Ref: MA/TH

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **29th September 2021** at **08.30am to 12.15pm** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Video	Patricia Hilton Dietician	Note	8.30-9.00
2.	**FORMALITIES** to declare the meeting open. Welcome to Anita Thomas.	Verbal	Mark Addison Trust Chair	Note	9.00-9.05
	a) Apologies for Absence: Richard Sim	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 28th July 2021	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**CEO Update**	Enclosure	Patricia Miller	Note	9.05-9.20
4.	**COVID-19 Update**	Verbal	Inese Robotham / Anita Thomas	Note	9.20-9.25
5.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (August and September) a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee d) Risk and Audit Committee	Enclosure	Committee Chairs and Executive Leads	Note	9.25-9.45
6.	**Maternity Services – Learning From Sheffield CQC Review**	Enclosure	Nicky Lucey / Jo Hartley	Approve	9.45-10.00

7.	**Safest Nursing and Midwifery Staffing**	Enclosure	Nicky Lucey	Approve	10.00-10.15
Coffee Break 10.15 – 10.30					
8.	**Well Led Self-Assessment**	Verbal	Patricia Miller	Approve	10.30-10.35
9.	**Strategy Implementation Update**	Enclosure	Nick Johnson / Ciara Darley	Note	10.35-10.50
10.	**Annual EPRR Statement** (Risk and Audit Committee)	Enclosure	Inese Robotham Tony James	Approve	10.50-11.00
11.	**Charity Annual Report and Accounts**	Enclosure		Approve	11.00-11.10
12.	**Guardian of Safe Working Hours Report**	Enclosure	Alastair Hutchison Kyle Mitchell	Note	11.10-11.20
13.	**GMC Survey Report**	Enclosure	Alastair Hutchison Audrey Ryan	Note	11.20-11.30
14.	**Board Assurance Framework and Risk Register**	Enclosure	Nick Johnson/Nicky Lucey	Note	11.30-11.40
15.	**Recovery Report**	Enclosure	Nick Johnson	Note	11.40-11.50
16.	**WRES Data**	Enclosure	Dawn Harvey	Note	11.50-12.00
17.	**Questions from the Public**	Verbal	Mark Addison	Note	12.00-12.15
	CONSENT SECTION				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
18.	**Maternity reports:** **a. Maternity Safety Report** (from Quality Committee)	Enclosure	Nicky Lucey	Note	
19.	**Charity Risk Policy**	Enclosure	Simon Pearson/Nick Johnson	Ratify	
20.	**IPC Annual Report** (Quality Committee)	Enclosure	Nicky Lucey	Ratify	
21.	**Committee Risk Process**	Enclosure	Trevor Hughes	Note	

22.	**Any Other Business** Nil notified				
23.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 24th November 2021** at Vespasian House TBC.				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 08.30am on 28 July 2021 in the Boardroom, Vespasian House, Dorchester and via Lifesize videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Sue Atkinson	SA	Non-Executive Director (via Lifesize)
Margaret Blankson	MB	Non-Executive Director (via Lifesize)
Judy Gillow	JG	Non-Executive Director
Paul Goddard	PG	Chief Financial Officer
Dawn Harvey	DH	Chief People Officer
Alastair Hutchison	AH	Chief Medical Officer
Ian Metcalfe	IM	Non-Executive Director
Patricia Miller	PM	Chief Executive Officer
Inese Robotham	IR	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Liz Beardsall	LB	Deputy Trust Secretary (minutes) (for the Head of Corporate Governance)
Emma Hoyle	EHo	Deputy Chief Nursing Officer (for the Chief Nursing Officer)
Angela Lederer	AL	Without Limits Network Chair (item BoD21/023) (via Lifesize)
Members of the Public:		
Judy Crabb	JC	DCHFT Public Governor (via Lifesize)
Apologies:		
Trevor Hughes	TH	Head of Corporate Governance
James Metcalfe	JM	Divisional Director
Nick Johnson	NJ	Deputy Chief Executive
Nicky Lucey	NL	Chief Nursing Officer
Richard Sim	RS	Divisional Director
Stephen Slough	SS	Chief Information Officer
Natalie Violet	NV	Corporate Business Manager

