration, fundraising and support costs of the Charity.

Total funds at 31 March 2019 were £1,082,000 of which £825,000 related to restricted funds. Unrestricted funds totalled £257,000. Reserves (unrestricted funds) were therefore £257,000 and the Trustee considers the position to be satisfactory in the short term.

In the longer term, the Dorset County Hospital Charity Fundraising Strategy 2019-2023 is in development and this will establish the strategic framework, key themes and the approach that will underpin the development of the Charity.

Our future plans

The Corporate Trustee has committed to a long term role for the Charity. The Charity has developed its Business Plan for 2019/20 as part of its longer term Charity Strategy 2019-23. The key activities for 2019/20 will include;

- Building on the successful achievement of the Charity's major £1.75 million Cancer Appeal. We will launch a follow on appeal in 2019/20 to secure further funding to deliver a comprehensive reconfiguration of the hospital's existing Chemotherapy unit. This will transform the experience of cancer patients and their families providing new, more spacious chemotherapy treatment facilities and support services.

- We will invest in new specialist fundraising posts to provide the skills and capacity required in our fundraising team to deliver our Charity's growth forecasts in line with our new strategy.

- We will develop a new website and increase our social media activity to improve our digital fundraising capability and increase supporter engagement.

- We will implement planned fundraising communications and marketing activities to continue to increase our profile and facilitate growth in individual giving and fundraising.

- We will continue to fundraise and receive funds in support of our wards and specialist care areas to enhance patient care across our hospital.

- Work will be ongoing to identify new capital projects at Dorset County Hospital which will form the basis of future major appeals; in line with the strategic priorities of Dorset County Hospital NHS Foundation Trust.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Structure, Governance and Management

The Dorset County Hospital NHS Foundation Trust Charitable Fund was entered on the Central Register of Charities on 28 June 1996 as registered Charity number 1056479. At 31 March 2019, the Charity comprised 36 individual funds. The notes to the accounts distinguish the types of fund held and disclose separately details of the income, expenditure and balances associated with these funds.

Donations and other income and assets received by the Charity are accepted and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 2006 and the National Health Service and Community Care Act 1990 and the funds are held on trust by the corporate body.

The Charity's unrestricted fund was established using the model declaration of trust; and all funds held on trust as at the date of registration were either part of this unrestricted fund or registered as separate special purpose funds under the main Charity. Subsequent donations and gifts received by the Charity that are attributable to the original funds are added to those fund balances within the existing Charity. Each fund within the Charity has a nominated fund representative, from the Foundation Trust, who is the point of contact for staff wishing to access the fund via a charitable application.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and, by the use of designated funds, the Corporate Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers and staff. Where substantial funds have been received which have specific restrictions set by a donor, a restricted fund has been established. The separate funds registered as linked charities with the Charity Commission are:

Unrestricted Funds:

General Purpose Charitable Fund
Patients General Purpose Charity
Staff General Purpose Fund

Restricted Funds:

Arts in Hospital
Cancer Services Charity
Children's Services Trust
Diabetic Fund
The Lillian Martin Ophthalmology Fund
Renal Fund
Special Care Baby Unit (SCBU)
West Dorset Medical Society for Post Graduate Education & Research Charity

In addition, twenty four unrestricted designated funds have been set up by the Corporate Trustee along with the Cancer Appeal Fund, which was established as a restricted fund.

Acting for the Corporate Trustee, the Charitable Fund Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- control, manage and monitor the use of the fund's resources
- provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income.
- ensure that best practice is followed in the conduct of all its affairs fulfilling all of its legal responsibilities.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

- keep the Foundation Trust Board of Directors fully informed on the activity, performance and risks of the Charity.

The accounting records and the day-to-day administration of the funds are dealt with by the finance department located at Dorset County Hospital, Williams Avenue, Dorchester, Dorset DT1 2JY.

Fundraising Practices
The Charity's approach to fundraising is in line with the Charity's fundraising strategy and associated plans. The primary sources of funding are grants, donations and legacies, community and staff fundraising events. The Charity does not currently employ any commercial third parties to undertake fundraising on our behalf or professional fundraising agencies. The Charity does not currently carry out mass direct marketing activities including mail, email, telephone, door to door or street fundraising. The Charity does not have any subsidiary trading companies.

The Trustees have reviewed the Charity Commission Charity fundraising: a guide to trustee duties (CC20) guidance and are confident that obligations are being fulfilled. The Corporate Trustee has registered the Charity with the Fundraising Regulator to comply with all recognised fundraising standards including those of the Code of Fundraising Practice. The Charity is a member of the Association of NHS Charities and its Head of Fundraising is a full member of the Institute of Fundraising.

Each of our staff team is aware of the Code of Fundraising Practice and our volunteers and members sign up to comply with the Code of Fundraising practice. We regularly brief the staff team on developments in the Code.

We have an open complaints policy and process, which the Trustees have reviewed and agreed. During the year the Charity received no fundraising complaints.

Financial oversight of income generation and expenditure is provided by the Charitable Funds Committee, which reports to every Board meeting. The Charity is part of Dorset County Hospital NHS Foundation Trust's Information Assurance Structure in relation to Information Governance including data protection policy and GDPR requirements as they relate to the Charity's activities. Risks are managed in line with our Risk Management Policy. Effective financial controls are in place and any serious incident would be reported to the Charity Commission and other relevant agencies.

Reports are filed in accordance with the regulations set out by the Charity Commission.

Fundraising Performance

During the year total donations, legacies and grants came to £785,000 against a plan of £775,000. When comparing 2017/18 to 2018/19 income from donations, legacies and grants was lower, from £1,084,000 received in 2017/18 to £785,000 in 2018/19. Though legacy income was significantly lower (£490,000 in 2017/18 compared to £5,000 in 2018/19); other income streams grew including the impact of the end of the Cancer Appeal, providing a rising trajectory for the Charity's non-legacy income year on year. This actually reflects a significant uplift in the Charity's baseline (non-legacy income) from £594,000 in 2017/18 to £780,000 in 2018/19.

We benchmark our fundraising activity with our peers through the Association of NHS Charities and monitor the comparative success of campaigns and overall fundraising cost to income ratios. We continue to perform well with a relatively low cost to income ratio. The Charity plans to invest in its resources during 2019/20 to build its fundraising skills and capacity to increase its income in the years ahead.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Trusteeship

The Charity has a Corporate Trustee: the Dorset County Hospital NHS Foundation Trust, as represented by its board of directors, and is governed by the law applicable to trusts, principally the Trustee Act 2000 and the Charities Act 2006. The Directors of the Foundation Trust during 2018/19 and up to the date this report and accounts were approved and signed were:

Mr M Addison	Chairman
Mr P Greensmith	Non-Executive Director (until 31st May 2019)
Mr M Rose	Non-Executive Director
Ms V Hodges	Non-Executive Director
Ms J Gillow	Non-Executive Director
Prof S Atkinson	Non-Executive Director
Mr I Metcalfe	Non-Executive Director

Ms P Miller	Chief Executive
Ms L Walters	Director of Finance & Resources (until 4 June 2018)
Mr P Goddard	Director of Finance & Resources (from 18 June 2018)
Ms R King	Director of Finance & Resources (Interim from 31 July 2018 to 30 September 2018)
Prof A Hutchison	Medical Director (from 02 July 2018)
Mrs J Pearce	Chief Operating Officer (until 30 September 2018)
Mrs L Power	Chief Operating Officer (from 5 September 2018 to 4 December 2018)
Mrs I Robotham	Chief Operating Officer (from 19 November 2018)
Mr M Warner	Director of Organisational Development & Workforce
Ms N Lucey	Director of Nursing and Quality
Mr N Johnson	Director of Strategy and Business Development

Charitable Funds Committee

The Charitable Fund Committee has devolved responsibility for the on-going management and administration of the funds on behalf of the Corporate Trustee, Dorset County Hospital NHS Foundation Trust. Membership of the Committee is limited to members of the Foundation Trust's Board of Directors. The members of the Charitable Fund Committee who served as agents for the Corporate Trustee during the year ended 31 March 2019; and their attendance at meetings of the Committee are shown in the table below.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Name	Position	24 April 2018	28 June 2018	24 Sept 2018	27 Feb 2019
Mr P Greensmith	Non-Executive Director & Chair of Charitable Fund Committee (until 31 May 2019)	✓	✓	✓	✓
Mr M Addison	Chairman and Non-Executive Directors. Chair of Charitable Fund Committee (from 1 June 2019)	✓	✓	-	✓
Mrs L Walters	Director Of Finance & Resources (until 4 June 2018)	✓	-	-	-
Mr P Goddard	Director Of Finance & Resources from 18 June 2018	-	-	✓	✓
Mrs J Pearce	Chief Operating Officer (until 30 Sept 2018)	✓	✓	-	-
Mrs L Power	Chief Operating Officer (from 5 Sept 2018 to 4 Dec 2018)	-	-	✓	-
Mrs I Robotham	Chief Operating Officer from 19 November 2018)	-	-	-	✓
Ms N Lucey	Director of Nursing and Quality	-	-	✓	✓
Ms V Hodges	Non-Executive Director	✓	✓	-	✓
Ms J Gillow	Non-Executive Director	✓	-	-	✓

Under a scheme of delegation, the Director of Finance of the Foundation Trust has day-to-day responsibility for the management of the Charitable Fund. Applications are approved under the following delegation levels:

Under £2,000	Director of Finance / Deputy Director of Finance
Between £2,000 and £10,000	Director of Finance and the Chair of Charitable Fund Committee
Over £10,000	Charitable Fund Committee

Role of the Board of Trustees

The primary objectives of the Board of Trustees are to take overall responsibility for the activities of the Charity and to give strategic direction in determining and safeguarding the vision and mission of the Charity. The Board ensures that the Charity is managed properly and that its assets are protected.

Induction and training of Trustees

Non-executive members of the Trust Board are appointed by an appointments panel comprising of the Chair of the Foundation Trust, the Nomination and Remuneration Committee of the Council of Governors of the Foundation Trust and the Vice Chairman of the Foundation Trust, acting as Senior Independent Non-Executive Director. All Executive Directors are appointed by the Chief Executive,

Trustee's Annual Report for the year ended 31 March 2019 (continued)

Chairman and non-executive directors of the Foundation Trust. Members of the Board of Directors and the Charitable Fund Committee are not individual Trustees under charity law but act as agents on behalf of the Corporate Trustee.

The Charity provides, in collaboration with the Foundation Trust, an induction pack for newly appointed members of the Board of Directors and Charitable Fund Committee. This pack provides information about the Charity, including the governing document, the Charitable Fund Committee terms of reference, past Trustee Annual Report and Accounts, scope and policies and minutes, and information about Trusteeship generally, including Charity Commission booklet CC3, The Essential Trustee and CC20 Charity Fundraising: a guide to trustee duties. The Chairman gives new members of both the Board of Directors and the Charitable Fund Committee a briefing on the current policies and priorities for the charitable funds; a guided tour of the Dorset County Hospital Foundation Trust's facilities; and any additional training that their role may require.

Statement of Corporate Trustee's responsibilities
The Corporate Trustee is responsible for preparing the Trustee's Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Corporate Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period. In preparing these financial statements, the Corporate Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any departures disclosed and explained in the financial statements; and;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in operation.

The Corporate Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and which enables it to ensure that the financial statements comply with the Charities Act 2016 the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. The Corporate Trustee is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Expression of gratitude
On behalf of all the patients and staff who have benefited from improved services due to donations and legacies, the Corporate Trustee would like to thank everyone who has contributed towards the Dorset County Hospital NHS Foundation Trust Charitable Fund in the last year.

Approved on behalf of the Corporate Trustee
Signed

Mark Addison
Chairman and Chair of the Charitable Funds Committee,
Dorset County Hospital NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Charitable Fund

Independent Auditor's Report to the Corporate Trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund

We have audited the financial statements of the Dorset County Hospital NHS Foundation Trust Charitable Fund (Dorset County Hospital Charity) for the year ended 31 March 2019 which comprise the Statement of Financial Activities, Balance Sheet, Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland"

In our opinion the financial statements:

- give a true and fair view of the state of the company's affairs as at 31 March 2019, and of its results for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the trustees' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the trustees have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The trustees are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are

Independent Auditor's Report to the Corporate Trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund (continued)

required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement [set out on page 15], the trustees are responsible for the preparation of financial statements which give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the Charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the Charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK), we exercise professional judgment and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

Independent Auditor's Report to the Corporate Trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund (continued)

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Charity's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustees.

- Conclude on the appropriateness of the trustees' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Charity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Charity to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Use of our report

This report is made solely to the Charity's corporate trustee in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. Our audit work has been undertaken so that we might state to the Charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and the Charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

……..
Ian Carrington (Senior Statutory Auditor)
For and on behalf of Edwards & Keeping, Statutory Auditor

Unity Chambers
34 High East Street
Dorchester
Dorset. DT1 1HA

Edwards & Keeping is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Statement of Financial Activities for the year ended 31 March 2019

	Note	Unrestricted funds £000	Restricted funds £000	Total funds 2019 £000	Total funds 2018 £000
Income from:					
Donations and legacies	4	179	606	785	1,084
Investments	6	7	-	7	2
Total income		186	606	792	1,086
Expenditure on:					
Raising funds	7	16	119	135	133
Charitable activities	8				
Medical and surgical equipment		149	474	623	786
Furniture and fittings		3	1	4	50
Artwork expenses		-	-	-	11
Patients' welfare and amenities		28	(72)	(44)	199
Staff welfare and amenities		2	1	3	2
Total expenditure		198	523	721	1,181
Net income / expenditure		(12)	83	71	(95)
Transfers between funds		(6)	6	-	-
Net movement in funds for the year		(18)	89	71	(95)
Reconciliation of funds					
Funds brought forward at 1 April 2018		275	736	1,011	1,106
Funds carried forward at 31 March 2019	18	**257**	**825**	**1,082**	**1,011**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Balance Sheet as at 31 March 2019

	Note	Unrestricted funds £000	Restricted funds £000	Total funds 2019 £000	Total funds 2018 £000
Current assets					
Debtors	14	24	17	41	99
Cash and cash equivalents	15	334	881	1,215	1,214
		358	898	1,256	1,313
Liabilities					
Creditors: amounts falling due within one year	16	(101)	(73)	(174)	(302)
Net current assets		257	825	1,082	1,011
Net assets		257	825	1,082	1,011
The funds of the charity					
Restricted income funds		-	825	825	736
Unrestricted funds		257	-	257	275
Total funds	18	**257**	**825**	**1,082**	**1,011**

Signed
Paul Goddard, Director of Finance & Resources
Dorset County Hospital NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Charitable Fund

Statement of Cash Flows for the year ended 31 March 2019

	Note	Total funds 2019 £000	Total funds 2018 £000
Cash flows from operating activities:			
Net cash provided by operating activities	17	(6)	221
Cash flows from investing activities:			
Interest received	6	7	2
Net cash provided by investing activities		7	2
Change in cash and cash equivalents in the year		1	223
Cash and cash equivalents at 1 April 2018	15	1,214	991
Cash and cash equivalents at 31 March 2019	15	**1,215**	**1,214**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019

1. Accounting policies

a) Basis of preparation

The Charity constitutes a public benefit entity as defined by FRS 102. The accounts (financial statements) have been prepared under the historic cost convention and in accordance with the Statement of Recommended Practice (SORP): *Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102)* issued on 16 July 2014, the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

The accounts have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following SORP 2015 (FRS 102) issued on 16 July 2014 rather than the Statement of Recommended Practice *Accounting and Reporting by Charities* effective from 1 April 2005 which has since been withdrawn.

The Corporate Trustee considers that there are no material uncertainties about the ability of Dorset County Hospital NHS Foundation Trust Charitable Fund to continue as a going concern.

In future years, the key risks to the Dorset County Hospital NHS Foundation Trust Charitable Fund are a fall in income from donations but the Corporate Trustee has arrangements in place to mitigate these risks (see the risk management and reserves sections of the annual report for more information).

b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified as a restricted fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

Those funds which are not restricted income funds are unrestricted income funds that are sub analysed between designated (earmarked) funds where the Corporate Trustee has set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Corporate Trustee's discretion. The major funds held in each of these categories are disclosed in note 18.

Special purpose funds registered as linked charities when the main Charity was registered may be either unrestricted designated funds or restricted funds.

c) Income

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of the income can be measured with sufficient reliability.

Where there are terms or conditions attached to income, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

Notes to the accounts for the year ended 31 March 2019 (continued)

d) Income from legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted.
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition have been met.

e) Expenditure

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement.
- The amount of the obligation can be measured or estimated reliably.

f) Irrecoverable VAT

Where irrecoverable VAT is incurred, it is charged against the category of expenditure for which it was incurred.

g) Recognition of expenditure and associated liabilities as a result of grant

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant.
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant.
- There is an established pattern of practice which indicates to the recipient that we will honour our commitment.

The Corporate Trustee has control over the amount and timing of grant payments and consequently where approval has been given by the Charitable Funds Committee on behalf of the Corporate Trustee and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached.

Notes to the accounts for the year ended 31 March 2019 (continued)

However, when they are then those conditions have to be met before the liability is recognised.

Where an intention has not been communicated, then no expenditure is recognised but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met then no liability is recognised but a contingent liability is disclosed.

h) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 10.

i) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the Charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the Charity's objects. The costs of generating funds represent fundraising costs please see note 7. Fundraising costs include expenses for fundraising activities and the cost of employing the Fundraising Team within the support costs.

j) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 8.

k) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

l) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90 day notice interest bearing savings accounts.

m) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

n) Pensions

Employees of the Charity are entitled to join the NHS Pensions Scheme.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable participating bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Charity of

Notes to the accounts for the year ended 31 March 2019 (continued)

participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

From 1st April 2015 a new NHS Pension Scheme was introduced superseding the 1995 and 2008 schemes. The 2015 scheme is a Career Average Revalued Earning (CARE) scheme. In a CARE scheme the pension is based on pensionable pay right across the individual's career and is worth 1/54th of career average re-valued earnings of pensionable pay per year or membership. The pension earned each year is based on pensionable pay in that year and is revalued by a set rate linked to inflation, each year up to retirement or leaving the scheme.

Members who have accrued benefits in the 1995 and / or 2008 scheme will retain the benefits accrued in the scheme and at retirement these benefits will be treated separately and calculated in accordance with the rules of the 1995 or 2008 section. The 1995 and 2008 schemes are a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last 3 years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership.

With effect from 1 April 2015 members can choose to exchange part of their pension for a lump sum, up to a 25% of the capital value. The revaluation rate is a rate set by Treasury plus 1.5% each year. On death, a pension of 33.75% of the member's pension is normally payable to the surviving spouse.

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

Notes to the accounts for the year ended 31 March 2019 (continued)

2. Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the two types of fund that Dorset County Hospital Charity manage.

2a Statement of Financial Activities for the year ended 31 March 2018

	Unrestricted funds £000	Restricted funds £000	Total funds £000
Income from:			
Donations and legacies	280	804	1,084
Investments	2	-	2
Total income	282	804	1,086
Expenditure on:			
Raising funds	19	114	133
Charitable activities			
Medical and surgical equipment	102	684	786
Furniture and fittings	33	17	50
Artwork expenses	12	(1)	11
Patients' welfare and amenities	83	116	199
Staff welfare and amenities	4	(2)	2
Total expenditure	253	928	1,181
Net income / (expenditure)	29	(124)	(95)
Transfers between funds	(26)	26	-
Net income / (expenditure)	3	(98)	(95)
Reconciliation of funds			
Funds brought forward at 1 April 2017	272	834	1,106
Funds carried forward at 31 March 2018	**275**	**736**	**1,011**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019 (continued)

2b Balance Sheet as at 31 March 2018

	Unrestricted funds £000	Restricted funds £000	Total funds £000
Current assets			
Debtors	53	46	99
Cash and cash equivalents	336	878	1,214
	389	924	1,313
Creditors: amounts falling due within one year	(114)	(188)	(302)
Net current assets	275	736	1,011
Net assets	275	736	1,011
Total funds	**275**	**736**	**1,011**

3. Related party transactions

Dorset County Hospital NHS Foundation Trust Charitable Fund is a subsidiary of Dorset County Hospital NHS Foundation Trust. Control is exercised by Dorset County Hospital NHS Foundation Trust through corporate trusteeship arrangements.

Dorset County Hospital NHS Foundation Trust is the primary beneficiary of the Charity. The Charity has provided funding to the Foundation Trust for approved expenditure made on behalf of the Charity. This funding of £586,000 (2018: £1,048,000) is detailed in note 8. At 31 March 2019 the Charity had made £88,000 (2018: £218,000) of grant commitments to the Foundation Trust which had not yet been paid. The Foundation Trust also charges the Charity for financial services administrative expenses of £22,000 (2018: £22,000) and employs the fundraising team on behalf of the Charity and charges 100% of the posts, including employment on-cost, to the Charity £119,000 (2018: £114,000).

During the year none of the members of the Foundation Trust Board of Directors or Senior Foundation Trust staff or parties related to them were beneficiaries of the Charity. Neither the Corporate Trustee nor any member of the Foundation Trust Board of Directors has received honoraria, emoluments or expenses from the Charity in either year and the Corporate Trustee is covered through indemnity insurance taken out by the Foundation Trust to cover Board Members.

As an unincorporated Charity, control of the Charity vests with the Corporate Trustee.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019 (continued)

4. Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total funds 2019 £000	Total funds 2018 £000
Donations and fundraising	59	410	469	290
Legacies	5	-	5	490
Grants	115	196	311	304
	179	**606**	**785**	**1,084**

Donations from individuals are gifts from members of the public, relatives of patients and staff. The income is collected through our cash office.

5. Role of Volunteers

Like all charities, Dorset County Hospital NHS Foundation Trust is reliant on a team of volunteers for our smooth running. Our volunteers perform the following role:

- Fund Representatives – There are 40 Dorset County Hospital NHS FT staff that help to manage how the Charity's designated funds are spent. These funds are designated (or earmarked) by the Corporate Trustee to be spent for a particular purpose or in a particular ward or department. Each fund representative will act as the first stage approver in the approval process for spending the designated funds to help ensure that the funds are spent in accordance with the objects of the Charity.

.

6. Investment income

	Unrestricted funds £000	Restricted funds £000	Total funds 2019 £000	Total funds 2018 £000
Cash on deposit	**7**	**-**	**7**	**2**

Investment income was generated from cash held on deposit in the Government Banking Service bank account for Dorset County Hospital NHS Foundation Trust Charitable Fund.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019 (continued)

7. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2019 £000	Total 2018 £000
Fundraising office	16	4	20	19
Fundraising events	-	-	-	-
Support costs	-	115	115	114
Total	**16**	**119**	**135**	**133**

8. Analysis of charitable expenditure

The Charity made available grant support to Dorset County Hospital NHS Foundation Trust for a range of funding applications for equipment, training, and other services not funded by NHS Exchequer.

	Grant funded activity £000	Support costs £000	Total funds 2019 £000	Total funds 2018 £000
Medical and surgical equipment	593	30	623	786
Furniture and fittings	4	-	4	50
Artwork expenses	-	-	-	11
Patients' welfare and amenities	(45)	1	(44)	199
Staff welfare and amenities	3	-	3	2
	555	**31**	**586**	**1,048**

The Charity does not make grants to individuals. All grants are made to Dorset County Hospital NHS Foundation Trust to provide for the care of NHS patients in furtherance of our charitable aims. The Corporate Trustee operates a scheme of delegation for the charitable funds.

9. Movements in funding commitments

	2019 £000
Opening balance at 1 April 2018 (see note 16)	272
Additional commitments made less unused amounts reversed during the year (see note 8)	555
Amounts paid during the year	(659)
Closing balance at 31 March 2019 (see note 16)	**168**

Notes to the accounts for the year ended 31 March 2019 (continued)

As described in note 8, the Charity awards a number of grants in the year. Many grants are awarded and paid out in the same financial year.

10. Allocation of support costs and overheads

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day-to-day management of a charity.

The bases of allocation used are as follows:

- Audit Fees – allocated directly to charitable activities and then apportioned across funds using fund balances.
- Financial Services – allocated based on expenditure incurred on raising funds and charitable funds.
- Fundraiser – allocated between raising funds and charitable funds based on time split of 90% raising funds and 10% charity funds.
- Charitable Administrator - allocated directly to charitable activities on the basis all time spent undertaking admin of charity activities and then apportioned across funds using fund balances.
- Bank Charges - allocated directly to charitable activities and then apportioned across funds using fund balances.

	Raising funds £000	Charitable funds £000	Total funds 2019 £000	Total funds 2018 £000
Governance costs				
Audit fees	-	5	5	5
	-	**5**	**5**	**5**
Other support costs				
Financial services	2	20	22	22
Fundraiser	113	5	118	114
Charitable administrator	-	-	-	-
Insurance	1	-	1	1
Bank charges	-	1	1	-
	116	**31**	**147**	**142**

	Unrestricted funds £000	Restricted funds £000	Total funds 2019 £000	Total funds 2018 £000
Raising funds	1	115	116	114
Charitable activities	8	23	31	28
	9	**138**	**147**	**142**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019 (continued)

11. Trustees remuneration, benefits and expenses

The Charity's trustees give their time freely and receive no remuneration or expenses for the work that they undertake as trustees.

12. Analysis of staff costs

	2019 £000	2018 £000
Salaries and wages	99	92
Social security costs	10	9
Employers pension contribution	10	13
Total	119	114

The average headcount during the year was 3.28 (2018: 3.00) with three employees plus a fourth employee appointed during January 2019 involved in fundraising, predominantly on the Cancer Appeal with a small proportion of their time providing support services to the charitable activities or the governance of the Charity.

No employees had emoluments in excess of £60,000 (2018: none).

13. Auditor's remuneration

The auditor's remuneration of £4,680 (2018: £4,560) related solely to the audit with no additional work being undertaken (2018: nil).

14. Analysis of current debtors

	2019 £000	2018 £000
Trade debtors	32	27
Accrued income	9	72
	41	99

Other debtors represent sums owed to the Charity by third parties at the year-end for grant and other income collected by the NHS Foundation Trust on behalf of the Charity through the issuing of invoices.

Notes to the accounts for the year ended 31 March 2019 (continued)

15. Analysis of cash and cash equivalents

	2019 £000	2018 £000
Cash in hand	1,215	1,214

No cash or cash equivalents or current investments were held in non-cash investments or outside the UK.

All of the amounts held on interest bearing deposit are available to spend on charitable activities.

16. Analysis of liabilities

	2019 £000	2018 £000
Creditors falling due within one year		
Trade creditors	1	25
Accruals for grants owed to NHS bodies	168	272
Other accruals	5	5
	174	**302**

17. Reconciliation of net income/ (expenditure) to net cash flow from operating activities

	2019 £000	2018 £000
Net income / (expenditure) for the year (as per the statement of financial activities)	**71**	**(95)**
Adjustments for:		
Interest receivable	(7)	(2)
Decrease in debtors	58	141
(Decrease) / Increase in creditors	(128)	177
Net cash (used in) / provided by operating activities	**(6)**	**221**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019 (continued)

18. Funds

	At 1 April 2018 £000	Income £000	Expenditure £000	Transfers £000	At 31 March 2019 £000
Unrestricted funds					
General Purpose*	16	134	(127)	-	23
Staff General Purpose*	1	-	-	-	1
Patients General Purpose*	-	-	-	-	-
Endoscopy	11	-	(2)	-	9
Emergency Department	2	2	-	-	4
Cardiac	24	3	-	-	27
Critical Care	17	3	(4)	-	16
Diabetes	1	1	-	-	2
Stroke	26	9	(5)	-	30
Urology	2	2	1	-	5
Kingfisher Ward	11	7	5	-	23
Purbeck Ward	4	-	-	-	4
DCH Research Fund	-	-	-	-	-
Ridgeway Ward	2	1	-	-	3
Dementia Fund	17	6	(9)	-	14
Forget-me-not Suite	6	-	-	-	6
Go Girls Fund	6	-	-	(6)	-
Maud Alexander Ward	1	2	1	-	4
Colorectal and Lower GI	4	4	(1)	-	7
Breast Care	1	-	-	-	1
Lulworth Ward	-	1	-	-	1
Hinton Ward	1	-	-	-	1
Prince of Wales Ward	4	2	-	-	6
DCH Therapies	1	5	-	-	6
Haemodialysis	1	4	(1)	-	4
Barnes Ward	2	-	-	-	2
Ophthalmology	114	-	(56)	-	58
	275	**186**	**(198)**	**(6)**	**257**
Restricted funds					
Children's Services Trust*	12	1	-	-	13
Art in Hospitals*	2	-	-	-	2
Cancer Services*	16	12	(1)	-	27
West Dorset Cancer Centre Campaign	269	580	(494)	6	361
Post Graduate Education & Research*	-	-	-	-	-
The Lillian Martin Ophthalmology Fund*	-	-	-	-	-
Special Care Baby Unit*	56	4	(15)	-	45
Renal Fund*	381	9	(13)	-	377
Diabetic Fund*	-	-	-	-	-
	736	**606**	**(523)**	**6**	**825**
Total funds	**1,011**	**792**	**(721)**	**-**	**1,082**

*Special purpose funds registered with the Charity Commission as linked charities

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2019 (continued)

Restricted funds arise where a donor gives money for a specific purpose. They comprise the special purpose funds registered with the Charity Commission and funds arising from public appeal. These funds can only be applied towards grants for the particular purpose specified. The Corporate Trustee is confident that sufficient resources are held in an appropriate form to enable each fund to be applied in accordance with any restrictions.

Designated funds arise where the donor has made known their non-binding wishes or where the Corporate Trustee has created a fund for a specific purpose. They include three general purpose funds registered as linked charities with the Charity Commission. Such funds are expendable at the discretion of the Corporate Trustee.

19. Transfers between funds

There was 1 transfer between funds:

The Go Girls raised a further fantastic amount of £25,000 towards the Cancer Appeal. This amount included the balance of £6,000 held in the Go Girls Fund and they agreed for this balance to be moved to the Cancer Appeal during December 2018.

20. Contingency Assets

The Charity was notified via Mustoe Shorter Solicitors on 5 February 2019 of a residual beneficiary legacy for the Special Care Baby Unit at Dorset County Hospital but the value could not be reliably measured at 31 March 2019 when the solicitors were collecting the assets and liabilities of the Estate.

The Charity was notified via Smee & Ford on 2 April 2019 of a residual beneficiary legacy with 1/7th share Dorset County Hospital, for general donations and 1/7th share for Dorset County Hospital Dorchester, with the wish that the Renal Unit shall benefit. The value, however, could not be reliably measured at the 31 March 2019 when the solicitors were collecting the assets and liabilities of the Estate.

21. Events after the Reporting Period

The receipt of the legacy for the Special Care Baby Unit at Dorset County Hospital in Note 20 Contingent Assets will be recognised in 2019/20 accounts where the probability and ability to estimate with sufficient reliability were confirmed on 1 May 2019. The legacy is estimated by Mustoe Shorter to be £34,000

Dorset County Hospital NHS Foundation Trust Charitable Fund
Dorset County Hospital
Williams Avenue
DORCHESTER
Dorset
DT1 2JY

Edwards & Keeping
Unity Chambers
34 High East Street
DORCHESTER
Dorset
DT1 1HA

Dear Sirs

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your audit of the financial statements of the Charitable Fund for the year ended 31 March 2019. These enquiries have included inspection of supporting documentation where appropriate. All representations are made to the best of our knowledge and belief.

General

1. We have fulfilled our responsibilities as corporate trustee as set out in the terms of your engagement dated 10 October 2018, under the Charities Act 2011 for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view and for making accurate representations to you.

2. All the transactions undertaken by the charity have been properly reflected and recorded in the accounting records.

3. All the accounting records have been made available to you for the purpose of your audit. We have provided you with unrestricted access to all appropriate persons within the charity and with all other records and related information requested, including minutes of management and trustee meetings and correspondence with the Charity Commission.

4. The financial statements are free of material misstatements, including omissions.

Internal control and fraud

5. We acknowledge our responsibility for the design, implementation and maintenance of internal control systems to prevent and detect fraud and error. We have disclosed to you the results of our risk assessment that the financial statements may be misstated as a result of fraud.

6. We have disclosed to you all instances of known or suspected fraud affecting the entity involving management, employees who have a significant role in internal control or others that could have a material effect on the financial statements.

7. We have also disclosed to you all information in relation to allegations of fraud or suspected fraud affecting the entity's financial statements communicated by current or former employees, analysis, regulators or others.

Assets and liabilities

8. The charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets.

9. All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as appropriate.

10. We have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classifications of assets and liabilities reflected in the financial statements.

Accounting estimates

11. Significant assumptions used by us in making accounting estimates, including those mentioned at fair value, are reasonable.

Law and regulations

12. We know of no instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

Related parties

13. Related party relationships and transactions have been appropriately accounted for and disclosed in the financial statements. We have disclosed to you all relevant information concerning such relationships and transactions and are not aware of any other matters which require disclosure in order to comply with legislative and accounting standards requirements.

Subsequent events

14. There have been no events subsequent to the year-end which require adjustment or disclosure in the financial statements.

Going concern

15. We believe that the charity's financial statements should be prepared on a going concern basis on the grounds that current and future sources of funding or support will be more than adequate for the charity's needs. We have considered a period of twelve months from the date of approval of the financial statements. We believe that that no further disclosures relating to the charity's ability to continue as a going concern need to be made in the financial statements.

Grants and donations

16. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of such income.

Yours faithfully

.....
Signed on behalf of the Trustee

.....
Date

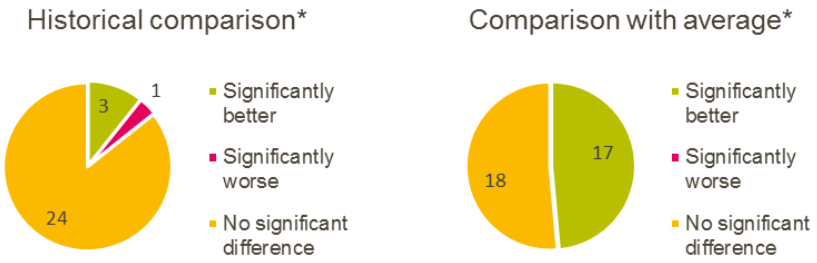
Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 2019**
Report Title	**Urgent & Emergency Care Survey 2018**
Author	Neal Cleaver, Deputy Director of Nursing and Quality Ali Male, Patient Experience & Engagement Lead
Responsible Executive	Nicky Lucey, Director of Nursing and Quality

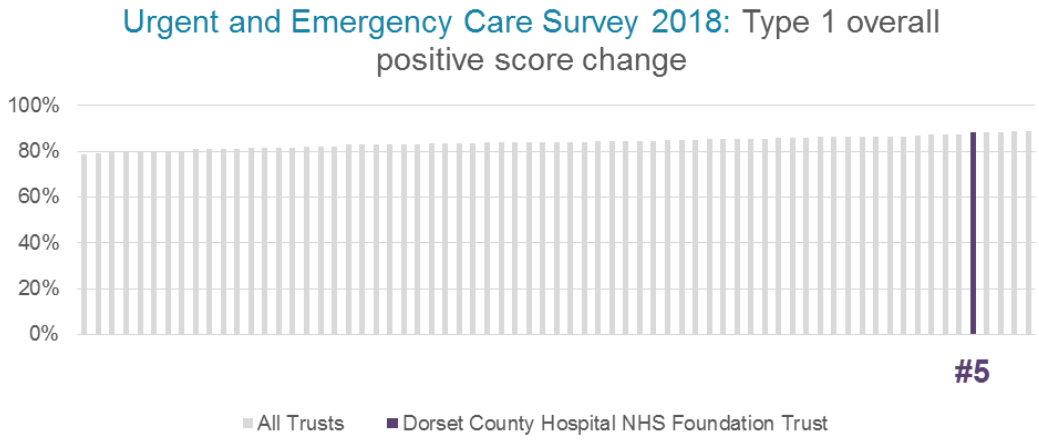
Purpose of Report (e.g. for decision, information)

To provide a summary of the national ED and Urgent Care survey 2018

Summary

.





Inpatient survey summary:
Summarised below are the key changes in the inpatient survey, with the main report showing the detail.

SECTION	NATIONAL AVERAGE COMPARISON	HISTORICAL COMPARISON
Arrival	Better in all fields	No change
Waiting	Better in all fields	Better in 1 field
Doctors and Nurses	Better in 2 fields	No change
Care and Treatment	Better in 1 field	Better in 1 field
Tests	No change	No change
Pain	Better in 1 field	No change
Hospital Environment and Facilities	Better in 2 fields	Worse in 1 field
Leaving A+E	Better in 3 fields	No change
Overall	Better in 1 field	Better in 1 field

The only area identified in the full report as 'Worse in 1 field based on historical data' is below. Although this is an area that the Patient Experience Group will discuss for improvement, it should be noted that the results remain above the national average:

Q34	Did not feel threatened by other patients or visitors

Historical

2012	2014	2016	2018
97%	96%	98%	95%

Organisation type

Average	Organisation
93%	95%

Paper Previously Reviewed By
Survey summary will be reviewed by the Patient Experience Group in June and an action plan developed.
Quality Committee 18 June 2019

Strategic Impact
NHS Foundation Trusts are required to publish survey results. Using this feedback will help deliver further improvements to patient care. This relates to Strategic Objective 1 – Delivering outstanding services every day; Objective 3 – collaborative working with our patients and partners; and Objective 4 – Enabling and empowering staff.

Risk Evaluation

- Failure to act on the results of the survey will have a negative impact on both staff wellbeing and patient care and strategic objectives

Impact on Care Quality Commission Registration and/or Clinical Quality As the report of these priorities incorporates standards and metrics that are utilized by the CQC it will be important to note progress or exceptions to these standards.	
Governance Implications (legal, clinical, equality and diversity or other): Trust Boards must have oversight of the inpatient and staff survey results. Inability to achieve the improvements associated with these could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.	
Financial Implications None currently identified	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	a) Note the report b) Support the Patient Experience Group leading on the Trust action plan

Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 2019**
Report Title	**NHS Urgent & Emergency Care Survey 2018**
Author	Alison Male, Patient Experience & Engagement Lead Neal Cleaver, Deputy Director of Nursing and Quality

1. Introduction

This document summarises the findings from the NHS Urgent & Emergency Care Survey 2018, carried out by Picker, on behalf of Dorset County Hospital (DCH) NHS Foundation Trust.

Picker was commissioned by 69 organisations to run the Urgent & Emergency Care survey - this report presents DCH results in comparison to those organisations. A total of 35 questions from the survey can be positively scored. Of these 28 can be compared historically between the 2018 and 2016 surveys. DCH results include every question where we had the minimum required 30 respondents.

A total of 1250 patients from our Trust were invited to complete the questionnaire. 1201 patients were eligible for the survey, of which 497 returned a completed questionnaire, giving a response rate of 41% (compared to the Picker average response rate of 30%) and our previous 2016 response rate of 38%.