BoD21/023	**Staff Story**
	The Chair welcomed Angela Lederer, a finance manager at the Trust and Chair of the hospital's Without Limits network. She gave the Board a frank account of her experiences since she started at the hospital two years ago including issues of communication with her line manager, her physical and cognitive impairments and challenges within the working environment. She explained how, by taking the brave step to initiate a dialogue with her manager, she was able to improve the dynamics of the relationship and her working experience. Angela highlighted her belief that making small changes was the best way to facilitate change. The Board discussed with Angela the work of the Without Limits network, and how the hospital's networks were able to shine a light on positive and negative practice so that the Trust could take action to address the issues that arose. The wider issue of good line management was discussed, including the role of appraisal and the use of coaching at the Trust. The Chair thanked Angela for her open and honest account.
BoD21/024	**Formalities**

	The Chair declared the meeting open and quorate. He welcomed everyone to the first face to face formal meeting of the Board of Directors for 15 months. Apologies for absence were received from Trevor Hughes, James Metcalfe, Nick Johnson, Nicky Lucey, Richard Sim, Stephen Slough and Natalie Violet.
BoD21/025	**Declarations of Interest**
	There were no conflicts of interest declared in the business to be transacted on the agenda.
BoD21/026	**Minutes of the Meeting held on the 26 May 2021**
	Members of the Board considered the minutes of the meeting held on 26 May 2021**.** These were agreed as an accurate record of the meeting, subject to a minor correction from the Chief Operating Officer (COO) which had already been actioned by the corporate governance team.
	Resolved: that the minutes of the meeting held on 26 May 2021 were approved.
BoD21/027	**Matters Arising: Action Log**
	The action log was considered and updates were noted. Approval was given for the removal of completed items. There were no other matters arising. The Chief Executive Officer (CEO) asked that the review of the revised report front sheets be added to the Board action log for consideration by the whole Board. **ACTION: LB** It was noted that the People and Culture Committee 2021/22 priorities were yet to be approved by the Board, and the CEO asked for these to be circulated and approved outside the meeting. **ACTION: LB**
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.
BoD21/028	**CEO Update**
	The CEO drew the Board's attention to the previously circulated report and highlighted the updates regarding the appointment of Sajid Javid, the NHS England Chief Executive recruitment process, the Queen awarding the NHS the George Cross, the Health and Care Bill second reading, the NHS net zero carbon target, the increase in the Elective Recovery Fund threshold, guidance in healthcare settings following the national easing of COVID restrictions, and current self-isolation rules. Sue Atkinson, as Lead NED for Maternity, asked for the Race and Health Observatory (RHO) Board's maternal health report to be shared with her and the maternity team. The CEO confirmed it had been shared with the Head of Midwifery and she would check with the RHO regarding wider circulation. **ACTION: PM** The Board discussed the development of the Integrated Care System health inequalities strategy and in light of this the Deputy CEO/Director of Strategy would be drafting an interim approach for the Trust. It was noted that lessons could be

	learnt from the north-west where this work was well underway. The Board asked the CEO to underline in her weekly brief that the Board fully supported staff in ensuring patients and visitors continued to adhere to the PPE and social distancing guidance for healthcare settings. **ACTION: PM** The Chair thanked the CEO for her report.
	Resolved: that the CEO Update be received and noted.
BoD21/029	**COVID-19 Update**
	The Chief Operating Officer provided the Board with an operational update on the COVID position at the Trust, reporting that the main pressures being faced in the hospital were not currently due to COVID. Back-door pressures remained high as did pressure on the ambulance service. The Trust continued to take the steps required to keep patients safe, including instances of mixed sex accommodation. It was noted that whilst this was vital for maintaining safety, it meant that patients were not receiving optimum care. Staff wellbeing and staffing levels remained a significant concern. The executive team were continuing to make plans for the possibility of another significant peak in COVID cases.
	Resolved: that the COVID-19 Update be noted.
BoD21/030	**Performance Scorecard and Board Sub-Committee March Escalation Reports**
	The Non-Executive Chairs of the Board sub-committees provided feedback from committee meetings held the previous week, noting: **People and Culture Committee:** the new People Performance report and dashboard; appointment of a full time Freedom to Speak Up Guardian; recruitment including international nurses; workforce risks and the triangulation work with Quality Committee (QC) and the Finance and Performance Committee (FPC); the importance of having the right organisational culture to attract and retain staff; the agency usage deep dive and the new working group on agency use; Dignity and Respect at Work programme; and that there had been no red flag safe staffing incidents during the reporting period. **Quality Committee:** workforce risks focusing on the impact on patient safety and the triangulation of this work with the People and Culture Committee (PCC) and FPC; concerns regarding stroke outcomes with a deep dive planned for the August committee meeting; compliance with quality metrics remained good and this was an accolade to the staff; the theatre culture review and revised workforce model for the Older Peoples' Unit were referred by QC to PCC; and the committee also undertook its regular review of maternity safety including the Ockenden Report actions (see item BoD21/033). **Finance and Performance Committee:** the review of the new performance dashboard; the proposal to review prior investments was approved and would be built into the committee workplan; workforce risks and the triangulation of this work with PPC and QC; focus on agency spend and alternative staffing solutions. It was noted that the Premises Assurance Model (PAM) self-assessment was recommended to the Board for approval (Part Two Board) and that the committee would continue to monitor the PAM action plan as part of its ongoing work