Top 5 scores (compared to average)	
75%	Q39. Told side-effects of medications
49%	Q10. Examination not delayed
71%	Q41. Family or home situation considered
83%	Q11. Able to get help whilst waiting
75%	Q35. Able to get suitable food or drink

Most improved from last survey	
49%	Q10. Examination not delayed
74%	Q40. Told when could resume normal activities
90%	Q46. Rated care as 7/10 or more
92%	Q21. Right amount of information given on condition or treatment
75%	Q35. Able to get suitable food or drink

Bottom 5 scores (compared to average)	
85%	Q44. Enough information to care for condition at home
61%	Q30. Told how would receive the results of tests
92%	Q20. Family, friend or carer able to talk to a doctor
97%	Q45. Treated with respect and dignity
96%	Q17. Had confidence and trust in the doctors/nurses

Least improved from last survey	
84%	Q24. Staff did not contradict each other
96%	Q29. Understood results of tests
95%	Q34. Did not feel threatened by other patients or visitors
96%	Q17. Had confidence and trust in the doctors/nurses
90%	Q8. Waited under an hour in A&E to speak to a doctor/nurse

Overall results:

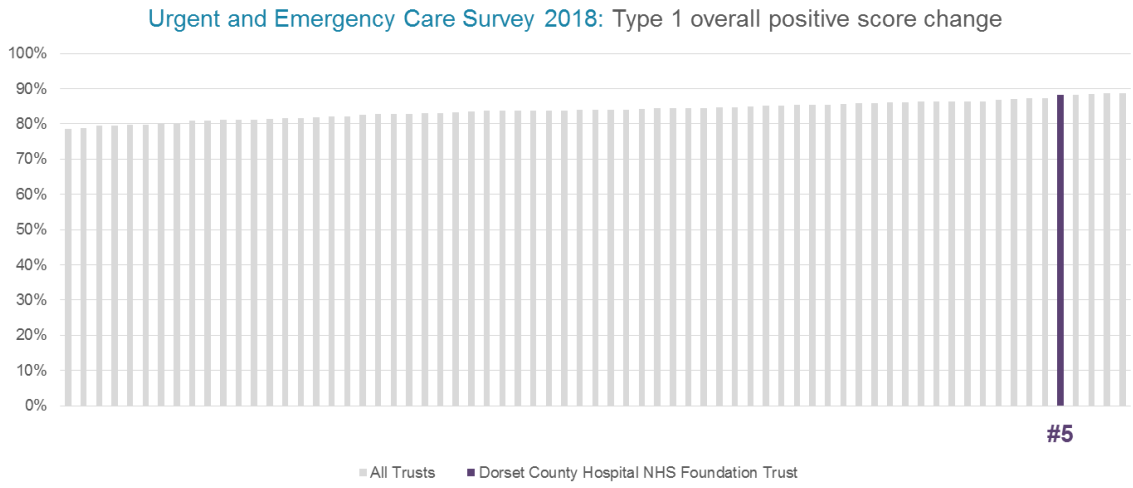
Key Improvements since 2016
Q10. Examination not delayed
Q40. Told when could resume normal activities
Q46. Rated care as 7/10 or more
Q21. Right amount of information given on condition or treatment
Q35. Able to get suitable food or drink

Our core strengths
Q39. Told side-effects of medications
Q10. Examination not delayed
Q41. Family or home situation considered
Q11. Able to get help whilst waiting
Q35. Able to get suitable food or drink

Issues to address
Q44. Enough information to care for condition at home
Q30. Told how would receive the results of tests
Q20. Family, friend or carer able to talk to a doctor
Q45. Treated with respect and dignity
Q17. Had confidence and trust in the doctors/nurses

Our Views
90% Q46. Rated care as 7/10 or more
97% Q45. Treated with respect and dignity
98% Q15. Doctors and nurses listened to patient

LEAGUE TABLE: overall positive score



2. Arrival

Compared to the historical data DCHFT is **significantly better in 2 fields**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q5	Waited under an hour in the ambulance	99%	98%	96%	98%	93%	98%
Q6	Enough privacy when discussing condition	90%	93%	92%	95%	92%	95%

3. Waiting

Compared to the historical data DCHFT is **significantly better in 5 fields**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q8	Waited under an hour in A&E to speak to a doctor/nurse	92%	92%	90%	90%	84%	90%
Q9	Waited under two hours to be examined by a doctor/nurse	-	-	90%	91%	86%	91%
Q10	Examination not delayed	50%	45%	35%	49%	35%	49%
Q11	Able to get help whilst waiting	-	-	-	83%	73%	83%
Q12	Spent under 12 hours in A&E	-	-	-	98%	94%	98%

4. Doctors & Nurses

Compared to the historical data DCHFT is **significantly better in 2 fields**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q13	Enough time to discuss condition with doctor/nurse	-	-	-	97%	96%	97%
Q14	Understood explanation of condition and treatment	97%	96%	93%	96%	94%	96%
Q15	Doctors and nurses listened to patient	99%	98%	97%	98%	97%	98%
Q16	Doctor or nurse discussed anxieties or fears about condition or treatment	88%	88%	87%	90%	85%	90%
Q17	Had confidence and trust in the doctors/nurses	98%	97%	97%	96%	96%	96%
Q18	Doctors/nurses didn't talk in front of patients as if they weren't there	87%	89%	86%	89%	85%	89%
Q20	Family, friend or carer able to talk to a doctor	-	-	-	92%	92%	92%

5. Care & Treatment

Compared to the national average DCHFT is **significantly better in 1 field**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q21	Right amount of information given on condition or treatment	90%	89%	88%	92%	85%	92%
Q22	Enough privacy when being examined or treated	98%	99%	99%	99%	98%	99%
Q23	Enough attention from medical or nursing staff	93%	97%	95%	95%	93%	95%
Q24	Staff did not contradict each other	85%	91%	87%	84%	83%	84%
Q25	Involved in decisions about care and treatment	93%	93%	93%	93%	92%	93%

6. Tests

Compared to the national average DCHFT is **not significantly different in any areas**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q27	Understood why tests were needed	94%	95%	94%	95%	93%	95%
Q29	Understood results of tests	97%	99%	98%	96%	94%	96%
Q30	Told how would receive the results of tests	-	-	-	61%	61%	61%

7. Pain

Compared to the national average DCHFT is **significantly better in 1 field**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q32	Staff helped control pain	83%	94%	88%	91%	84%	91%

8. Hospital Environment & Facilities

Compared to the national average DCHFT is **significantly better in 2 fields and significantly worse in 1 field**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q33	A&E department was very or fairly clean	98%	98%	98%	99%	96%	99%
Q34	Did not feel threatened by other patients or visitors	97%	96%	98%	95%	93%	95%
Q35	Able to get suitable food or drink	68%	77%	71%	75%	67%	75%

9. Leaving A&E

Compared to the national average DCHFT is **significantly better in 3 fields**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q38	Told purpose of medications	98%	96%	100%	100%	98%	100%
Q39	Told side-effects of medications	50%	53%	75%	75%	60%	75%
Q40	Told when could resume normal activities	66%	76%	66%	74%	68%	74%
Q41	Family or home situation considered	64%	70%	70%	71%	58%	71%
Q42	Told about symptoms to look for	-	-	-	81%	76%	81%
Q43	Told who to contact if worried	76%	83%	77%	78%	75%	78%
Q44	Enough information to care for condition at home	-	-	-	85%	85%	85%

10. Overall

Compared to the historical data DCHFT is **significantly better in 1 field**

		Historical				Organisation type	
		2012	2014	2016	2018	Average	Organisation
Q45	Treated with respect and dignity	98%	99%	98%	97%	97%	97%
Q46	Rated care as 7/10 or more	84%	91%	83%	90%	83%	90%

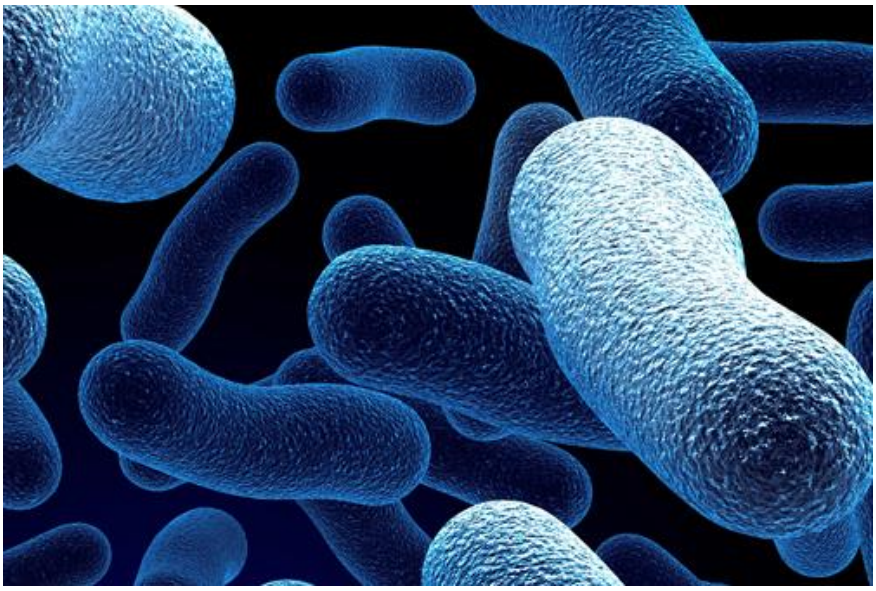
11. RECOMMENDATIONS:

- Note the contents of this report
- Analysis of patient comments for further detail and themes
- Compare results with Trusts who perform well in areas in need of improvement
- Develop action plan, to be shared with Patient Experience Group and reported to Quality Committee

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2018-19



Nicola Lucey - Director of Nursing and Quality/ Director of Infection Prevention and Control
Emma Hoyle - Associate Director Infection Prevention and Control
Dr Paul Flanagan – Infection Control Doctor

INDEX

Executive summary		3
1.	Introduction	4
2.	Infection Prevention & Control arrangements	5
3.	Healthcare Associated Infections	6
4.	Outbreaks of infection	9
5.	Clinical Audit	9
6.	Education	12
7.	Policy development/review	12
8.	Infection Control week	13
9.	Facilities report	14
10.	Estates report	16
11.	Decontamination report	20
12.	Antimicrobial report	24
13.	Conclusion	32
Appendix 1 IPC Workplan 2019/2020		33

EXECUTIVE SUMMARY

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

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

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

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

Overall 2018/19 was a successful year, meeting key standards and regulatory requirements for infection prevention and control. Below is the highlight of those:-

- The Trust met the trajectories set for MRSA bacteraemia and *Clostridium difficile* infections for 2018-2019
- The Trust has successfully reduced healthcare acquired infections year on year
- Hand hygiene compliance has remained high and sustained at 97%
- Only one outbreak of Norovirus which was well contained and occurred for a short period only
- The Trust achieved above the national average for several elements of the PLACE assessments for the year.
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to control pseudomonas and legionella in tap water in high risk areas
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNet).

INTRODUCTION

This is my third year as Director of Nursing and Quality with the responsibility of Director for Infection Prevention and Control (DIPC) and this report summarises the work undertaken in the Trust for the period 1st April 2018 – 31st March 2019.

The Annual Report provides information on the Trust's progress of the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

I am pleased to report good progress against the trajectory for HCAIs. The Trust met the target for zero cases of MRSA bacteraemia and reported 10 cases of *Clostridium difficile* against a target of 13 cases. In addition, the Trust has been very proactive in reviewing trends and improvements in Gram-negative blood stream infections (BSIs) with sharing across system partners as part of the Dorset STP. The Infection Prevention and Control Team has seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection and prevention.

These low rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff employed by the trust. The commitment to deliver safe, clean, quality care for patients remains pivotal in the goal to reduce healthcare associated infections to an absolute minimum of non-preventable cases.

I am proud of the efforts, innovation and leadership in practice of the Infection Prevention and Control team as without their support the quality improvements towards our strategic mission "Outstanding care for people in ways which matter to them" would not be possible. Their support for training and engaging with the clinical teams has been at the highest standard, reflective of the care provided and experience by our visiting public.

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

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

1. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2018- 2019. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

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

2.2 DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2018-2019:

- Monthly MRSA Bacteraemia surveillance;
- Monthly *Clostridium difficile* surveillance;
- Monthly hand hygiene rates;
- Outbreak and incident reports;
- Antibiotic Stewardship Report;
- Progress with national ambition to reduce Gram Negative Blood Stream Infections by 50% by 2021

2.3 INFECTION PREVENTION and CONTROL TEAM

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

- Nicola Lucey, Director of Nursing and Quality/ Director of Infection Prevention and Control
- Dr Paul Flanagan, Consultant Microbiologist and Infection Control Doctor – Joined October 2018
- Emma Hoyle, Associate Director Infection Prevention and Control
- Abigail Warne, Specialist Nurse – Ongoing Maternity Leave since June 2018
- Julie Park, IPC Nurse – Ongoing Maternity Leave since September 2018
- Christopher Gover, Specialist Nurse – Seconded to team to cover Maternity Leave
- Debs Scott-Denness - Seconded to team to cover Maternity Leave
- Helen Belmont – Bank Specialist Nurse
- Cheryl Heard, Administrator
- Rhian Pearce, Antimicrobial Pharmacist – Returned from Maternity Leave November 2018

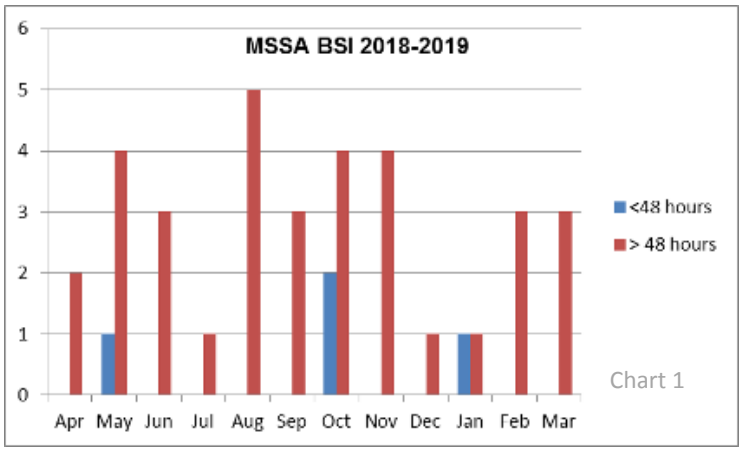
2. HEALTHCARE ASSOCIATED INFECTIONS

3.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

There were no cases of MRSA bacteraemia in 2018-2019. The last case of MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA (blood samples taken ≥48hours post admission) have significantly reduced.

3.2 *Staphylococcus aureus* bacteraemia (MSSA)

In 2018-2019 there were a total of 38 cases of MSSA bacteraemia, of these 34 cases were identified <48 hours of admission and 4 identified >48 hours after admission (Chart 1). This is a significant reduction complared to last years MSSA bacteraemia cases >48 hours which was 12 cases.



To achieve this reduction we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices. Analysis of cases in the >48 hour group has shown that only one was trust-acquired, with the other three relating to a source present prior to admission.

3.3 Gram Negative Blood Stream Infections

3.3.1 Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 2021 (PHE 2017). February 2019 it was announced that the date for achieving this reduction has been changed to 2023. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.)*

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

3.3.3 In 2018-2019 there were a total of 143 positive BSI samples for E.coli. 20 of these cases were attributed to the Trust (Chart 2). This was a decrease by 1 case from 2017-2018. All of these cases were reviewed via Root Cause Analysis (RCA) by the IPCT no trends or issues were identified to progress to Divisional involvement. All cases of E.coli that occur >48hrs after admission are reviewed by the Consultant Microbiologist and Infection Prevention & Control Team. A full data collection process is carried out in accordance with Public Health England guidance; this includes all mandatory and optional data. Full antibiotic review is carried out taking into account the preceding 28 days. No lapses in care have been identified in the cases 2018-2019.

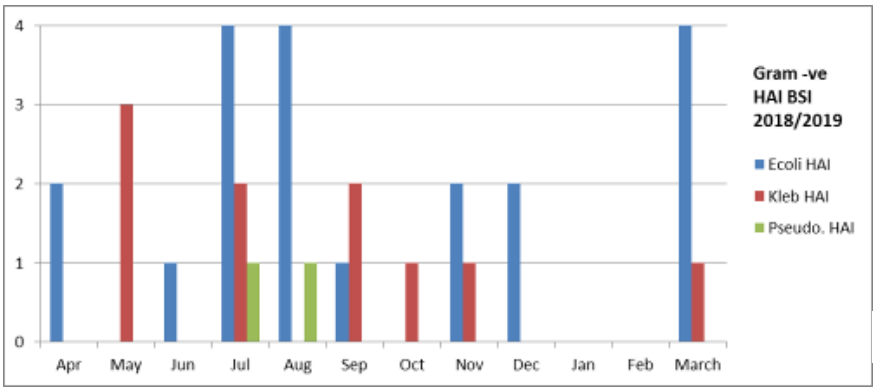


Chart 2

3.3.4 In 2018-2019 there were a total of 42 positive BSI samples for Klebsiella sps, 10 of these cases were attributed to the Trust (Chart 2). This was an increase by 5 cases from 2017-2018.

3.3.5 In 2018-2019 there were a total of 7 positive BSI samples for Pseudomonas *aeruginosa*, 2 of these cases were attributed to the Trust (Chart 2). This was a decrease by 5 cases from 2017-2018.

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

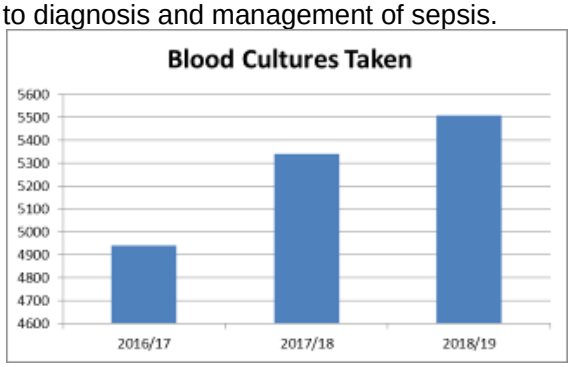


Chart 3

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

- Review of urinary catheter care including documentation and discharge
- Participation in national Surgical Site Surveillance audit for Bowel Surgery to benchmark Trust 2017/2018.
- Audit and subsequent actions into monitoring of indwelling devices e.g. Peripheral vascular cannula
- Individual review of *E.coli* BSI cases

Within Dorset the four healthcare Trusts are working together on joint projects to seek solutions to this target as the majority of cases are community acquired and support is required to achieve resilience county wide. Nationally, the decrease in gram negative BSI has not been recognised and NHSE/i have agreed to stretch the target to 20203. This will enable further engagement with primary care.

3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

This has been the most successful year to date for reducing cases of CDI. The Trust trajectory for the year was 13 cases. In total the Trust reported 10 cases detected >3 days after admission; of these cases 7 were appealed as non-preventable with no lapses in care; this resulted in 3 cases reported as hospital acquired (Chart 4).

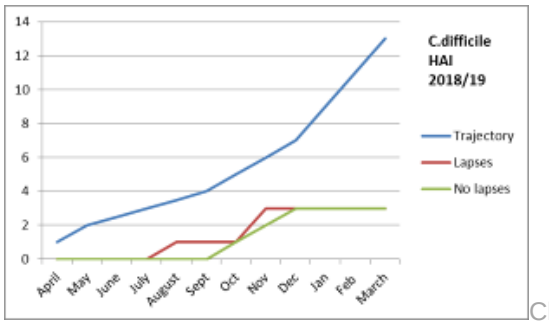


Chart 4

All samples are forwarded to the PHE reference laboratory for ribotyping. This provides an overview of the different strains of *Clostridium difficile* toxins and an opportunity to ensure that any potential linked cases are reviewed and outbreaks detected early. Over the course of the year we identified 6 different phage types. We can confidently say that we have not had any outbreaks or linked cases of CDI in the Trust 2018-2019.

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

3. OUTBREAKS OF INFECTION

4.1 Norovirus

Outbreaks of this viral illness have been identified at the Trust during this year in line with seasonal reporting. Individual cases have also been reported in very small numbers. There has been 1 outbreak of Norovirus 2018-19. This was identified quickly, patients sampled and isolated in line with Trust policy. In comparison with the national average the number of bed days lost due to outbreaks remains low.

4.2 Influenza

There has been a national reduction in cases of Influenza A & B during the Winter 2018/2019 in comparison to the previous year. The Trust was able to demonstrate learning from the previous year and the impact at operational level for the Trust was minimal.
In preparation for 'Flu Season' all Trust staff were offered the annual flu vaccine. 82.6% of front line staff were immunised and 79.17% of all staff, an increase from 63.23% the previous year.
The Trust did not have any outbreaks of influenza and all cases identified in the Trust were isolated and treated in a timely manner.

5 CLINICAL AUDIT

5.1 SURGICAL SITE SURVEILLANCE

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

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

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

During 2018-2019 the IPC team have supported 2 modules for surveillance. Surveillance. The IPCT are able to facilitate a less time consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

Over the last year the accessibility of ICNet has been increased for the surgeons to monitor and keep a live active list of their potential and actual infections. Aligned

with the national 'Getting it right first time' (GIRFT) audit this will continue over the Summer of 2019.

Surgical Site Surveillance of Hip Replacement

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for April- June 2018 (Table 1) and last 4 periods for which data was available.

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

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

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

Table 1 April – June 2018 Hip Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Apr-Jun 2018	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	98 98 81.6%	337 337 79.8%
Surgical Site Infection	No. of inpatient/readmission % infected	3 3.1%	3 0.9%
	No of post discharge confirmed % infected	2 2.1%	5 1.5%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	5 5.1%	8 2.4%

Surgical Site Surveillance of Breast Surgery (Jan – March 2019 - data not available for 2019-2020 Annual report)

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

5.2 Peripheral Venous Cannula (PVC)

In 2014 national guidance was published for the prevention of healthcare associated infections in NHS Hospitals. A full GAP analysis was undertaken and the insertion and management of Peripheral Venous Cannula (PVC) was one area that required improvement. PVC's are commonly used devices in acute hospitals, used for the administration of intravenous fluids and drugs. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance

suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required.

Regular auditing commenced in January 2016 and remains ongoing. Should compliance fall below 90% additional weekly/monthly audits are carried out. Divisional leads are invited to IPCG on a bi-monthly basis to discuss their areas results. The annual average for compliance is 90%.

5.3 Compliance with Urinary Catheter Policy

Over the past year the following audits have been completed in relation to Urinary Catheter Care

- Discharge from DCHFT with Urinary Catheter Pathway

Trust wide compliance in issuing patients with catheter care record on discharge from hospital: Urgent and Integrated Care 32% Family Services and Surgical 80%. Divisional Matrons are reporting findings via their Quality Groups and working with staff to improve results.

- Indwelling Urinary Catheter Recording on Vital Pac

Trust wide compliance in recording patients with urinary catheters on VitalPac has improved by 10% over the last year. Monthly audits are now in place and compliance at year end: Urgent and Integrated Care 86% Family Services and Surgical 89%

5.4 Carbapenemase producing enterobacteriaceae audit

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK, over the last 8 years, we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

Public Health England recommend that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status.

This audit aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Regular audits have shown overall trust compliance rates to be at 89%. IPCT continue to work with ward teams to ensure these assessments are completed on admission.

6. EDUCATION

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

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

Mandatory Training for clinical and non-clinical staff has been offered via an online workbook. Overall compliance with mandatory IPC training over the year was 84% for clinical staff and 92% for non-clinical staff. IPCT recognised that additional support and training was required and so now provides monthly face to face formal mandatory training sessions for staff in addition to the online package. This has been in place from early 2019.

7. POLICY DEVELOPMENT/REVIEW

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

- Infection Prevention and Control Operational Policy for Haematology/Cancer Ward
- Hand Hygiene Policy
- Guidelines for patients discharged with an Urinary Catheter (urethral & suprapubic)
- Aseptic and Aseptic Non-Touch Technique (Clean) Protocol
- Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Policy
- Scabies, Treatment of - Suspected or Confirmed Guidelines
- Isolation Policy
- Seasonal Influenza Policy
- Guidelines for the use of portable fans in the healthcare setting
- Clostridium difficile policy

8. INFECTION CONTROL WEEK

This year's Infection Control Week focused on 'the gloves are off' – reducing inappropriate glove use and promoting good hand hygiene risk assessments. The wards and departments did not disappoint and created some wonderful educational display boards and worked hard to highlight the importance the topic. During the

week the annual judging of the displays led by Patricia Miller and Nicola Lucey, took place.

Overall winner – Kingfisher Ward

The winners included:
Award for Most Imaginative – Ilchester Ward
Award for Most Educational – Maternity
Award for Most Entertaining – Renal Dialysis
Overall Winner – Kingfisher Ward for demonstrating strategic awareness, most aligned to Trust values and link to evidence based practice

Other participating wards – Abbotsbury, Ridgeway, Purbeck, Moreton, Prince of Wales Wards, Theatres and the Stroke Unit.

We were also supported with Reps from Schülke, Clinell, Vernacare, Daniels and GoJo who kindly donated prizes for the winners and some came in to promote IPC with stands in Damers restaurant. Damers restaurant also made a brilliant themed cake for another competition. Poundbury Garden Centre and the Plaza Cinema also provided some prizes.

9. FACILITIES REPORT - CLEANING SERVICES (PAUL ANDREWS)

TO PROVIDE AND MAINTAIN A CLEAN AND APPROPRIATE ENVIRONMENT THAT FACILITATES THE PREVENTION AND CONTROL OF INFECTIONS.
CLEANING SERVICES

9.1 CLEANING SERVICES

9.1.1 Management Arrangements

The Head of Estates and Facilities is responsible for high standards of cleaning service delivery across all areas of the Trust. The Deputy Facilities Manager is responsible for the 'day to day' running of the service supported by an 'in house' team which is made up of a Housekeeping Team Leader supported by Housekeeping Supervisors and Housekeeping staff.

Mandatory training for all housekeeping staff is currently recorded as 94 %

9.1.2 Monitoring and Auditing

Dorset County Hospital has robust systems in place to ensure that all healthcare premises provided are suitable and fit for purpose. The environments are monitored to ensure they are clean, maintained and in good physical repair and condition. Various audits are carried out by IPC and Housekeeping Services, which include the '49 elements', and inspections all monitor standards of cleanliness and ensure that environmental policies and procedures are adhered to. In addition the Trust participates in the annual Patient-Led Assessments of the Care Environment (PLACE).

PLACE assessments are a system for assessing the quality of the patient environment. They are conducted via self-assessments with external patient and Healthwatch validation, and assessments are undertaken every year. The results are reported publicly to help drive improvements in the care environment.

The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The non-clinical activities of concern are cleanliness; food and hydration; privacy and dignity and wellbeing and condition, appearance and maintenance of healthcare premises and a disability and dementia domain which measures whether the premises are equipped to meet the needs of a disabled person and dementia sufferers against a specified range of criteria. Additionally for 2018 there was more focus on disability and dementia awareness categories. These categories focus on the issues of access and mobility provided for disabled patients during their stay, aspects relating to food and food service, and the provision of dementia friendly environments.

DCH comparison by Upper Quartile of South of England and Acute Small Trusts

	DCH Scores for 2018	National Average for 2018	Upper Quartile of South of England	Upper Quartile of Acute Small-country wide
Cleanliness	99.48%	98.59%	99.42%	99.48%
Food	96.81%	90.71%	93.32%	91.75%
Organisational Food	92.10%	89.60%	93.1%	92.16%
Ward Food	97.66%	91.88%	94.25%	92.85%
Privacy, Dignity and Wellbeing	86.67%	85.81%	87.97%	84.85%
Condition, Appearance and Maintenance	94.46%	94.72%	95.97%	96.06%
Dementia	78.84%	81.34%	87.72%	84.58%
Disability	84.24%	85.47%	90.54%	88.03%

In summary the 2018 PLACE results for Dorset County Hospital demonstrated a high level of compliance across the Trust with the majority of categories scoring above the national average and noting improved or sustained practice in many areas.

In order to ensure that cleanliness and environmental standards are maintained to the highest standards robust technical and managerial monitoring systems have been put in place.

Technical cleaning audits are carried out weekly and monthly by a team of appropriately trained personnel, and patient leads, to provide and monitor data as required by the national cleaning standards. The minimum target score set by the Trust (using the 2007 NHS National Standards of Cleanliness Criteria) is as follows:

- Very high risk areas 98%
- High risk areas 95%
- Significant risk areas 85%
- Low risk areas 75%

In areas where the target score is not reached there is a rectification timeframe set at 24 hours for very high risk and 48 hours for high risk areas. Additional focused monitoring and validation of the audit scores also takes place in liaison with the IPC team and an action plan is agreed and implemented. As a Housekeeping team we have maintained 100% auditing in all very high and high risk areas for 2018.

9.1.3 Deep Cleaning Programme

The deep cleaning programme of ward areas was started during 2017 and plans are in development to continue this in 2019-20, with areas identified and working alongside our Estates colleagues to address works that are required prior to the housekeeping deep clean using the HPV machine.

The Trust embraces the process of decontamination with hydrogen peroxide vapour (HPV) misting machines and uses this as normal practice where a 'deep cleaning' requirement has been identified by Nursing or the Infection Control Team and where upgrades or refurbishment has taken place.

9.1.4 Patient Feedback

Feedback from 'Friends and Family' shows housekeeping receive consistently positive feedback for the delivery of very high cleaning standards across Dorset County Hospital.

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

10.1 WATER QUALITY

Throughout 2018, the Estates Team have maintained responsibility for the Trust's water services, reporting to the Water Quality Management Group (WQMG). Activities to maintain water quality continue to be supported and audited by independent experts in water hygiene management from Water Hygiene Centre with the WQMG sitting FOUR times per annum.

The 'Water Safety Policy' and accompanying 'Operational and Maintenance Procedures' documents were both formally adopted this year by WQMG.

Regulatory requirements to ensure the wholesomeness and sufficiency of the DCH borehole supply have been amended following changes to the *Private Water Supplies (England) Regulations 2016*. As a consequence both check and audit analysis of the supply has been delegated to the authority, the Community Protection Division of the Dorset Councils Partnership to enhance communication and reduce costs.

There has been considerable success in the closure of items identified in the 2016 L8 Risk Assessment and other water safety related issues that have emerged during the year including;

- Replacement of North Wing Cold Water Storage Tanks (CWST),
- Deactivation of Children's Centre CWST and dead-leg removal,
- Installation of pilot system for Hot Water System temperature monitoring,
- Upgrade of borehole dosing system.

Other outstanding items, primarily issues around dead-legs, back-flow prevention and intrusive inspection, have had to be deferred to FY19/20.

In 2019 several Risk Assessments, such as Legionella, are due to be carried out. These will form an integral part of the full internal review of DCH outlets, currently underway, to improve compliance and assurance regarding water safety at point of use including flushing, hot water boiler servicing and such like.

Pipework corrosion issues continue to occur resulting in leaks. These primarily present risks to continuity of supply rather than direct infection issues. Investigations supported by BSRIA laboratories (Building Services Research and Information Association) have determined the likely root cause to be a latent defect from original construction. As a consequence leaks are handled on an ad hoc basis with a concurrent project underway to mitigate the consequences of isolation when effecting repairs by means of additional isolation valves.

The Robert White Centre has now been brought into service with all utilities and equipment currently under warranty. Full handover of the facility to Estates Dept. is due in May 2019 and will be included in all surveillance and routine safety schedules.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has continued according to previous schedules across the Trust. It is the Estates Dept. intention to bring this work in-house to improve costs and control. A review of sampled outlets and scheduling will take place as part of this development.

Over the period covered by this report, MAR18 – MAR19, there were TWELVE instances of raised Pseudomonas counts discovered during regular surveillance testing;

- POW – FOUR separate instances.
- Fortuneswell Ward – FIVE separate instances.
- SCBU – ONE instance.

WSP procedures were followed in all instances and, based on subsequent investigation, are believed to have extrinsic causes. There were no instances of Legionella detected.

10.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME

The Deep Cleaning programme of ward areas commenced in 2017 and this has continued throughout 2018. It is supported by the Estates Team who undertake any necessary refurbishment work prior to the housekeeping team using the hydrogen peroxide vapour process (HPV fogging) to clean the agreed areas.

10.3 REPLACEMENT FLOOR COVERINGS

During 2018/19 the Estates delivery team and contractors have completed more than 120 various flooring repairs and a number of necessary replacements in corridors, shower rooms & ward or non-clinical areas.

10.4 DECORATION AND ENVIRONMENT

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

10.5 VENTILATION

During 2018/19 Estates and Housekeeping have continued to carry out high level deep cleaning in critical areas. Any deficiencies are reported through the Decontamination Group.

The Estates team have continued to carry out annual validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B. They carry out any remedial works that are recommended. We have TWO Appointed Person's and work is carried out under a Permit to Work system. All validation reports are checked by our Authorising Engineer whose next visit is due in April 2019.

10.6 WARD AUDITS

Environmental audits and the Estates Department have continued to support the weekly audits in association with Infection Control, Pharmacy Housekeeping and Patient Representatives.

10.7 CAPITAL WORKS

10.7.1 Robert White Centre - The construction took over 18 months and was handed over in June 2018. The construction site was adjacent to the main cancer inpatient ward so careful measures were used to minimise the risk of infection from construction dust. This worked successfully and there were no recorded cases of infection attributed to the construction work.

The end result is the trust now has an HTM compliant space with measures including fully lagged pipes throughout with no dead legs, the addition of 24 wash hand basins to the Trust estate, correct air flow rates in all rooms, regular cleaning that takes in to consideration the higher frequency of immunocompromised patients, appropriate signage to encourage the correct use of basins and sinks.

10.7.2 MRI Scanner - The replacement of the MRI scanner included enhancements to ventilation flow rates in the scanner room to conform to guideline level and the

creation of a trolley wait area with ventilation and water services in the space operating to a compliant level for cannulation.

10.7.3 Emergency Department - The refurbishment of cubicles in the major injuries area of ED was carried out in a live clinical environment, Measures to mitigate infection of adjacent live areas included solid demarcation lines, access adopted through an alternative area of the hospital, liberal use of tack mats and regular site meetings with the IPC team to review practices. The completed project has added an additional wash hand basin, improved flooring and ventilation in the area.

10.7.4 Mortuary - The mortuary was fully refurbished to bring it to a compliant HTM level that also satisfies the Human Tissue Authority requirements. This work took approximately 5 months to complete and included weekly meetings on site with representatives from IPC. IPC-related improvements include:

- Addition of a boot wash and shower/changing room immediately adjacent to the post mortem suite
- Removal of all porous material from the post mortem suite and addition of hygienic cladding to the walls and stainless steel surface covers
- New flooring throughout including colour changes to clearly show clean, transitional and dirty areas
- New fridges with compliant separation
- Ventilation improvements to all areas to comfortably meet HTM flow rates
- Dedicate post mortem benches with integrated water services
- New sluice unit
- Removal of dead leg pipework

10.7.5 Other Capital Works

Three heavy use toilets in North Wing 1 Entrance were refurbished. Work included new floors, modifications to the ventilation to improve airflow and coating the walls in hygienic cladding to make cleaning easier and more effective.

Compliant wash hand basins were added to rooms in the rehabilitation department and in the surgical assessment unit.

A new toilet was formed in the service corridor in response to demand for toilets in that area. This has helped balance the use of toilets in the area and improves cleanliness.

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

11.1 STERILE SERVICES

11.1.1 Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485.

The Notified Body Intertek attended in July 2018 to complete a Transition Audit to certify that the QMS meets the latest version of BS EN 13485:2016.

This Accreditation continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

The next surveillance Audit by the Notified Body Intertek is scheduled for May 2019.

11.1.2 Environmental Monitoring

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

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

The laboratory also tests:

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

Latest testing of all areas occurred on 14 February 2019 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

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

ProReveal testing was introduced in May 2018 following an update to HTM 01-01; this involves 50 instruments per washer (200 in total) being tested on a quarterly basis to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance
and can effectively manage SSD on a day to day basis.

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

11.1.3 Tracking and Traceability

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

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

11.1.4 Shelf Life Testing

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

11.1.5 Staff Training

All Supervisors have now attended the SSD Managers/Supervisors course at Eastwood Park. This City & Guild qualification gives assurance that they have a full understanding of the Decontamination process.

11.2 ENDOSCOPY DECONTAMINATION UNIT

11.2.1 Quality Management System - Accreditation

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

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

11.2.2 Environmental Monitoring

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

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

The laboratory also tests:

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

Latest testing of all areas occurred on 14 February 2019.

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

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

11.2.3 Tracking and Traceability

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

11.3 TRUST WIDE AUDITS

11.3.1 Audit #4430 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Health Technical Memorandum) 01-01:2016 that full traceability of reusable items can be evidenced. In relation to invasive probes, used in the Outpatient or Theatre setting, this requires the completion of the Tristel

Wipe audit book and the insertion of the Tristel Wipe decontamination sticker being placed in the patient's health care record.

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

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

The 2018 audit showed that compliance with the use of the appropriate system is overall very good and has been sustained in those areas familiar with its use.

The only non-conformance related to appropriate record keeping in the patient's health care records and additional training will be arranged; that particular area will now be under increased surveillance to ensure future compliance.

11.3.2 Audit #4423 Decontamination and Single Use Instruments

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

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

The outcome of the 2018/19 audit showed excellent and sustained compliance with the appropriate storage of sterile items and the transportation of contaminated items.

The only non-conformances related to the failure to display a 'single use' poster in some storage areas. These were rectified on the day the results were reviewed.

It was agreed at the Decontamination Group meeting that the Decontamination Lead would undertake spot checks to ensure compliance is maintained.

12 ANTIMICROBIAL REPORT - Rhian Pearce, Antimicrobial Pharmacist Antimicrobials: Summary report for financial year 2018/19.

1. Overview

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

A growing body of evidence demonstrates that Antimicrobial Stewardship (AMS) can both optimise the treatment of infections and reduce adverse events. AMS now features heavily on the government's healthcare agenda, with numerous publications and directives issued to promote stewardship across all healthcare settings.

2. Summary 2018/19

It has been a challenging year for stewardship at DCHFT, without an antimicrobial pharmacist in post for 15 months. This coincided with the departure of two microbiologists and a general lack of pharmacy resource. We are, therefore, pleased to welcome Dr Lucy Cottle to the team, who has brought a renewed sense of enthusiasm and focus to stewardship at DCHFT. Under her clinical leadership, we are confident that the stewardship programme will be a success

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

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

  Effective antimicrobial oversight is the foundation of any stewardship program. Regional and national benchmarking of antimicrobial prescribing is a significant stimulus for driving improvement, but sustained progress can only be delivered through continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship team.

- We are updating our exiting guidelines to incorporate robust diagnostic criteria as well as streamlining information into an easy-to-use format. We also aim to reconfigure our webpage to make our guidelines easier to access.

- Audits have been performed on an ad-hoc basis. Limited resource has hampered a formal programme of sustained audit activity. Existing paper-based audit tools are being transferred to an electronic system to improve data capture and automate reporting. Timely reporting with feedback to clinicians is recognised as a significant driver for changing behaviour and improving prescribing.

- Our formal work plan has been updated to reflect key national recommendations relating to stewardship.

- DCHFT has achieved part of the AMR CQUIN (Commissioning for Quality and Innovation) for 2018/19. Of note, a progressive reduction in antimicrobial consumption over to the last 5 years has allowed DCHFT to meet this particular CQUIN target for the third year running. Our performance compares favourably to the regional and national benchmark.

- DCHFT did not meet the 90% CQUIN target in Q4 for the 72hr empiric review of antibiotic prescriptions. Our overall performance for this particular CQUIN is consistent with the national picture, see 3.1 for further detail).

- Continued work on increasing the range of antimicrobial guidance available.

- Participation in *Clostridium difficile* RCA meetings and identifying themes related to antimicrobial prescribing and pharmaceutical review of patients.

3. AMR and 72hr empiric review CQUIN targets for the financial year 2018/19

Antibiotic prescribing in UK hospitals has been increasing steadily, adjusted for admissions; rising by 6% between 2010 and 2014. Piperacillin-tazobactam and carbapenem prescribing have risen more sharply; by 62% and 42% respectively in 5 years. Additionally, prescribing rates across UK hospitals appear to be variable, and although some variability is expected due to differences in case mix, it does not fully explain the picture. These increases in prescribing and unexplained variability have coincided with increased antimicrobial resistance. This ongoing rise in antibiotic prescribing and resistance prompted NHS England to instate mandatory national CQUINs. 2019 is the third cycle of AMR CQUINs;

1 Reduction in antibiotic consumption as measured by Defined Daily Dose (DDD) per 1,000 admissions against the baseline (2016/17 calendar year, minus 2%) as follows:

i. Reduction by ≥2% of total antibiotic consumption
ii. Reduction by ≥2% of consumption of carbapenems

Unlike previous years, the CQUIN for 2018/19 does not include a target for reducing piperacillin/tazobactam consumption. This follows a global shortage in 2017, which resulted in a dramatic reduction in piperacillin/tazobactam use.

2 Increase the proportion of antibiotic usage within the Access group of the AWaRe* category:

- Access group ≥55% of total antibiotic consumption (as DDD/1000adm)
  OR
- Increase by 3 percentage points from baseline 2016 calendar year.

*WHO created the Access, Watch and Reserve antibiotic categories to assist antimicrobial stewardship. Antibiotics are categorised as follows:

Reserve – antibiotics that need to be reserved due to antimicrobial resistance
Watch – second-line agents
Access – antibiotics which are narrow spectrum and used as first-line treatment options.

3 To provide documented evidence of antibiotic review within 24 -72hrs of initiation in patients diagnosed with sepsis. Compared to previous years, the outcome of the review needed to comply with more stringent criteria, based on 'START SMART, THEN FOCUS' objectives. This was a scaled target, with the expectation of 90% compliance by the final quarter.