	programme and would also receive an annual report. **Risk and Audit Committee:** the committee did not discuss the workforce risks paper that was seen at PCC, QC and FPC as the Board had previously agreed it would tolerate the workforce risk score as the Trust was doing all it could to mitigate this risk. It was agreed that the Risk and Audit Committee (RAC) would review this in November to establish whether the organisation was still content to tolerate the risk. RAC also discussed funded capital schemes and related risks; the revision of the Board Assurance Framework (BAF); and the proposed 'risk summit' which would follow from the revision of the BAF. It was queried whether the Summary Hospital-level Mortality Index (SHMI) should be rated as green on the performance scorecard and the Chief Medical Officer (CMO) said he would look in to the rating. **ACTION: AH**
	Resolved: that the Performance Scorecard and Board Sub-Committee Escalation Reports be noted.
BoD21/031	**Recovery Framework**
	The COO presented the previously circulated framework on behalf of the Director of Strategy. The framework set out the hospital's approach to the recovery work which had been ongoing since the end of the second COVID wave and focused on the two priorities of people and services. The approach and objectives were aligned to the national 2021/22 Priorities and Operational Planning Guidance. Elective recovery trajectories would be reported via the new dashboard to FPC and narrative reporting to the Board would commence from September. The framework provided transparency on the governance framework for the two priority areas of recovery. The Board were asked to approve the framework. The Board discussed the impact of the change to the Elective Recovery Fund threshold from 85% to 95% and it was noted that system work was underway including modelling in relation to the threshold change. The role of FPC and QC in monitoring potential harm to patients during the recovery period was noted. It was noted that the framework was a high-level document and there was significant detailed work unpinning this, especially with reference to health inequalities data and monitoring via the new dashboard. It was suggested that future iterations of the plan may need to be reviewed with a net-zero lens, with a focus on a greener recovery.
	Resolved: that the Recovery Framework be approved.
BoD21/032	**Medical Revalidation Report**
	The Chief Medical Officer (CMO) presented the previously circulated report, highlighting that 2020 had been an abnormal year for revalidation as the requirements had been stood down by NHS England during the pandemic until April 2021. Staff had been encouraged to continue with revalidation but, in line with the NHS England guidance, many opted not to. The key issue of a lack of appraisers was discussed and plans to train an increased number of Locally Employed Doctors (LEDs) as appraisers for other LEDs were welcomed. It was noted that work was underway to streamline the appraisal paperwork for consultants and bring this in line with the paperwork used for other appraisals in the Trust.

	The Board thanked Julie Doherty, Deputy Medical Director and Responsible Officer, for her detailed report and her work throughout the year on revalidation.
	Resolved: that the Medical Revalidation Report be approved.
	CONSENT SECTION
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.
BoD21/033	**Maternity Safety Report**
	The previously circulated report, which had been discussed at the July Quality Committee meeting, was noted for information. The CEO raised concerns about potentially identifiable information in the report and requested that the Maternity Report be removed from the hospital website until the amendments were made. **ACTION: EHo; LB**
	Resolved: that the Maternity Safety Report be noted.
BoD21/034	**CNST Submission**
	The Board ratified the CNST Submission which had previously been approved by the Board outside the meeting on 30 June 2021.
	Resolved that: the CNST Submission be ratified.
BoD21/035	**Quality Account 2020/21**
	The Board ratified the Quality Account 2020/21 which had previously been approved by the Board outside the meeting on 30 June 2021. It was noted that the CNO was discussing the possibility of an accessible version of the report and that this action was being pursued by the Quality Committee.
	Resolved that: the Quality Account 2020/21 be ratified.
BoD21/036	**Questions from the Public**
	The Board's only observer had left earlier in the meeting due to a prior commitment and no questions had been received in advance of the meeting.
BoD21/037	**Any Other Business**
	The Chair raised the issue of the format of future meetings and it was agreed that the Board favoured in person meetings but with the option for members to join virtually. It was agreed that meetings would continue at Vespasian House for the time being.
BoD21/038	**Date and Time of Next Meeting**
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 29 September 2021** in the Vespasian House Boardroom, Dorchester and via Lifesize.