3.1 DCHFT's performance against the CQUIN target.

DCHFT has successfully reduced total and carbapenem antibiotic usage for the financial year 2018/19, comfortably achieving the CQUIN goal. This represents a total reduction of 25% for total antibiotic usage and 35% for carbapenems, compared with the 2016 baseline calendar year (Fig.1,2). A reduction in carbapenem consumption has coincided with an 81% increase in the use of carbapenem sparing agents (Fig. 3).

DCHFT'S performance compares favourably with other Trusts in the region (Fig 1), achieving the greatest reduction in antibiotic consumption overall. In 2013/14, antibiotic consumption was higher than the national and regional average (Fig 1). A progressive reduction in consumption coupled with an increase in admissions over the last 5 years has brought total antimicrobial and carbapenem consumption well below the regional and national mean (Fig 1,2). This is a noteworthy achievement, especially following the introduction of the sepsis CQUIN goals in 2017/18 -2019/20, where we might expect overprescribing of broad-spectrum antimicrobials and inappropriate continuation of these agents.

Fig 1

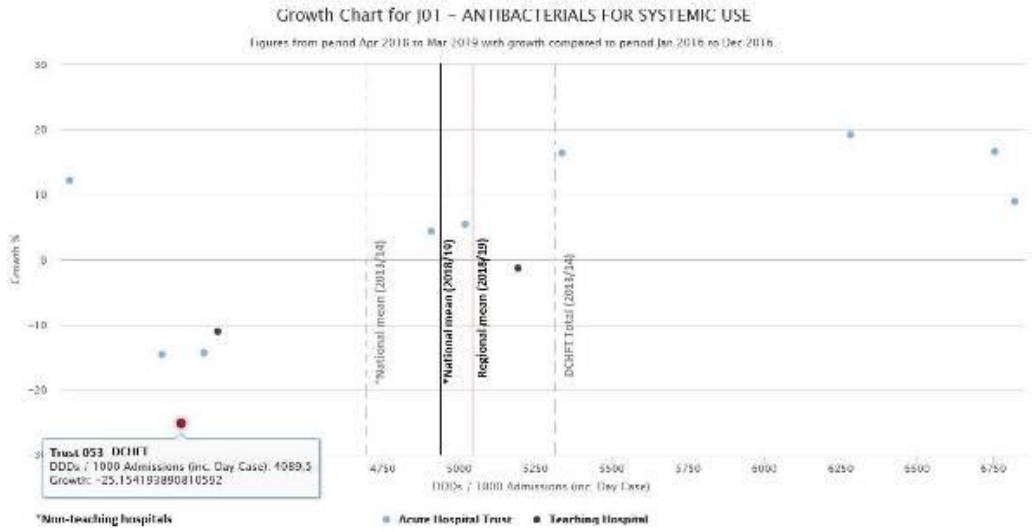


Fig 2

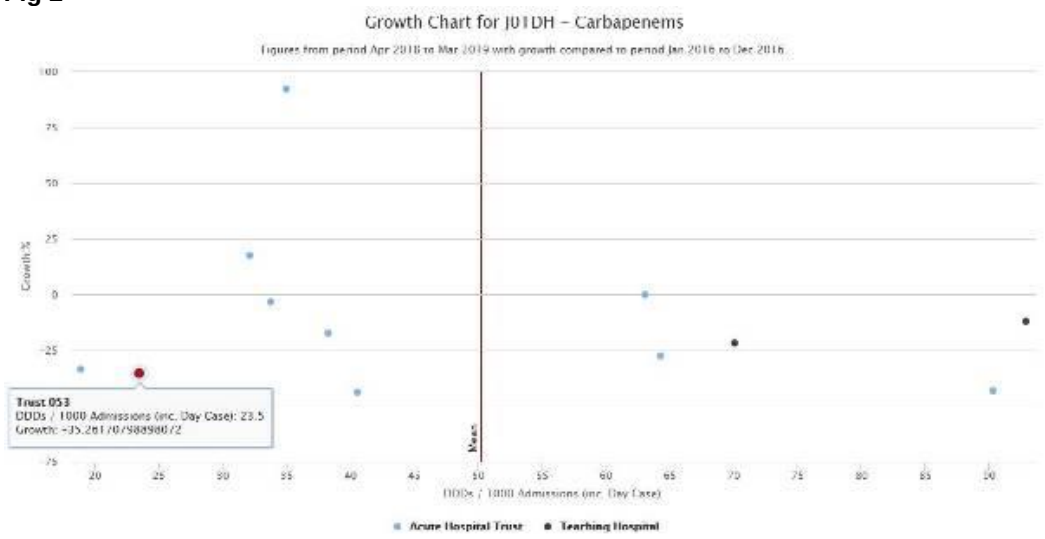
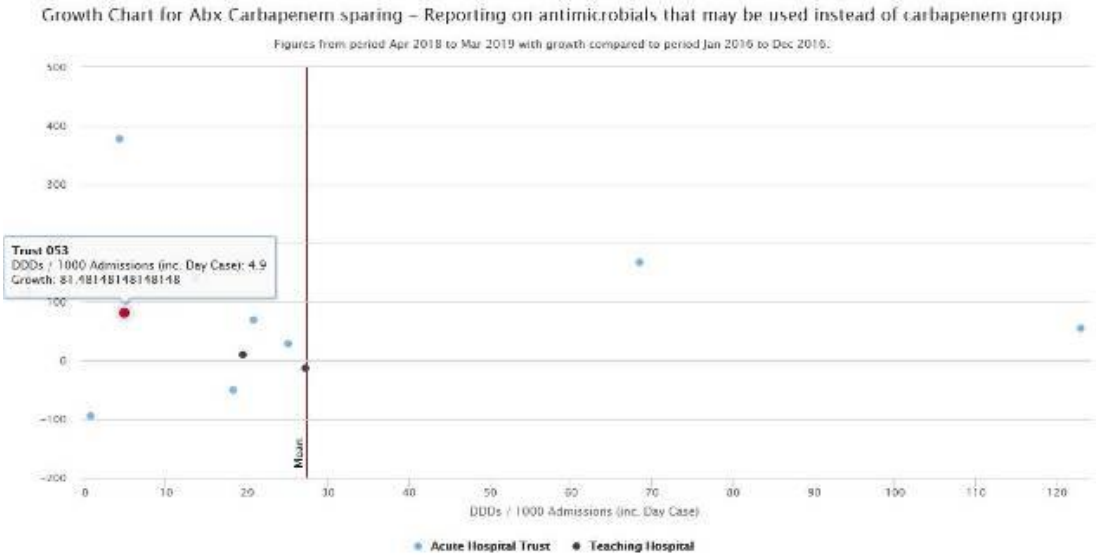
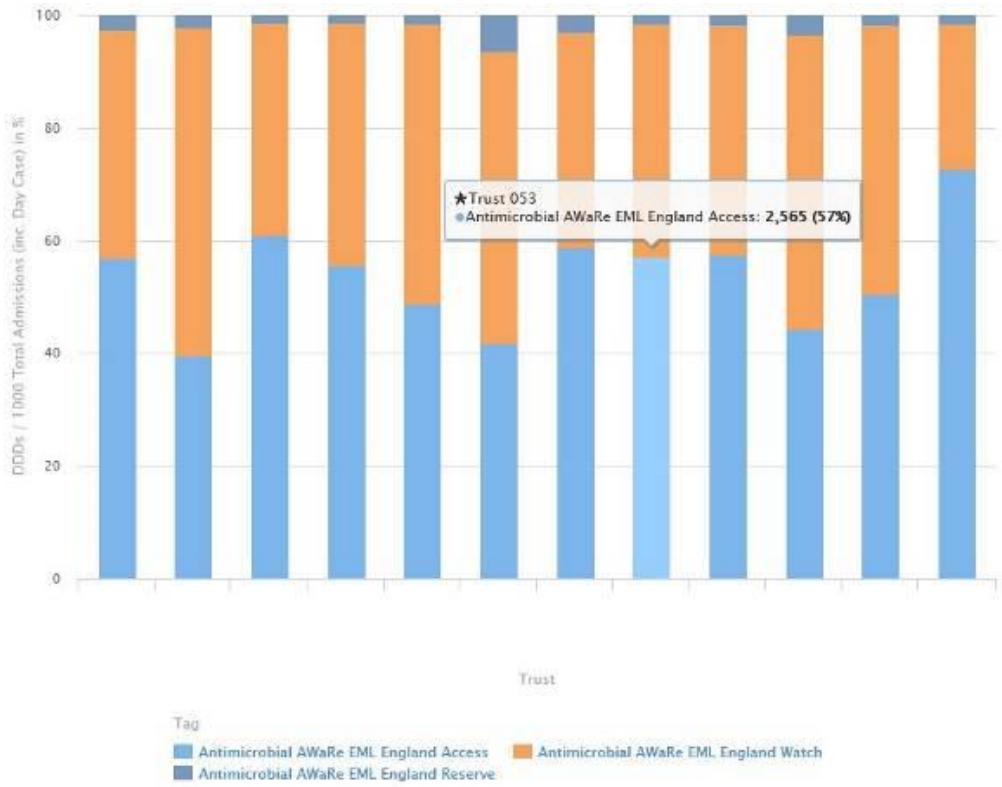

Growth Chart for JU1DH – Carbapenems
Figures from period Apr 2018 to Mar 2019 with growth compared to period Jan 2016 to Dec 2016
Growth %
Trust 053
DDDs / 1000 Admissions (inc. Day Case): 23.5
Mean
DDDs / 1000 Admissions (inc. Day Case)
Acute Hospital Trust
Teaching Hospital

Fig 3


Growth Chart for Abx Carbapenem sparing – Reporting on antimicrobials that may be used instead of carbapenem group
Figures from period Apr 2018 to Mar 2019 with growth compared to period Jan 2016 to Dec 2016.
Trust 053
DDDs / 1000 Admissions (inc. Day Case): 4.9
Growth: 81.481481481481
Mean
DDDs / 1000 Admissions (inc. Day Case)
Acute Hospital Trust
Teaching Hospital

57% of DCHFT's total antibiotic consumption for 2018/19 comprises antibiotics from the AWARE access category (Fig. 4), exceeding the CQUIN threshold of 55%. This target has been introduced to monitor the proportion of narrow-spectrum antibiotics used. This is a sensible measure, as using consumption data alone, measured by DDDs, is a poor surrogate for overall antibiotic stewardship performance. In reality, a Trust would meet the consumption targets by using a larger proportion of broad-spectrum antibiotics instead of narrow-spectrum agents. This is a known limitation of how antibiotic consumption figures are currently calculated, and using AWARE categorisation alongside consumption helps mitigate this limitation.

Fig 4 Proportion of total antibiotics by AWARE category



DCHFT failed to meet the 90% target for 72 hr review of antimicrobials in Q4, achieving 74% instead. However, a sustained improvement earlier in the year meant DCHFT met the targets for the previous quarters (Q1, Q2, Q3). The overall trend and attainment figures are broadly in line with the national picture (Fig. 5)

In a further breakdown of results, it can be seen that DCHFT performed particularly poorly for intravenous to oral antimicrobial switch (IV/PO switch) and de-escalation indicators (Fig 6), falling well below the national mean. Our existing EPMA system, lacks the functionality to support de-escalation and review of antimicrobials, e.g. the use of 'soft stop dates' that prompt a review of antimicrobials, previously possible on paper-based drug charts.

Fig 5

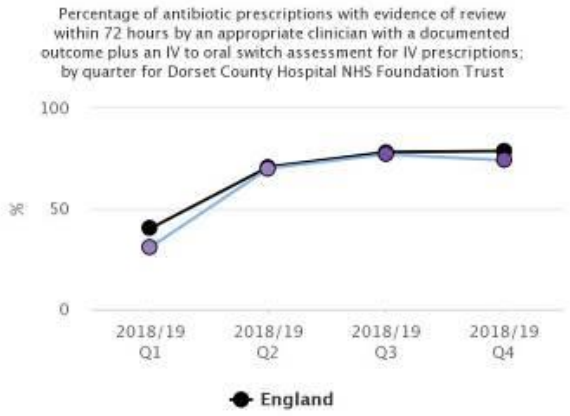
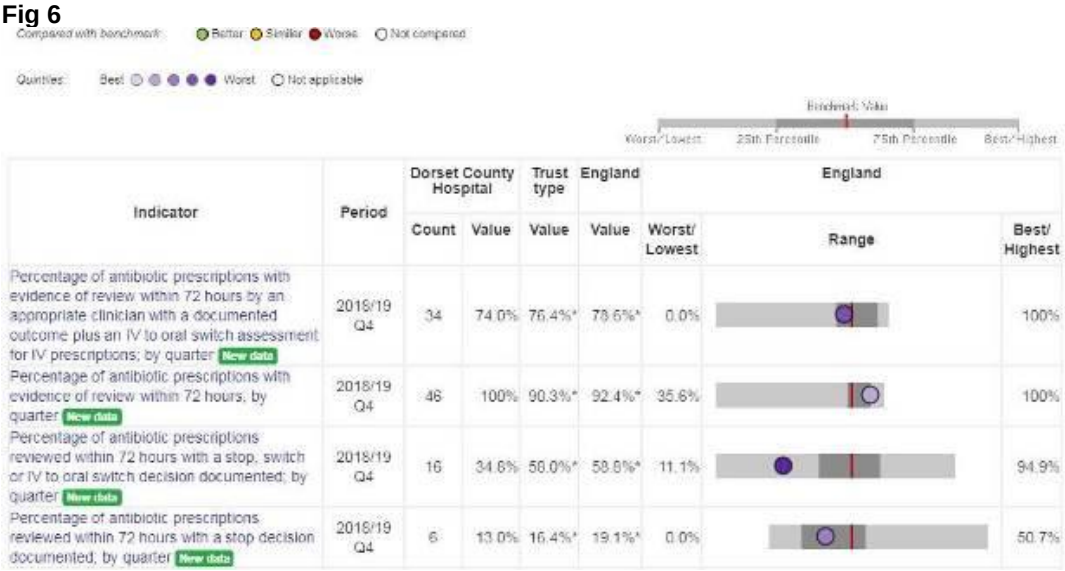


Fig 6



Indicator	Period	Dorset County Hospital		Trust type	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage of antibiotic prescriptions with evidence of review within 72 hours by an appropriate clinician with a documented outcome plus an IV to oral switch assessment for IV prescriptions; by quarter New data	2018/19 Q4	34	74.0%	76.4%*	78.6%*	0.0%		100%
Percentage of antibiotic prescriptions with evidence of review within 72 hours; by quarter New data	2018/19 Q4	46	100%	90.3%*	92.4%*	35.6%		100%
Percentage of antibiotic prescriptions reviewed within 72 hours with a stop, switch or IV to oral switch decision documented; by quarter New data	2018/19 Q4	16	34.8%	56.0%*	58.8%*	11.1%		94.9%
Percentage of antibiotic prescriptions reviewed within 72 hours with a stop decision documented; by quarter New data	2018/19 Q4	6	13.0%	16.4%*	19.1%*	0.0%		50.7%

These data are unadjusted for the confounding effects of case mix, age and sex. As such, direct comparison between DCHFT and the national or regional average is limited. In addition, the audit indicators used by the CQUIN are prone to inter-rater variability, which may in part explain the variability seen across England (Fig. 6).

Outcome data were not collected or published as part of the CQUIN, and as such there is concern over the unintended consequences of the CQUIN goals, including its potential impact on patient outcomes.

5. Summary of future work

- A thorough analysis of our performance against the CQUIN targets for 2018/19 has highlighted areas of weakness. Improving our guidelines and their accessibility is a crucial measure in remedying these deficits. The current Trust site for antibiotic guidelines is challenging to navigate. To date, we have been unable to improve this webpage and are now exploring a web-based version of Microguide to replace the existing trust site. Microguide has an excellent track record in improving antibiotic prescribing in other Trusts and has been specifically developed as a platform for antimicrobial guidelines.

- To establish an AMR CQUIN group to monitor progress against the 2019/20 AMR CQUIN and steer intervention. This group will report to the AMS committee.

- Updating and streamlining the existing audit programme to incorporate CQUIN specific indicators for 2019/20. The CQUINs for 2019/20 focus on diagnosis and treatment of lower UTI in patients over 65, antibiotic prophylaxis in colorectal surgery and antifungal stewardship. Antimicrobial consumption trends will be monitored centrally and do not form part of the CQUIN for 2019/20.

  Next year's CQUIN has a demanding data collection element. NHS England has stipulated that stewardship teams should not collect data; instead, their time is better spent steering intervention and focussing on quality improvement measures. We would echo this recommendation and urge the Trust to recognise that the current data collection demands cannot be absorbed by the stewardship team, without displacing other core stewardship activities. This is likely to have a detrimental, and potentially irrevocable, impact on future stewardship outcomes.

- To develop a systematic approach for reviewing local susceptibility patterns as part of the antibiotic guideline development process.

- To delineate channels within the organisation to disseminate audit results and garner support for AMS. As an example, we intend to regularly present audit findings at divisional meetings.

- To better integrate the laboratory and stewardship programme to ensure rapid provision of test results and that clinicians understand their implications.

- We plan to introduce a comprehensive package of antimicrobial prescribing and stewardship training for doctors, nurse prescribers and pharmacists. This will be delivered via e-learning.

- We intend to introduce a new set of metrics for monitoring stewardship activity; focusing on process and outcome measures to better illustrate the value and sustainability of our programmes. We also hope that this will provide us with evidence for future investment and better resource allocation.

- As pharmacist recruitment and retention improves, we are keen to implement a framework for pharmacy-led interventions to optimise antimicrobial therapy, including dose optimisation and systematic conversion of intravenous to oral antimicrobial therapy.

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

CONCLUSION

2018-2019 has been a very successful year with significant reductions in healthcare acquired infections reported i.e. Clostridium difficile and MSSA blood stream infections. Trajectories for both MRSA and Clostridium difficile were achieved demonstrating excellent practice and engagement with infection prevention and control by Trust staff.

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

The annual work plan for 2019-2020 reflects a continuation of support and promotion of infection prevention & control. Looking forward to the year ahead the staff at DCHFT will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

2019-2020 will be an exciting year as the Trust develops its role within the Infection Prevention and Control Integrated Care System (IPC ICS) working closely with the other Dorset Health Trusts to share and provide quality infection control Dorset wide.

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

Emma Hoyle

Associate Director Infection Prevention & Control

Appendix 1

Infection Prevention & Control Work Plan 2019-2020

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Associate Director Infection Prevention & Control	Bi-Monthly	
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet	Contract renewal	Associate Director Infection Prevention & Control	Nov 2019	
		The Trust will maintain a high standard of Infection Prevention & Control	Divisional Matrons to develop HCAI improvement plans for 2019-2020 Divisional Heads of Nursing work with Clinical staff to review IPC programme relevant to Division	Heads of Nursing to report progress against divisional IPC plan at IPG on rotational basis	Divisional Matrons Heads of Nursing / Quality	Sept 2019	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings IPC performance standard dashboard to be met Learning from performance data to be disseminated	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Heads of Nursing / Quality	March 2020	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	DCHFT will maintain a clean and safe environment for patient care	Dorset County Hospital to support PLACE assessment	The environment is safe and clean	Infection Prevention & Control Team	Sept 2019	
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	Facilities Manager	
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	IPC Team Facilities Manager Estates Manager Patient representatives Pharmacy	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		All clinical equipment is clean and ready for use at point of care	Use of Clean/Dirty indication stickers implemented Trust wide 2018/19	All clinical equipment will be identified as clean or requiring cleaning	IPCT to implement audit process Divisional Heads of Nursing / Matrons to monitor	August 2019	
		DCHFT will maintain a clean and safe water system	Policy to be updated and communicated and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy	Head of Estates	March 2020	
3	Provide suitable accurate information on infections to service users and their visitors	Patients will be fully informed about their presenting infections. All new cases of *CDifficile,* MRSA and ESBL will be counselled by an IPCN	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and contact details	Positive patient feedback	IPCT	March 2020	
		The Trust will have up to date patient information relating to infection control	Review of all IPC patient information. Check meets standards and revise accordingly	Positive patient feedback	IPCT	March 2020	
4	Provide suitable accurate information on infections to any person concerned with providing	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher & Emergency Department, providing clinical support	Minimum cross infection, reduced prolonged outbreaks of infection, reduced	IPCT	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	further information support nursing/ medical care in a timely information	patients and staff	to staff and patients	HCAIs			
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people	Achieve trajectory for *Clostridium difficile* infection (CDI) of ≤ 16 cases (does not include cases whereby no lapses of care were identified	Undertake Root Cause analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset- Healthcare Acquired and Community Onset Healthcare Acquired	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Divisional Head of Nursing / Matrons	March 2020	
		Reduce rates of Gram-negative blood stream infections (BSI) by 50 % by 2023	Undertake IPC led Root Cause analysis of all hospital acquired cases of gram negative BSI – escalate to full RCA if lapses in care	All cases of Gram negative BSI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Associate Director Infection Prevention & Control	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		Ensure the Trust is robustly prepared for Winter	Review Influenza Policy Summer 2019 Ensure staff are familiarised with the Outbreak/Noro policy	The Trust will be able to function effectively during the Winter months and Infection Control standards are maintained	Associate Director Infection Prevention & Control	November 2018	
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	High standards of hand hygiene practice throughout the Trust.	Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve<90% to present action plan to IPG.	Hand hygiene results >95% and sustained at this level for all wards/departments Departmental Managers to report to IPG with action plan when hand hygiene results <90%.	Divisional Head of Nursing / Matrons	Monthly	
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT	Bi-Monthly	
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2019	
		Education	Support DCHFT mandatory training programme Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2020	
7	Provide or secure adequate isolation	Ensure the risk of cross infection is reduced	Undertake annual audit of isolation precautions	Audit identifies appropriate	IPCT	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	facilities	Trust wide	to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation.	precautions to effectively manage patients with infections.			
8	Secure adequate access to laboratory support as appropriate	IPCT to support and be involved in the county wide pathology project ensuring delivery of safe patient care is not affected	IPCT to be involved in county wide meetings where appropriate and provide expert support for the project	Safe transition of service	Associate Director Infection Prevention & Control	March 2020	
			IPCT at DCHFT to take nursing lead on development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project to be implemented once funding released	One ICNet system across Dorset	Associate Director Infection Prevention & Control	Nov 2019	
9	Have and adhere to policies, designed	Audit programme- to audit compliance with	PVC audits undertaken to ensure compliance	PVC observations will be observed every shift and	IPCT	Quarterly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	for the individual's care and provider organisations that will help to prevent and control infections	Key IPC policies	with observation standard	recorded on Vital Pac			
			Urinary catheter documentation audits undertaken to ensure compliance with observation standard	Urinary catheters will be reviewed on a daily basis and care documented on Vitalpac	IPCT	Monthly	
			Audit compliance with CPE screening recommendations.	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust.	IPCT	Biannually	
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads	March 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			to be developed and implemented Results to be presented at Divisional Governance Meetings and IPC				
			Participation in the national GIRFT Audit 2019 for Surgery	Completion of 6 month audit. Audit identifies low infection rates post operatively.	Associate Director Infection Prevention & Control/Medical Director	October 2019	
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	Audit identifies compliance with safe management of storage and disposal of sharps	IPCT	June 2019 (IPCT) July 2019 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask train the trainer sessions planned July 2019	All clinical staff will have access to FFP3 training and able to care for patients using airborne precautions	Divisional Matrons	July 2019	
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for	Ensure all 'IPC Emergency Boxes' are maintained and in date	All clinical staff are aware and able to support the emergency	Associate Director Infection Prevention & Control / Lead		

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		'high risk' infectious patients	Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	preparedness of the trust for IPC issues	Emergency Planner		

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

Emma Hoyle – Associate Director Infection Prevention & Control May 2019

Title of Meeting	**Board of Directors**
Date of Meeting	**31 July 2019**
Report Title	**Trust Clinical Audit Plan**
Author	**Julie Doherty, Deputy Medical Director and Chair of the CEIG**
Executive	**Alastair Hutchison, Medical Director**

Purpose of Report

For assurance.

Summary

The Trust Clinical Audit Plan (TCAP) is cross referenced to the BAF and corporate risk register. The plan includes national and local audits aimed at addressing key standards & risks highlighted in the Patient Safety, Experience and Quality reports e.g. dementia screening targets; stroke service standards; falls and fracture neck of femur standards; histopathology turnaround times and infection control measures. There are also links with our CQC action plan, including ED environment (action 18, SD15 ref); mental health care (action 16, MD3) and End of Life Care.

In addition the TCAP supports with the following Quality Account Priorities for 2019-2020:

Patient Safety:

- Introducing three High Impact Interventions to Reduce Hospital Falls
- Improved Mortality Surveillance and Learning from Deaths
- Improving early identification and treatment of Delirium

Clinical Effectiveness:

- Improving timely access to Mental Health services when needed (joint goal with Dorset HealthCare University Health Care Trust)
- Reducing unwarranted variation (Implementing best practice linked to clinical audits)

Patient Experience:

- Improving the identification of Nutritional needs and support offered to patients

Additional resources have meant that the trust is able to participate in the National Audit of Rheumatoid and Early Inflammatory Arthritis 2019-20 and contribute to the National Ophthalmology Audit.

The TCAP identifies priority audits, each department will in addition be engaging in local audits not listed on the TCAP. Audits should be agreed within the clinical department and at divisional level with further approval from the Clinical Audit Department. The processes for national and local audits are summarised in the Trust Clinical effectiveness and Audit Strategy 2017-20.

The TCAP is monitored via the Clinical Audit Department, with progress recorded on their central spreadsheet and RAG rating updated accordingly.

Local audits are monitored at departmental level with exception reporting upwards through care groups to division as appropriate. The Clinical Audit department also provide a check against progress and request feedback from the named audit lead.

Learning from audit is shared by a variety of means including:

- At Departmental clinical governance meetings with escalation reports into Care Group then Divisional clinical governance meetings. Escalation reporting from divisions to the CEIG. Feedback then back to teams via divisional representatives at CEIG.
- The Clinical Audit Department reports to CEIG
- Departmental and Divisional newsletters
- Clinical Audit department progress reports on the national audit programme
- Trust Strategic Clinical Audit Lead annual report and update reports to clinical teams
- Cross –divisional learning via trust committees and groups e.g. Sepsis Committee; Hospital Mortality Group
- Regionally and nationally via networks e.g. PanDorset Mortality Reviews for Learning from Deaths; Neonatal network (MBRRACE); Major Trauma Review Committee (TARN)

TCAP Previously Reviewed By:

CEIG

Quality Committee and Risk and Audit Committee 21 May 2019

Strategic Impact

The quality of the reporting provided to committee and board level links directly with strategic objective one and our ambition to provide assurance of outstanding care. The robustness of the organisational governance impacts upon the Trust reputation and strategic objectives.

Risk Evaluation: Failure to participate in audits could be detrimental to the reputation of the Trust and impact on quality improvement.

Impact on Care Quality Commission Registration and/or Clinical Quality

Robust governance processes will strengthen the Trust's assurance to the CQC and assure that the Trust can achieve an 'outstanding' status for the Well-Led Domain.

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

The Trust governance arrangements are set out to monitor all services within its remit and to provide assurance of the robust processes around risks and actions identified to mitigate these.

Financial Implications

Undetermined, but could incur penalty if unable to address areas in need of improvement.

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

Trustwide Clinical Audit Plan (TCAP) 2019-20 Progress Chart

		Audit Details						
BAF ref: Last updated May 18	Corporate Risk Reg Ref: last updated May 18	Rag Rating*	Audit No	NR/RR/QI	NCAPOP	Structure and Care Group	Specialty	Audit Title
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4441	NR	y	Division A Care Group 1	Cardiology	Acute Coronary Syndrome (Acute Myocardial Ischaemia) (MINAP)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4442	NR	y			Cardiac Rhythm Management (CRM)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4444	NR	y			National Heart Failure Audit (NICOR)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4445	NR	y			Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	N/a		4446	NR			Endocrinology & Diabetes	National Diabetes Footcare Audit (NDFA)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4447	NR	y			National Diabetes Inpatient Audit (NaDIA) inc. NaDIA Harms
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	N/a		4449	NR				National Diabetes Audit (NDA)
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4392	NR				National Pregnancy in Diabetes Audit (NPID)
				NR			Acute Medicine	Society for Acute Medicine's Benchmarking Audit (SAMBA)
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4452	NR			Renal	Renal Replacement Registry (Dorset Haemodialysis Audit)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Vascular	National Vascular Registry (RCS)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	N/a		4536	RR		Division A Care Group 2	Dietetics	MUST audit
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2				NR			Older People	National Audit of Inpatient Falls - part of Falls and Fragility Fractures Audit program (FFFAP)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2				NR				Parkinson's Audit
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049 Failure to manage the deteriorating patient 1015		4374	NR	y		End of Life Care	National Audit of Care at the End of Life (NACEL)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	To be added to Risk Register June 2018 - no improvement and poor medical engagement		4343	NR	y			National Audit of Dementia (2017-19)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Respiratory	National Asthma & COPD Audit Programme(Adult Asthma, COPD, C&YP Asthma, PR)
BAF Objective 1 OUTSTANDING r1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4409	NR	y			National Lung Cancer Audit (NLCA)
BAF Objective 1 OUTSTANDING R1, R2, R3				NR				National Smoking Cessation Audit (BTS)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4407	NR	y		Stroke	Sentinel Stroke National Audit programme (SSNAP) (RCP)

BAF ref: Last updated May 18	Corporate Risk Reg Ref: last updated May 18	Rag Rating*	Audit No	NR/RR/QI	NCAPOP	Structure and Care Group	Specialty	Audit Title
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049 Emergency Department Target, Delays to care and Patient flow 1009			NR	Y	Division A Care Group 3	ED	Assessing Cogitive Impairment in Older People/Care in Emergency Depts RCEM
BAF Objective 1 OUTSTANDING r1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049 Emergency Department Target, Delays to care and Patient flow 1009			NR	y			Care of Children in Emergency Dept RCEM
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049 Emergency Department Target, Delays to care and Patient flow 1009			NR	y			Mental Health Care in Emergency Depts RCEM
BAF Objective 1 OUTSTANDING R1, R2, R3				NR				NASH3 National Audit of Seizure Management in Hospitals
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4453	NR	y		Trauma	Major Trauma Audit (TARN)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y	Division A Care Group 4	Blood Sciences	Serious Hazards of Transfusion (SHOT)
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a			C			Histopathology	Local audit programme held by dept
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a			C			Microbiology	Compliance Audits 2018-19
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Infection Control	PHE Surgical Site Surveillance Audits
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y			Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a			QI			Pharmacy	NPSA Audits
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4454	QI				Controlled Drugs Audit
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4455	QI				Safe and Secure Storage of Medicines
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4392	QI				Phamacy Intervention Audit
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		(local audits TBR)	QI				Obervation of administration of medicines Audit.
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y	Division B Care Group 1	Breast	National Audit of Breast Cancer in Older Patients (NABCOP)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Colorectal	Bowel Cancer (NBOCAP)
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a			C			Endoscopy	JAG Compliance Bundle
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Gastroenterology	Inflammatory Bowel Disease (IBD) Registry Biologics Programme
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y			National Gastrointestinal Cancer Programme (Operates a continuous data collection model. From 2018 this project brings together the previously separate NBOCA and NOGA audits)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2				NR			Orthopaedics	PROMS Elective Surgery
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4645	NR	y			National Joint Registry (NJR)

BAF ref: Last updated May 18	Corporate Risk Reg Ref: last updated May 18	Rag Rating*	Audit No	NR/RR/QI	NCAPOP	Structure and Care Group	Specialty	Audit Title
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4648	NR	y			National Hip Fracture Database (NOF) 2018-19 (part of Falls&FragilityFractures Audit Program FFFAP)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Urology	BAUS: Nephrectomy; Percutaneous nephrolithotomy & Radical prostatectomy/ Cystectomy / Femaile Stress Unrinary Incontinence 2017-2021
BAF Objective 1 OUTSTANDING R1, R2, R3				NR		Division B Care Group 2	ENT	Endocrine and Thyroid National Audit (BAETS)
BAF Objective 1 OUTSTANDING R1, R2, R3							Maxillofacial	Head and Neck Cancer - Poole
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049 Opthalmology Service Capacity 1045		4542	NR	y		Ophthalmology	National Ophthalmology Audit
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a			RR			Orthodontics	Annual Peer Assessment outcome (PAR) audit
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2				C				IR(ME)R Audit
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y		Rheumatology	National Audit of Rheumatoid and Early Inflammatory Arthritis
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4635	NR				Fracture Liaison Service Database (FLS-DB) part of FFFaP
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4623	NR	y	Division B Care Group 3	Anaesthetics	National Emergency Laparotomy Audit (NELA) 2018-2019
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4425	NR	y		Critical Care ITU/HDU	Case Mix Programme (CMP) ICNARC
				NR/ QI				Perioperative Quality Improvement Program (PQIP)
BAF Objective 1 OUTSTANDING R1, R2, R3	N/a		4405	RR			Operating Departments / Theatres	WHO Checklist
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4				QI		Division B Care Group 4	GUM	2019 BASHH national audit: syphilis
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4				QI				2019 BHIVA national audit: psychological support
BAF Objective 1 OUTSTANDING BAF Objective 3 COLLABORATIVE Risk R2, R3, R4				QI				2019 BASHH regional audit: management of gonorrhoea
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4				QI				2019 BASHH regional audit: management of HIV and hepatitis co-infection
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4				QI				2019 Sexual Health Dorset audit: chlamydia partner notification (with RBH and DHUFT)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4	Financial Sustainability 1049		3905	NR	y		Maternity	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4420	NR	y			National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)

BAF ref: Last updated May 18	Corporate Risk Reg Ref: last updated May 18	Rag Rating*	Audit No	NR/RR/QI	NCAPOP	Structure and Care Group	Specialty	Audit Title
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4	Financial Sustainability 1049		4061	NR	y			National Maternity and Perinatal Audit (NMPA)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4432	NR	y		Paediatrics	UK Cystic Fibrosis Registry
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4450	NR	y			Diabetes (Paediatric) (NPDA)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y			Child Health Clinical Outcome Review Programme NCEPOD
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4176	NR	y			National Audit of Seizures and Epilepsies in Children and Young People (RCPCH)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y	Trustwide		Medical and Surgical Clinical Outcome Review Programme NCEPOD
BAF Objective 1 OUTSTANDING BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4443	NR	y			National Cardiac Arrest Audit
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE Risk R2, R3, R4	Financial Sustainability 1049			RR	y			Safeguarding Adults
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective 3 COLLABORATIVE R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y			Learning Disability Mortality Review Programme (LeDeR)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049		4375	NR	y			Reducing the impact of serious infections (Antimicrobial Resistance & Sepsis)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y			National Mortality Care Record Review Programme (NMCRRP)
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2	Financial Sustainability 1049			NR	y			Seven Day Hospital Services
BAF Objective 1 OUTSTANDING R1, R2, R3 BAF Objective SUSTAINABLE 5 Risk R2				RR				Learning from Incidents
BAF Objective 1 OUTSTANDING R1, R2, R3				RR				Coding Audits

Rag Rating	Key
green	Completed. Report and Action Plan received
amber	Progress as planned
red	Progress not made as planned.
shaded	Not running during current year.

NR	National Requirement - Quality Account Audit
RR	Risk Register
QI	Quality Improvement
C	Compliance/accreditation

Title of Meeting	Board of Directors
Date of Meeting	31 July 2019
Report Title	Medical Revalidation Progress Report (Annual) and Statement of Compliance
Author	Julie Doherty, Responsible Officer
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.
This is the annual report covering the period of 31 March 2018 to 1 April 2019.

The Board is requested to:

i) Consider and accept the report (noting it will be shared with the higher level responsible officer in NHS England South)

ii) To consider any needs/resources associated with the action plan

iii) To approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is in compliance with the regulations. The Statement of Compliance is to be signed by the CEO or Chairman on behalf of the Board. Deadline for submission of the Statement of Compliance to NHS England and NHS Improvement is 27 September 2019

The Revalidation Lead for NHS England (Dr Mike Prentice) in his letter to RO's on 18 July states:
'Board-level accountability for the quality and effectiveness of appraisal rates is extremely important and this report, along with the resulting action plan, should be presented to your board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account'.

Summary

Systems continue to remain in 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

Responsible Officer Annual Board Report

For the period 1 April 2018 – 31 March 2019

Date of Report: 15/07/19

Authors: Dr Julie Doherty (RO)

Carol Mogford (HR)

Executive summary

At 31 March 2019 DCHFT had 264 doctors with a prescribed connection.

Overall appraisal rate was 74.6% which is a reduction of 13.5% on our rate for 2017-18. From the AOA comparator, similar sector Designated Bodies overall appraisal rate was 89.3%. Consultant appraisal rate was 86.7% (92.2% 2017-18); SASG 70.8%% (80.4% 2017-18) and temporary / short term contract holders 53.4% (83.3% 2017-18).

For 2018-19 temporary & short term contract holders accounted for 27.7% of doctors with a prescribed connection to DCHFT, compared to 20.4% last year. Appraisal rates were a topic of discussion with NHS England at our follow up visit on 9 July with suggestions as to how we might improve.

27 doctors revalidated during the reporting year. 2 doctors had their revalidation deferred for 6 months (a neutral process). Both deferrals were due to insufficient supporting information. One of these doctors has subsequently revalidated. All revalidation recommendations were made on time.

Our main issues relating to appraisal & revalidation remain the same as for 2017-18 and include appraisal rates less than our target; the retention and recruitment of sufficient appraisers; governance of & support to locums and 'As & When' contract holders (balancing service provision, quality of care and gathering supporting information for revalidation) and peer support / CPD for case investigation & management when responding to concerns about a doctor's practice.

NHS England & NHS Improvement South West conducted a Higher Level Responsible Officer (HLRO) Quality Review on 9 July 2019 to support us in further improving our appraisal and revalidation processes. Our last review was carried out in 2014. This was a follow up visit to look at progress with our action plan.

In June 2019 NHS England and NHS Improvement provided a revised template for the Annual Board Report. Whilst still setting out the key requirements for compliance with RO regulations, it provides a format to demonstrate not only basic compliance but continued improvement over time. The revised version contains items to help designated bodies assess their effectiveness in supporting medical governance in

keeping with the General Medical Council (GMC) handbook on medical governance. This publication describes a four- point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC).

For this year's annual board report we have used this template with the aim of:

a) supporting us in our pursuit of quality improvement,
b) providing the necessary assurance to the higher-level responsible officer, and
c) collating evidence for future CQC inspections.

https://www.gmc-uk.org/registration-and-licensing/employers-medical-schools-and-colleges/effective-clinical-governance-for-the-medical-profession

https://www.england.nhs.uk/publication/fqa-for-responsible-officers-and-revalidation-annex-d-annual-board-report-and-statement-of-compliance/

https://www.england.nhs.uk/medical-revalidation/

DCHFT Annual Board Report

Section 1 – General:

The board of Dorset County Hospital NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

   Date of AOA submission: 29/05/19 (deadline 07/06/19)

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Dr Julie Doherty is the RO for DCHFT

   Comments: DCHFT has a split Medical Director / RO role. This is managed by good communication and regular 1:1 meetings between the Medical Director (MD)and RO.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

Comments: We are however short of 6 medical appraisers. It is requested that Divisions look again within their Care Groups to identify appropriate and interested consultants and especially SASG doctors to take on the role of medical appraiser. Orthopaedics, general medicine and possibly paediatrics are areas under-represented for appraisers. Departments would need to find 0.2PA per appraiser within the job plan from their budgets.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes

Comments: The Medical Appraisal Policy is currently under review to strengthen arrangements regarding short term locum and As & When contract holders. It is proposed that we only offer appraisals to doctors providing > 3months service and whose appraisal anniversary falls within their time of employ at DCHFT. This will free up capacity for our existing appraisers and reduce the impact that our shortage of appraisers is having on appraisal rates and stress for longer term / permanent employees. The proposal was deemed appropriate by NHS England & NHS Improvement (NHSE & NHSI) South West at their visit on 9 July 2019.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Yes, we had an external visit from the HLRO NHSE& NHSI South West on 9 July 2019. We are awaiting the formal written feedback from that review.