Action Log – Board of Directors Part 1

Presented on: 29 September 2021

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 28 July 2021						
BoD21/027	**Matters Arising: Action Log**	Review of the revised report front sheets be added to the Board action log (from the NED action log) for consideration by the whole Board.	**TH**			
BoD21/027	**Matters Arising: Action Log**	The CEO asked for the People and Culture Committee priorities 2021/22 to be circulated and approved outside the meeting.	**LB**		**Complete.** Circulated to Board 03 08 21.	Yes
BoD21/028	**CEO Update**	Sue Atkinson asked for the Race and Health Observatory (RHO) Board's maternal health report to be shared with her and the maternity team. The CEO confirmed it had been share with the Head of Midwifery and she would check with the RHO regarding wider circulation.	**PM**			
BoD21/028	**CEO Update**	The Board asked the CEO to underline in her weekly brief that the Board fully supported staff in ensuring patients and visitors continued to adhere to the PPE and social distancing guidance for healthcare settings.	**PM**		**Complete.** Included in CEO Brief 30 07 21.	Yes
BoD21/030	**Performance and Escalations**	It was queried whether that Summary Hospital-level Mortality Index (SHMI) should be rated as green on the performance scorecard and the Chief Medical Officer (CMO) said he would look in the rating.	**AH**			
BoD21/033	**Maternity**	The CEO raised concerns about	**EHo; LB**		**Complete.** Revised	

	Safety Report	potentially identifiable information in the report and requested that the Maternity Report be removed from the hospital website until the amendments were made.			papers published on website.	
Actions from Committees…(Include Date)						

Meeting Title:	Board of Directors
Date of Meeting:	29 September 2021
Document Title:	**Chief Executive's Report**
Responsible Director:	Patricia Miller, Chief Executive
Author:	Natalie Violet, Corporate Business Manager to the CEO

Confidentiality:	The document is not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Chief Executive	22 September 2021	Approved

Purpose of the Paper	For information.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	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. The key developments nationally are as follows: • Amanda Pritchard was confirmed as the new Chief Executive of NHS England, commencing on 01 August 2021 replacing Simon Stevens. • Baroness Dido Harding announced she will not seek to be reappointed as Chair of NHS Improvement at the end of her four-year term in October. • The Prime Minster announced the Government's plan for autumn and winter 2021 for England, designed to steer the country through this period and protect the NHS. • NHS England and NHS Improvement published guidance on provider collaboratives outlining expectations for how providers should work together in provider collaboratives. Offering principles to support local decision-making and suggestions on the function and form for systems and providers to consider. • The recruitment process for Integrated Care Board Chairs and Chief Executives has commenced ahead of becoming statutory organisations from April 2022. The recruitment process for Chairs is currently at the interview stage with the Chief Executive advert running until 25 September and interviews expected in October. • The Government announced an additional £5.4 billion to support the COVID-19 response over the next six months. This includes £1 billion further Elective Recovery Funding. • The Government announced plans to reform the NHS and social care to tackle COVID backlogs, reform adult social care, and bring the health and social care system closer together on a long term, sustainable footing. To fund this reform an increase in National Insurance will take place from April 2022. • A six-week open consultation seeking views on the proposal to mandate COVID-19 and Flu vaccinations for frontline healthcare staff in England has been launched. • The Department of Health and Social Care published the Integrated Care Partnership (ICP) engagement document. The document expands on the role that ICPs will play within statutory arrangements for ICSs. This includes producing an integrated care strategy for their area, agreeing collective objectives, and facilitating joint action on health outcomes and							

	the wider determinants of health. It positions ICPs as a critical part of ICSs and builds on NHSE/I's ICS design framework to provide more detail on the expectations of ICPs, as well as the timing of implementation. Locally the biggest concern remains with emergency demand and staffing. The hospital continues to experience significant non-COVID emergency activity resulting in very high bed occupancy rates. This picture is mirrored across our system partners. South Western Ambulance Trust is consistently on the highest level of escalation and responding to unprecedented demand. System-wide Executive System Resilience meetings have been taking place. All our system partners are looking at additional measures to mitigate risks, and the system Quality Surveillance Group has noted the UEC service as high risk. However, all organisations are faced with significantly increased demand and workforce challenges. Our teams across the hospital are working incredibly hard and demonstrating considerable resilience under this pressure. Staffing, particularly nursing remains challenging. Daily staffing meetings are continuing to ensure staffing levels in clinical areas are as safe as possible.
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the information provided.