Action for next year: See Action Plan at appendix E

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Comments: We currently offer appraisal to locum / short-term placement doctors working at DCHFT. We have accepted prescribed connections for such doctors providing < 3 months service to DCHFT. This however has not consistently resulted in those doctors holding an appraisal as scheduled nor their completing their colleague / patient 360 feedback despite our providing such (at a cost to the Trust). The policy for short term locums and As & When doctors is therefore under review. We do consistently support these doctors in their CPD and progress towards their revalidation. Information regarding risk events / complaints is provided to the doctor to support reflection, professional development, revalidation and governance.

Action for next year (including carry over from last year's action plan):

To strengthen governance and QA processes for locum's / Short – term contract (>3months) holders via

1. Introduce requirement for contract holder to meet with clinical lead and engage in local educational & clinical governance programme – via a 'contract of expectations. This will support the doctor in gaining evidence for appraisal and revalidation whilst also supporting systems for patient care & safety. (GMC handbook Principle 1b)
2. Review of contract with HR to introduce a minimum period of work per 6-12 month contract to support revalidation
3. Introduce locum exit forms to provide the doctor with feedback on their performance. NHSE & NHSI have example templates available and will share

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Actions from last year:
Recruit more appraisers to continually improve appraisal target rates (aim 92% for AOA to be in higher performing band).

Comments:
Appraisal takes account of all relevant information relating to the doctors scope of practice and fitness to practice. Scope of practice forms are in place to support appropriate information sharing across organisations where a doctor works. MPIT forms are used for RO to RO transfers of information.

Disappointingly our appraisal rates for 2018-19 are significantly lower than for 2017-18 at 74.6%.
The greatest reduction is seen in the appraisal rates for temporary or short term contract holders. We have proposals in place to limit our acceptance / continuation of a prescribed connection for As & When contract holders who are performing no or very limited duties and plan liaison with managers and HR to better understand the issues faced by both parties. We also have plans to liaise further with HR colleagues regarding contracts for locums / short term contract holders of 3 months or less.
Following discussion at our HLRO Quality Review meeting we also plan to meet with HR to discuss how to more effectively enforce the Trust's requirement for employees to have an annual appraisal meeting (including that which is scheduled in a timely manner)

Action for next year:

1. Meeting to be scheduled between RO / MD and Director of HR / Deputy Director HR to discuss contract for doctors at DCHFT (relating to appraisal requirements)
2. RO to use non-engagement (REV6) notification as per medical appraisal policy 2018 for those doctors who do not hold an annual appraisal meeting in the time specified within the policy

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments:

We request postponement forms from doctors where it is known that an annual appraisal is likely to be delayed e.g due to leave. The Revalidation team conduct an audit of missed appraisals (attached at Appendix A).

For new starters we aim that they keep their appraisal anniversary. Where the appraisal anniversary is not available the current process is that the doctor will be offered an appraisal 6-12 months from their start date.

10% of missed appraisals were due to 'lack of time'. This is no longer to be considered an appropriate reason for a missed appraisal anniversary. We need to change the culture form 'I'm too busy to have an appraisal' to ' I am so busy I really need an appraisal (and performance review)' This will require a change in mind-set for doctors who naturally strive to put patients and clinical work first. Support will be needed from line managers and clinical leads to change culture and support clinicians in scheduling appraisals (reorganising clinical work where necessary). Ideally the appraisal should be scheduled well in advance (particularly where the appraiser is already allocated). This was feedback from our HLROQR and is reinforced at RO and appraisal leads network meetings.

Action for next year:

1. Remove 'lack of time' from postponement form as no longer to be considered a valid reason for postponement. Reinforce the message at Appraiser meetings; consultant forum, with SASG lead and at departmental governance meetings
2. Revalidation team to consider whether there are any adjustments we can make to reporting & / or scheduling of appraisal for' new starters more than 3 months from appraisal due date' as these comprise 48% of our reasons cited for a missed appraisal.
3. Liaison with Clinical Directors to discuss & review how Care Groups and departments monitor medical appraisal rates. Consider introduction of published RAG table to identify doctors nearing their appraisal anniversary and aid scheduling of their appraisal.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Comments:

The Medical and Dental Staff Appraisal and Revalidation Policy EM06 was ratified at the LNC on 4 September 2018 and issued via the Trust intranet in November 2018.

Action for next year:

1. Policy revision to include further information regarding locum and short term contract holders

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Actions from last year:
Recruit more appraisers to continually improve appraisal target rates (aim 92% for AOA to be in higher performing band).
Aim for appraiser : appraisee ratio nearer 1:6

Comments:
We continue to struggle to identify sufficient appraisers to meet the demands of appraisal. With this in mind we allocate educational supervisors to doctors who are occupying an unfilled training post. However we still have a shortage of 6 appraisers for our doctors. A number of our experienced appraisers regularly appraise more doctors than the standard 6 allocated per remuneration in their job plans (though not usually > 12). We are reviewing our medical appraisal policy to ensure that our permanent and longer term contract holders receive priority (see above).

Action for next year:

1. Complete the updates to the Medical Appraisal Policy and take to LNC for agreement and ratification.
2. Liaison with Divisional & Clinical Directors to encourage more doctors to take on medical appraiser roles

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Comments:

Medical appraisers are invited to attend the quarterly appraisers meetings for peer support. At these meetings we discuss updates from the Responsible Officer and Appraiser Network (ROAN) and from GMC ELA meetings. We discuss issues relating to appraisal and revalidation and explore how to continuously improve our systems. Attendance at these meetings is ~30% of appraisers each meeting.

We have previously scheduled meetings on different days of the week to try to improve attendance rates though this did not boost rates significantly. The information is therefore also sent out in a quarterly newsletter from the RO and is available on the Medical Appraisal and Revalidation webpage (managed by the revalidation administration officer).

Performance as an appraiser is discussed at appraisal as part of their scope of practice. QA of outputs from appraisal is via ASPAT on PReP. Feedback from ASPAT is now available to the appraiser within their PReP portfolio (following liaison with PReP IT support team). The RO aims to complete~2 ASPAT per appraiser per annum. An annual feedback meeting with the RO is offered to appraisers (with variable take up). Appraisees also provide feedback to appraisers via PReP.

Initial external training (Miad) is provided for appraisers with 3 yearly refresher. The appraisal lead and RO are available to meet with appraisers to discuss performance and / or training issues and support appraisers in QI.

The appraisal lead has this year started to QA inputs to appraisal.

Action for next year:

1. Publish attendance register for quarterly appraisers meetings to appraisers for inclusion in their supporting evidence

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments:

Inputs and outputs from Appraisal are quality assured as noted above.

The Board receive a bi-annual report on medical appraisal and revalidation.

We hold a monthly medical appraisal meeting. Membership for this group is the RO, Medical Director, Appraisal Lead, Medical HR advisor and Revalidation Administrator.

The RO has had discussions with neighbouring ROs and colleagues at ROAN (network meetings) to consider the pros and cons of a RO Advisory / Revalidation Governance group to support and improve governance systems for medical appraisal. A meeting is being organised to discuss this further with the Chairman of the Trust Board and remains an item on the action plan..

Action for next year:

1. Discuss with Chairman the proposal to introduce a RO Advisory / Revalidation Governance group and include a NED within the membership to better support QA of medical appraisal and revalidation. This would support DCHFT in QI and in achieving improved compliance with the GMC handbook on Effective Clinical Governance for the Medical Profession

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

Comments:

27 doctors have revalidated this year, with 2 deferrals due to insufficient supporting information. There have been no late submissions

Action for next year:

1. At the medical appraisal & revalidation team monthly meetings we have discussed the GMC's handbook on Effective Clinical Governance for the Medical profession with a view to using 'The GMC's organisational dashboard for revalidation and fitness to practice' to support benchmarking and continuous improvement.

https://www.gmc-uk.org/registration-and-licensing/employers-medical-schools-and-colleges/effective-clinical-governance-for-the-medical-profession

See p13 for link to dashboard. This allows RO to cross reference revalidation submissions and determine whether the RO is performing similarly to comparable designated bodies (DBs). Our rates of revalidations, deferrals, non-engagement notifications are in line with similar DBs.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Comments:

Doctors are informed of RO recommendations via email.

Recommendations to revalidate are confirmed via email to the Doctor at the time of submission via GMC Connect.

Recommendations to defer are discussed with the doctor either face to face or via email well before that recommendation is submitted.

Deferrals may be a joint agreement between Dr and RO depending on the reason for deferral. Reasons for deferral and actions the doctor needs to complete to enable a recommendation to revalidate to be made are set out clearly and provided in writing (usually via email). No recommendations of non-engagement have been submitted this year.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

Strengthen the governance & QA processes for appraisal & Revalidation recommendations via the introduction of an RO Advisory/ Governance Group (or equivalent) at DCHFT.TOR for such groups available via Regional network

Comments:

Discussions have been held at varying times over the past year regarding the introduction of such a governance and QA group though we have not to date agreed the inclusion of a NED within its membership. Discussions within ROAN and with GMC ELA have prompted a rethink regarding whether a NED or the appointment of a lay member would best meet requirements.

Clinical governance systems exist from departmental level, through Care Group to Divisional level and the Board supporting an environment to deliver continued improvement in quality and care. The Trust achieved 'Good' overall at the CQC inspection 2018.

Audit, colleague & patient feedback, risk reporting and Duty of Candour are actively promoted. Relevant training is provided in such areas. (GMC handbook Principle 1c)

Lay involvement is apparent on Trust groups and committees. There is an established Junior Doctors Forum with good engagement from chief registrar, Director Medical education, Guardian of Safe Working as well as junior doctors and senior management including CEO. (GMC handbook Principle 2a)

Learning from our own and external organisations is evident across the Trust in a variety of ways e.g. Mortality & Morbidity meetings; guideline development; clinical and managerial / strategic networks; newsletters. Patient feedback (examples available on wards and from risk management systems / Learning from Incident Panels) is used to improve service development. (GMC handbook Principle 2b).

There is an Introduction to Appraisal & Revalidation programme for new starters. A powerpoint presentation supports overseas doctors information and induction alongside the face to face meeting with the appraisal lead.

Action for next year:

The RO is to meet with the Chairman of the Board to discuss this further and to review how the Board and DCHFT can continuously improve systems in line with the GMC handbook on Effective Clinical Governance for the Medical Profession

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

Comments: Clinical governance systems are in place. Minor low level issues regarding conduct and performance of doctors are managed at local departmental level with escalation if there is a failure to respond or an increase in level of concern. Datix, with risk management systems, supports recording & investigation of clinical concerns for capability or conduct when a clinical risk has been identified. Information regarding risk events and complaints is provided for and discussed at appraisal.

Consultants do not at present have a formal annual face to face performance review with their clinical lead and service manager which feeds into their appraisal. We do ask for a scope of practice form to be completed by their lead / manager for discussion at appraisal.

Doctors in senior managerial roles (e.g. Divisional Director, Medical and Deputy Medical Directors do have a performance review as well as an annual appraisal)

Action for next year:

1. Revisit whether the Trust wishes to introduce an annual performance review for all consultants. This could then feed information into the appraisal. It would also give consultants an opportunity to receive direct feedback from their clinical lead and manager. This is particularly likely to be helpful to consultants who are appraised by SASG and feel that face to face senior specialty feedback is a missing element in supporting their development.

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

Comments:

Maintaining High Professional Standards is the approved policy used for responding to concerns.

Fitness to Practice issues are discussed at the RO / MD / GMC ELA meetings which are held regularly. The GMC ELA is available for informal / formal discussion by telephone between face to face meetings.

At the HLROQR on 9 July it was advised that the Medical Director and Deputy medical director should not routinely be named as case investigator nor manager as they may be required to chair an appeal or disciplinary panel.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.

Action from last year:

Review the QA processes and support for case investigation & management in place at DCHFT. Potential resource NCAS (now PPAS) CI and CM training with Action Learning sets (ALS) for peer support & opportunities to maintain CPD.

Comments:

Audit of case investigation & management not able to be completed as planned by June 2019 due to other HR / RO priorities.

Appendix C shows the numbers, types and outcomes of concerns. We have not specifically reviewed in appendix D the protected characteristics of the doctors.

The introduction of a Revalidation Governance group would help us to improve our QA for 'Responding to Concerns'.

Action for next year:

1. HR to compile a list of formally trained case investigators and case managers
2. HR (with RO & MD support) Audit of case investigation and management against standards in MHPS and GMC governance handbook
3. Contact neighbouring Designated Bodies (Yeovil, Bournemouth, Poole) to consider sharing of resources for case investigation and management and make links for peer support.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Yes

Comments:

MPIT forms (national process) are used. Telephone conversations may also occur where there are higher level concerns likely to impact on patient safety / outcomes.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

Comments:

HR policies include an Equal Opportunities Impact Assessment & statement

Processes could be strengthened by implementing actions in 4 above

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Comments:

In addition to pre-employment check there are systems to share information once a doctor has been offered a contract with DCHFT:

Sharing of information regarding new doctors entering employ occurs via MPIT forms from RO to RO.

Such forms are also used to share concerns (RO to RO) which arise during employment at DCHFT of any doctors who also practice elsewhere (e.g locum doctors; doctors with private practice)

HPANs (Health Professional Alert Notices) may also be used to share significant concerns about a doctor who has disconnected from DCHFT and not yet made a connection to a new Designated Body.

GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns.

Information sharing processes adhere to Caldicott principles. RO and MD share the role of Caldicott guardian. . (GMC handbook Principles 4e & f).

Section 6 – Summary of comments, and overall conclusion

See Action Plan at Appendix E

Overall conclusion:

The Trust continues to meet all statutory duties in relation to medical revalidation & RO regulations.

Our main issue this year is a fall in appraisal rates & appraisal rates below peers. Some suggestions for improvement have been put forward and this is an area for discussion with the Board and at Divisional Governance meetings.

The introduction of a RO Advisory (or Revalidation Governance) Group with NED inclusion in the membership would support Board level accountability for quality of medical appraisal.

The GMC Regional Liaison Service offers training to support Revalidation and may be something the Board would wish to consider for one of their development days. (GMC Handbook Principle 1a)

Section 7 – Statement of Compliance:

The Board of Dorset County Hospital NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Dorset County Hospital NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Revalidation ACTION PLAN (relating to Board Report 2018-19)

Area for development for DCHFT as RO service provider	Action	Responsibility	Timescale	Assurance	Progress
Improve appraisal rates (in line with peers)	i) Liaison with DD's, CD's and DM's to identify potential appraisers with agreed remuneration & resourced time for appraisers. ii) Meeting to be scheduled between RO / MD and Director of HR / Deputy Director HR to discuss contract for doctors at DCHFT (relating to appraisal requirements) iii) Review arrangements for acceptance of a prescribed connection and appraisal scheduling for short term contract / As &When Drs	RO with DD & DM RO / MD / Director HR RO / Revalidation administrator with HR advisor	Quarterly monitoring in line with NHSE returns	Appraiser to doctor ratio nearer 1:6 Improving appraisal rates	

	iv) Liaison with Care Group leads to improve their monitoring of medical appraisal rates – with proposal to introduce RAG table	Appraisal Lead / CDs and service managers with HR admin support			
Strengthening the clinical governance and QA arrangements for locum and As & When contract holders	i) Appraisal lead with RO and HR to explore the use of locum exit forms. ii) Introduce requirement for contract holder to meet with clinical lead and engage in local educational and clinical governance programme- e.g. via 'contract of expectations' iii) Review of contract to consider introduction of a minimum period of work per 6 or 12 month contract to support revalidation	i) RO & Appraisal lead making enquiries within Regional RO network. ii) DD's and DM's with CD's / clinical leads iii) HR (deputy director and medical HR advisor)	i) Oct 2019 ii) Oct 2019 iii)Jan 2020	Locum exit form in use Agreed & signed contract of expectations at start of post Attendance records at educational / CG sessions Employment contract update	MPIT generally RO to RO whereas we would like a form signed by a consultant or clinical supervisor that the locum can use within their portfolio. MPIT to be used if significant concerns arise. Awaiting template locum exit forms from NHSE/I

Strengthen the governance & QA processes for appraisal & Revalidation	Introduction of an RO Advisory or Revalidation Governance Group at DCHFT. TOR for such groups available via Regional network.	RO with Board / HR support	Jan 2020	ROAG (RGG) TOR / minutes	
Consider how to improve the QA of case investigation and peer support to case investigators and case managers when responding to concerns about doctors	i) Review the QA processes & support for case investigation & management in place at DCHFT ii) Compile a list of trained case investigators and managers iii) Liaise with neighbouring RO to determine interest in sharing resources and peer support	Deputy Director HR RO	June 2020	Audit of case investigation & management Buy in to NHS Resolution resources (if agreed)	
I confirm that the action plan above has been discussed and agreed with my Board or equivalent		*Responsible officer - Signature & Date*			

Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**88**
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due window'	3
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	1
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	42
Postponed due to incomplete portfolio/insufficient supporting information	2
Appraisal outputs not signed off by doctor & or appraiser within 28 days	10
Lack of time of doctor	9
Lack of engagement of doctor	0
Other doctor factors -Total Reasons: Exit exams Learning new appraisal system Annual leave Retirement & return Unable to agree appraisal date To better align appraisal with revalidation Unplanned Absence Death in Family Change from F/time to P/Time Difficulty in accessing PReP IT from home Appraiser delay Relocation Sick Leave (short term)	17 0 0 3 1 1 1 1 2 1 1 3 1 2
Appraiser factors(total)	**2**
Unplanned absence of appraiser	1
Lack of time of appraiser	0

Other appraiser factors (describe): Failure to agree appraisal date	1
Organisational factors	**0**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	27
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	27
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	N/A
No responsible officer in post	
New starter/new prescribed connection established within 2 weeks of revalidation due date	
New starter/new prescribed connection established more than 2 weeks from revalidation due date	
Unaware the doctor had a prescribed connection	
Unaware of the doctor's revalidation due date	
Administrative error	
Responsible officer error	
Inadequate resources or support for the responsible officer role	
Other	
Describe other	
TOTAL [sum of (late) + (missed)]	0

Annual Report Template Appendix C

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	
Capability concerns (as the primary category) in the last 12 months	0
Conduct concerns (as the primary category) in the last 12 months	4
Health concerns (as the primary category) in the last 12 months	0
Some Other Substantial Reason (as the primary category) in the last 12 months	1
Remediation/Reskilling/Retraining/Rehabilitation	
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2019 who have undergone formal remediation between 1 April 2018 and 31 March 2019 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*	0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)	143
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)	48
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)	N/A
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)	145
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	N/A
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	73
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	3

TOTALS	264 + 145 DiT+ 3 other = 412
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	2
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	1 week – 1 month 3 - 6 months
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	Number
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	1
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
Practitioner Performance Advice Service actions:	Number
Number of doctors about whom the Practitioner Performance Advice Service (PPAS) has been contacted between 1 April and 31 March for advice or for assessment	3
Number of PPAS assessments performed	1

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors (not including doctors in training)	11
Temporary employed doctors (not including doctors in training)	10
Locums brought in to the designated body through 'Staff Bank' arrangements	119
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	140

Dr Mike Prentice
Revalidation Lead
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

PA Contact Details:
Tracy.calvert@nhs.net
Tel: 0113 825 3052

18 July 2019

Our Ref: 188
Publications Approval 000740

Dr Julie Doherty
Responsible Officer
Dorset County Hospital NHS Foundation Trust

Dear Dr Doherty

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 188 - Dorset County Hospital NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 18/19 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The 2018/19 slimmed down version of the AOA was designed to concentrate primarily on the quantitative measures of previous AOAs, the number of doctors with a prescribed connection and their appraisal rates. In this the sixth year of the AOA, I am pleased to report a continuing upward trend in the overall appraisal rate. This is extremely reassuring and I would like to thank you once again for your continued work. There is emerging evidence that creating the right environment for doctors to reflect on their clinical practice through appraisal is one which enables them to thrive and develop professionally. This benefits the patients that they look after and allows doctors to have confidence in their professional practice.

As well as revising the AOA, a review of reporting the other important aspects of the responsible officer function (monitoring of practice, responding to concerns, and identity/language checks) have moved to the annual Board report. The Board report, combined with the annual Statement of Compliance, has been re-designed to support a conversation within the designated body to review all the responsible officer's obligations and to agree an action plan for areas where further development is identified.
Assurance of the totality of the designated body's work on the responsible officer's duties will therefore be provided to the higher level responsible officer through both completion of the AOA and the statement of compliance, as signed off by the designated body's Board or equivalent management body.