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to understand the wider strategic and political context, could lead to the Board to make decisions that fail to create a sustainable organisation.
Financial	Y	Failure to address key strategic and operational risks will place the Trust at risk in terms of its financial sustainability.
Impacts Strategic Objectives?	Y	For the Board to operate successfully, it must understand the wider strategic and political context.
Risk?	Y	Failure to understand the wider strategic and political context, could lead to the Board making 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.
Decision to be made?	N	No decision required; this report is for information.
Impacts CQC Standards?	Y	An understanding of the strategic context is a key feature in strategy development and the Well Led domain. Failure to address significant operational risks could lead to staff and patient safety concerns, placing the Trust under increased scrutiny from the regulators.
Impacts Social Value ambitions?	N	No impact on social value ambitions
Equality Impact Assessment?	N	EIA not required; this report is for information
Quality Impact Assessment?	N	QIA not required; this report is for information

Chief Executives Report – September 2021

Strategic Update

National Perspective

NHS England Chief Executive
Amanda Pritchard was confirmed as the new Chief Executive of NHS England, commencing on 01 August 2021 replacing Simon Stevens. She is the first woman in the history of the NHS to hold the post. Prior to commencing in the role Amanda was the NHS' Chief Operating Officer, a role she held for two years.

NHS Improvement Chair
Baroness Dido Harding has announced, in a letter to the Secretary of State Sajid Javid, she will not seek to be reappointed at the end of her four-year term in October. It is expected an interim Chair will be appointed until April 2022.

COVID-19 Response: Autumn and Winter Plan 2021
On 14 September 2021 the Prime Minster announced the Government's plan for autumn and winter 2021 for England, designed to steer the country through this period. The plan includes two plans: Plan A and Plan B.

Plan A includes:

- **Building our defences through pharmaceutical interventions**: vaccines, antivirals, and disease modifying therapeutics.
- **Identifying and isolating positive cases to limit transmission**: Test, Trace, and Isolate.
- **Supporting the NHS and social care**: managing pressures and recovering services.
- **Advising people on how to protect themselves and others**: clear guidance and communications.
- **Pursuing an international approach**: helping to vaccinate the world and managing risks at the border.

Plan B includes:

- Communicating clearly and urgently to the public that the level of risk has increased, and with it the need to behave more cautiously.
- Introducing mandatory vaccine-only COVID-status certification in certain settings.
- Legally mandating face coverings in certain settings.

Plan B will only be enacted if the data suggests further measures are required to protect the NHS.

Local Relevance

Provider Collaboratives
In August NHS England and NHS Improvement (NHSE/I) published guidance on provider collaboratives – Working Together at Scale – outlining expectations for how providers should work together in provider collaboratives, offering principles to support local decision-making and suggestions on the function and forms for systems and providers to consider.

NHSE/I describe provider collaboratives as partnership arrangements involving at least two Trusts working at scale, with a shared purpose, and effective decision-making arrangements. They outline the benefits including reductions in unwarranted variation and health inequalities. Acute providers are expected to be part of one or more provider collaborative by April 2022. Providers and system partners, with support from NHSE/I, will be expected to identify shared goals, objectives, membership, and governance of each provider collaborative. There is also an expectation for defining responsibilities and ways of working between the ICS, places, clinical networks, cancer alliances, and other collaborations. The guidance includes three proposed models adopted by providers to form collaboratives: the provider

leadership board, lead provider, and shared leadership model along with several decision-making mechanisms and required staffing.

Trusts will be expected to support mutual accountability within provider collaboratives although, they will maintain their current accountabilities. NHSE/I are encouraging providers not to delay pursuing greater collaboration within existing legislation whilst the Health and Care Bill is being debated.