Board-level accountability for the quality and effectiveness of appraisal rates is extremely important and this report, along with the resulting action plan, should be presented to your board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Michael Marsh
Your local revalidation team's lead contact	Claire Brown
Your local revalidation team's contact details	england.revalidation-south@nhs.net

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2019. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing the required assurance to your higher level RO, and to NHS England.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer
cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 862 returns from designated bodies (DBs) to the 2018/19 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2019

The following information is presented as per your own AOA submission.

Name of designated body:	Dorset County Hospital NHS Foundation Trust
Name of responsible officer:	Dr Julie Doherty
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (Regional Team - South West)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Claire Brown at england.revalidation-south@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2018/19 for the full indicator definitions if required.

2018/19 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	94 (97.9%)	851 (98.7%)

2018/19 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 201**9	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	143	28190	53177
2.1.2	Staff grade, associate specialist, specialty doctor	48	5592	12543
2.1.3	Doctors on Performers Lists	0	35	47422
2.1.4	Doctors with practising privileges	0	1	1870
2.1.5	Temporary or short-term contract holders	73	8870	22314
2.1.6	Other doctors with a prescribed connection to this designated body	0	689	7128
2.1.7	**Total number of doctors with a prescribed connection**	264	43377	144454

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	124 (86.7%)	93.5%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	34 (70.8%)	88.8%	88.2%
2.1.3	Doctors on Performers Lists	N/A	91.4%	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	39 (53.4%)	77.8%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	72.1%	87.9%
2.1.7	**Total number of doctors who had a completed annual appraisal**	197 (74.6%)	89.3%	91.5%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Approved incomplete or missed appraisal (2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Approved incomplete or missed appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	4 (2.8%)	4.4%	4.2%
2.1.2	Staff grade, associate specialist, specialty doctor	6 (12.5%)	8.8%	8.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	4.2%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.1%
2.1.5	Temporary or short-term contract holders	17 (23.3%)	17.1%	13.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	22.5%	10.5%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	27 (10.2%)	7.9%	6.4%

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Unapproved incomplete or missed appraisal (3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had an Unapproved incomplete or missed annual appraisal between 1 April 2018 – 31 March 2019**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	15 (10.5%)	2.1%	2.2%
2.1.2	Staff grade, associate specialist, specialty doctor	8 (16.7%)	2.4%	3.2%
2.1.3	Doctors on Performers Lists	N/A	8.6%	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	2.2%
2.1.5	Temporary or short-term contract holders	17 (23.3%)	5.1%	4.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	5.4%	1.6%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	40 (15.2%)	2.8%	2.1%

2018/19 AOA indicator **SECTION 3:**		**Your organisation's response**
3.1	The last Annual Board report was signed off on:	26/09/2018 00:00:00
	The last Statement of Compliance was signed off on:	17/09/2018 00:00:00

2018/19 AOA indicator SECTION 4: Comments		Your organisation's response
4.1		

Title of Meeting	**Trust Board**
Date of Meeting	**31 July 2019**
Report Title	**Communications Activity Report – Q1 April-June 2019**
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. Included in the report is information about key campaigns, initiatives and events, and analytics for our social media channels and public website. There is also a summary of news releases issued over the quarter and media coverage.	
Paper Previously Reviewed By	
Strategic Impact	
Risk Evaluation	
Impact on Care Quality Commission Registration and/or Clinical Quality	
Governance Implications (legal, clinical, equality and diversity or other):	
Financial Implications	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	a) To receive for information

Communications Activity Report

Quarter 1: April – June 2019

1. Introduction

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

2. Key Campaigns, Initiatives and Events

Staff App Update

The staff app was launched in April and at the time of writing this report over 700 staff had downloaded the app. Feedback has been very positive and we are continuing to develop the content. We will continue to publicise the app to reach more staff.

Recruitment Microsite and Social Media

The communications and recruitment teams are working in partnership with Dorset Clinical Commissioning Group's digital team to develop a new dedicated recruitment microsite to offer information about job opportunities and the benefits of working at DCH. The CCG team are providing technical support and we are generating and maintaining the content.

At the time of writing this report, the microsite had been published for a pilot phase at https://joindchft.nhs.uk/ The recruitment team are now compiling additional content ahead of the official launch and promotion from 1 August 2019.

The communications officer is also supporting the recruitment team through the use of social media to promote key vacancies. We now publish a 'Job of the Week' and general jobs post each week through Facebook, Twitter and LinkedIn.

Summer Spectacular

Not strictly in Q4 but included as the event had just happened at the time of writing this report. The summer fete style event went extremely well with hundreds of visitors attending and enjoying an afternoon of stalls, displays and performances. Over £2,500 was raised for the Chemotherapy Appeal and other good causes. We hope to stage another Summer Spectacular next year if the school field is still available to use in July 2020.

The small organising committee worked incredibly hard over and above their day jobs to put together the event and have been nominated for Hospital Hero awards.

DCH Site Development

The communications team are supporting the staff and public engagement around the development of the DCH site. Engagement events were planned for early July to explain the plans to staff, stakeholders and the wider public, supported by information on our public website: https://www.dchft.nhs.uk/about/site-development/Pages/default.aspx

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

Trust Board Publicity
Following feedback from the Trust Board about raising the profile of Board meetings to boost attendance and awareness, the communications team is now publicising meetings ahead of them being held and Tweeting from Board meetings from the @DCHFT account about key discussions and decisions with the hashtag #DCHboard. The team go through the agenda ahead of meetings in preparation to ensure the key matters are highlighted.

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

In April we hosted a visit of the NHS Providers communications team who are touring provider trusts throughout the country. They were very impressed by the collaboration going on between Our Dorset comms teams.

We are currently supporting the promotion of a survey for NHS staff and the public to support the development of the updated Dorset STP: www.ourdorset.nhs.uk/lookingforward

GEM Awards
Our annual staff and volunteer awards ceremony was held at Kingston Maurward on 14 June. The comms team supported with photography and live tweeting on the night and post-event publicity.

3. Social Media

Social media engagement continues to flourish. Engagement on Facebook and Twitter pages continues to steadily grow and we are continuing to developing our other channels, including LinkedIn and Instagram. We were delighted to reach another Facebook milestone – 5,000 likes – which is a good illustration of how much our engagement has improved and continues to grow.

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

Facebook Analytics – www.facebook.com/DCHFT

	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20
Engaged users	90,673	102,546	115,118	92,238
Number of posts	148	222	173	164
Number of followers	3,700	4,020	4,850	4,929

Facebook Highlights for April

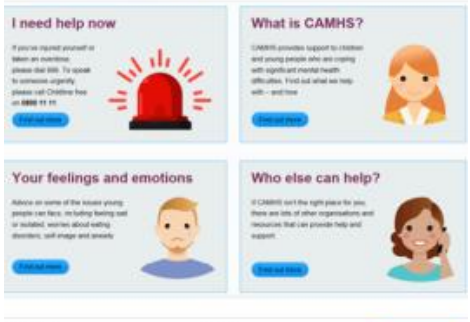
A brand new website for Dorset's Child and Adolescent Mental Health Service (CAMHS) is now up and running - https://camhsdorset.org/

Designed by Dorset HealthCare in partnership with young service users and their families, it replaces the old 'Where's Your Head At?' site, providing a one-stop-shop for anyone needing help and advice with stress, anxiety, eating disorders and other mental health issues.

It is much easier to use and navigate, is mobile-friendly, and features a lot more content – including videos developed by people with lived experience of these problems.

As well as signposting young people to the support they might need, there are also sections aimed at parents and carers, as well as health/social care professionals (including how to make a referral to CAMHS), plus details of what the service can provide.

You can give your feedback to the website here: https://camhsdorset.org/feedback



16,002 People Reached | 1,265 Engagements | Boost Post

73 | 5 Comments 159 Shares

Our Emergency Department is currently extremely busy. Please share and help us spread the word - the Emergency Department should only be used for serious or life-threatening conditions.

There are local alternatives to A&E available so please visit the Staywell Dorset website for advice about accessing GP, pharmacy, minor injury and urgent care services: staywelldorset.nhs.uk

If you're not sure which service to use you can also call 111.

You can find details of your local Minor Injuries Unit or Urgent Care Centre at: https://bit.ly/2UqVH1q

Thank you for your help, please share and help us cope with the high demand on our services. #StayWellDorset #HelpUsToHelpYou

11,776 People Reached | 741 Engagements | Boost Post

16 | 138 Shares

Are you considering a career in medicine? This July we are once again offering a two-day course to help those 16+ discover more about studying medicine.

You will be able to meet and talk to doctors and medical students here at #TeamDCH

Apply here: https://bit.ly/2HevIrt

8,852 People Reached | 1,067 Engagements | Boost Post

58 | 31 Comments 49 Shares

Facebook Highlights for May

Facebook Highlights for June

The Queen's Birthday Honours have just been officially published and we are hugely proud to announce that our Chief Executive Patricia Miller has been awarded an OBE for services to the NHS.

Patricia said: "I've worked for the NHS for almost 30 years and have always been extremely proud to be a public servant. I've been fortunate to work with some amazing staff and fantastic colleagues during that time and I couldn't have achieved what I have without them. Special thanks to staff and colleagues at Dorset County Hospital. It's a privilege to work alongside such a hardworking and dedicated team and to live within such a supportive local community."

#BirthdayHonours #TeamDCH

17,728 People Reached | 3,763 Engagements | Boost Post

421 | 139 Comments 45 Shares

Looking for a role in the NHS? See all our vacancies here:
https://bit.ly/2QDerKk
Latest vacancies include a Speech and Language Therapist, Orthotist and Digital Maternity Project Manager.
#TeamDCH #NHSJobs #NHS

Turn on job features for this post to reach more applicants. Turn On

5,789 People Reached | 835 Engagements | Boost Post

25 | 1 Comment 27 Shares

We had some very special visitors this afternoon from Manor Park First School who came to sing for our staff, patients and visitors! They chose the theme of musicals and blew us away! We loved it! 🎶

5,499 People Reached | 907 Engagements | Boost Post

164 | 11 Comments 19 Shares

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

	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20
Tweets	203	348	334	294
Tweet impressions	146,700	264,000	212,939	302,300
Profile visits	6,873	10,488	8,174	8,453
Mentions	851	798	896	967
Number of followers	3,238	3,414	3,741	3,940

Twitter Highlights for April

Top Tweet earned 2,950 impressions

One of our most iconic pieces of art is our beloved life-sized wooden carthorse, Agnes! Based on a real shire horse named Rubik, she took #Dorchester sculptor Mike Chapman more than five months to assemble. She can be found on Level 2 between the South and East wings.
pic.twitter.com/NyvcePWGVK

13 38

Top mention earned 137 engagements

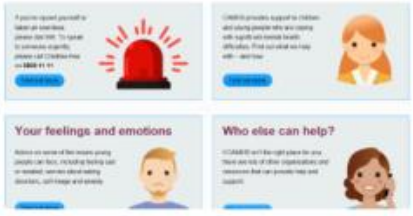
Sue Varley
@varley_susan · Apr 3

One Dorset Rheumatology Board members working together to develop the new service for Dorset @OneNHSinDorset @DCHFT @Poole_Hospital @RBCH_NHS @DorsetHealth
pic.twitter.com/aY22QZ1ukE

3 3 19

Top media Tweet earned 2,462 impressions

A new website for Dorset's Child and Adolescent Mental Health Service (CAMHS) is now up and running - camhsdorset.org Designed by @DorsetHealth in partnership with young service users and their families, it replaces the old 'Where's Your Head At?' site. #mentalhealth
pic.twitter.com/Jd0PcCLu1V



18 21

Twitter Highlights for May

Top Tweet earned 3,701 impressions

Our Director of Nursing and Quality, Nicky Lucey, wanted to give this message this #InternationalNursesDay
We want to take this moment to say a massive thank you to all our wonderful nursing staff at #TeamDCH! We would be lost without you! #ThankYouNurses
pic.twitter.com/2acY6A7SvV

16 53

View Tweet activity View all Tweet activity

Top mention earned 530 engagements

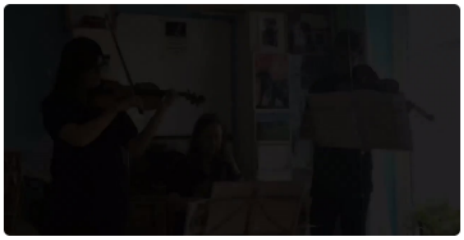
Poole Hospital
@Poole_Hospital · May 10

Our brilliant cardiology team accept the #suckalemonchallenge - all part of @pumpingmarvellous #heartfailureawarenessweek. We lay down the challenge to the cardiology team @DCHFT to follow suit
#hopeforheartfailure
pic.twitter.com/Sj40iqmNtA

7 19 93

Top media Tweet earned 2,240 impressions

We had an absolutely amazing day yesterday with @BSOrchestra! This was recorded with our patients in Barnes who all loved playing different instruments, singing along and reminiscing about their lives! An amazing project with @Artsinhospital!
I think you all know this one?
pic.twitter.com/6uEn8crLrm



6 28

Twitter Highlights for June

Top Tweet earned 6,764 impressions

The Queen's Birthday Honours have just been officially published and we are hugely proud to announce that our Chief Executive Patricia Miller has been awarded an OBE for services to the NHS #BirthdayHonours #TeamDCH pic.twitter.com/GhydYJyjch

13 15 118

View Tweet activity View all Tweet activity

Top mention earned 217 engagements

Richard Bradford
@dorsetandbeyond · Jun 24

Lovely to see @DCHFT has created a patch of wildflowers in the grounds of Dorset County Hospital - a great tonic for patients, staff and #pollinators alike. Would love to see more of the patches around #Dorchester to help #GetDorsetBuzzing..! @BSBIbotany @LGSpace @NearbyWild pic.twitter.com/8mDDwpnj84

1 24 104

Top media Tweet earned 2,166 impressions

Today we tested our readiness for a major incident with an exercise. Staff from throughout the hospital pulled together for an amazing #TeamDCH effort! It's reassuring to know if the worst ever happens, we are ready. @PHE_uk @NHSEngland @DorsetCCG pic.twitter.com/8RjtkENa8k

3 8 29

Instagram Analytics - www.instagram.com/dorset_county_hospital/

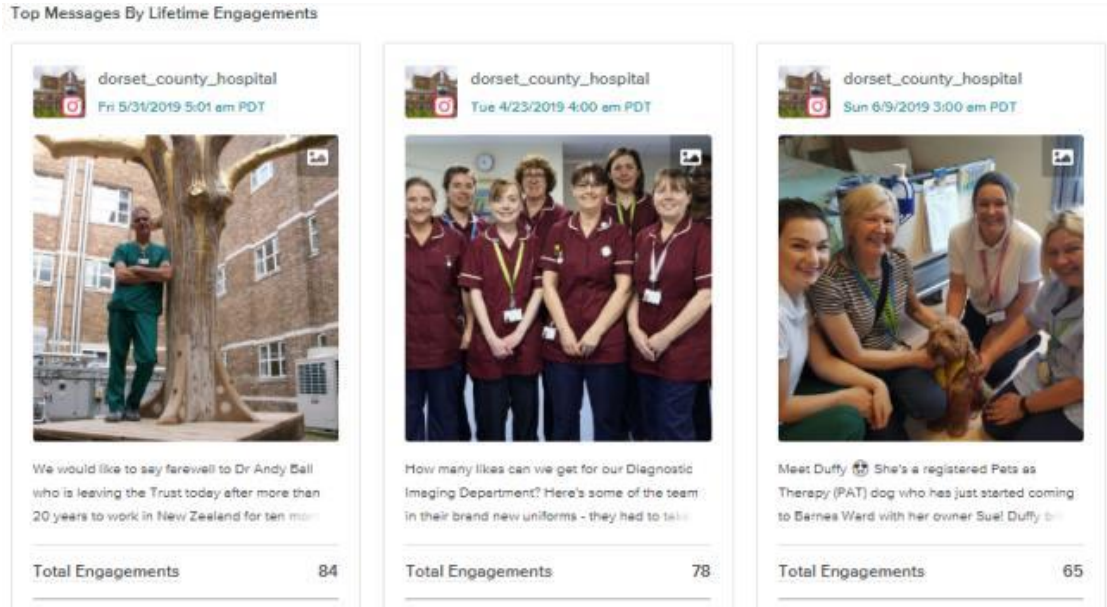
We launched an Instagram page in March in an effort to increase our audience reach. Although women between the ages of 25-34 are currently leading the force among fans, we have increased the number of men interacting with our posts, as well as young people.

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

Instagram Impressions

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

Instagram Highlights



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

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

4. Public Website

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

Website Analytics – www.dchft.nhs.uk

	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20
Page Views*	161,130	160,712	174,972	174,937
Unique Page Views**	118,468	118,189	129,020	127,270
Users	38,014	38,107	37,758	42,287
Average Session Duration	00:01:46	00:01:49	00:01:47	00:01:44

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

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

Top 10 Most Popular Webpages (April - June 2019)

Page	Page Views	Unique Page Views	Average Time on Page
Site Homepage	23,263	17,542	00:00:43
Staff Section Homepage	6,938	4,825	00:00:54
Visiting Hours	5,072	3,602	00:01:24
Contact Us	4,955	4,135	00:01:38
Visitors Section Homepage	4,196	2,837	00:00:19
Departments P-Z Homepage	4,103	2,907	00:00:24
Departments A-F Homepage	4,014	2,691	00:00:20

Patients Section Homepage	4,005	2,884	00:00:23
Wards Section Homepage	3,698	2,754	00:00:28
Departments G-O Homepage	3,521	2,302	00:00:21

5. StaffNet (Intranet)

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

6. News Releases

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

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

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

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

Generous donation boosts Friends' fundraising mission - 18 June 2019 A generous donation has pushed the latest fundraising initiative by Friends of Dorset County Hospital ever closer to their target.

Staff and volunteers recognised for hard work and dedication at GEM and Long Service Awards - 18 June 2019 It was an evening of glam and glitter as Dorset County Hospital staff and volunteers were recognised for their hard work and dedication at the 2019 GEM and Long Service Awards.

Dorset County Hospital gears up for first ever Summer Spectacular - 6 June 2019 Dorset County Hospital is gearing up for its first ever Summer Spectacular.

A Show of Hands for Dorset County Hospital - 6 June 2019 A new series of paintings exploring the range of emotions through simple hand gestures are brightening the corridors at Dorset County Hospital.

Dorset County Hospital shortlisted for national healthcare efficiency award - 17 May 2019 DCHFT is one of five trusts to be shortlisted for the CHKS national healthcare efficiency award as part of the 2019 Top Hospitals programme awards.

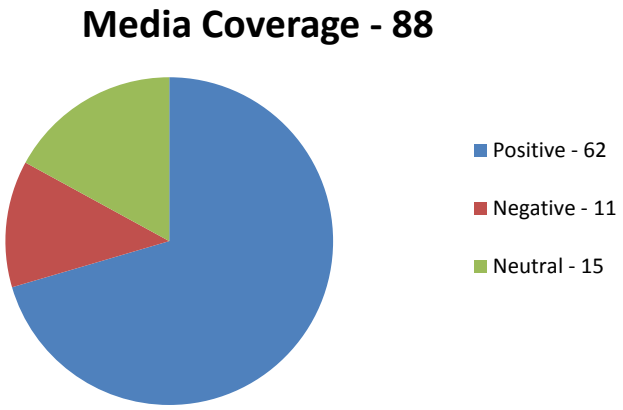
Dorset County Hospital scoop two prizes at NHS research awards - 9 April 2019 Research professionals and patients from Dorset County Hospital have been presented with two awards at a ceremony hosted by the National Institute for Health Research (NIHR) clinical Research Network (CRN) Wessex.

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:

- Red Cross discharge scheme
- Governor raises money for kidney patients
- Service changes at Bridport Hospital
- Help ease Easter pressures
- Hospital finances
- DCH shortlisted for national healthcare efficiency award
- Patricia Miller OBE
- Norovirus warning
- Patients object to dialysis treatment move
- Gearing up for DCH Summer Spectacular
- Lions Fun Run

There were a total of 88 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 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20
Media stories	68	81	79	88
Positive	46	55	57	62
Negative	12	15	6	11
Neutral	10	11	16	15

Susie Palmer
Communications Manager
July 2019