Discharge to Assess
On 05 August 2021 NHS Confederation and NHS Providers wrote to the Chancellor of the Exchequer and Secretary of State for Health and Social Care calling for an extension to the dedicated funding for the discharge to assess model into the second half of 2021/22 and a commitment to continue this funding permanently. The letter detailed the benefits of the model demonstrated throughout the pandemic including freeing up hospital beds, reduction in patients staying in hospital over 21 days, supporting people to live well at home, fewer people discharged to bedded setting, and a reduction in new admissions to care homes. Organisations continue to be challenged with delayed discharges however securing this funding would allow further refinement of the discharge to assess model and create stability. The current uncertainly is contributing to staff shortages and sustainability issues for social care providers, increasing delayed discharges.

The financial guidance and regime for the second half of 2021/22 is not expected until mid-September however it is anticipated to broadly continue as per the first half of the year with 3% efficiency savings.

Integrated Care System Lead Recruitment
The recruitment process for Integrated Care Board Chairs and Chief Executives has commenced, led by NHS England and NHS Improvement, ahead of becoming statutory organisations from April 2022. The recruitment process for Chairs is currently at the interview stage with the Chief Executive advert running until 25 September and interviews expected in October. Final confirmation of appointments to the 42 Integrated Care Systems across England is expected to be published at the end of October. Locally, Jenni Douglass-Todd has been confirmed as the Dorset ICS Chair designate and the Chief Executive role is included in the national recruitment.

Overseas Recruitment
To complement the work NHS England are doing on improving retention they have established a guiding group to increase the retention rate of overseas nurses. I have agreed to be a member of this group. Recognising the NHS is going to be reliant on overseas recruitment for many years this important work is being focused on why overseas nurses leave the NHS and putting actions into place to support them to stay. So far, the group have had two meetings focussing on putting in place multiple connected processes and systems in support of internationally recruited people and addressing the systemic, cultural issues that make internationally recruited people more likely to leave.

NHSX's What Good Looks Like Framework
On 31 August 2021, NHSX published the What Good Looks Like Framework outlining digital best practice for Trusts and integrated care systems. The framework was developed following a call from Trust leaders for a common vision of best practice in digital transformation. This guidance supports leaders to digitise, connect, and transform services for both individual organisations and ICS's. There are seven measures of success: well led, ensure smart foundations, safe practice, support people, empower citizens, improve care, and healthy populations. The Dorset system is currently undertaking a gap analysis to highlight any areas of concern.

National People Board
On 02 September 2021, I attended the National People Board meeting. The focus of the conversation was the future People and Workforce Strategy and an update on the Strategy Framework for Workforce Planning.

Additional Funding
On 06 September 2021 the Government announced the NHS would receive an additional £5.4 billion to support the COVID-19 response over the next six months. This includes a further £1 billion Elective Recovery Funding.

On 07 September 2021 the Prime Minister and Secretary of State for Health and Social Care detailed plans to reform the NHS and social care to tackle COVID backlogs, reform adult social care, and bring the health and social care system closer together on a long term, sustainable footing. To fund this reform an increase in National Insurance, by 1.25%, will take place from April 2022. It is expected this increase will generate £12 billion per year on average. From April 2023 onwards National Insurance contributions will return to 2021/22 tax year levels and a 1.25% Health and Social Care Levy will be introduced. Our Finance Teams are working through the impact of the National Insurance employer contribution increase.

NHS Confederation and NHS Providers both welcomed the additional funding but warned it is not enough to deal with the impact of the pandemic and rising demand on the NHS, leaving a funding gap for next financial year. Both organisations published a report, in early September, estimating the funding necessary for next financial year, which equated to an additional £10 billion of revenue funding needed to clear the elective backlog and provide a sustainable solution for social care.

Equality, Diversity, and Inclusion
On 08 September 2021, I attended the South West Leading for Inclusion Programme along with many of my Chief Executive colleagues across the Region. The day focussed on creating a community of Chief Executives through sharing lived experiences, taking a deeper look at issues of race, power, privilege, and equity, and understanding how these present. The group also looked at change models and frameworks moving away from traditional transactional methods, and we discussed our collective vision. Collaborative action groups are being formed to continue this journey with a further date planned in November.

Our internal Inclusive Leadership Programme continues. I am very proud of the staff engagement and participation in this programme. The second 'seeing differently' session took place in July with a focus on social rank and power. The 'responding differently' sessions commenced this month with the first one focussing on the relationship between intent and impact and the fact that unintended impact can have an adverse effect on someone for many years.

In August the HSJ published an article sharing our approach to building a culture of inclusion by ensuring our people have the knowledge, perspectives, and skills to lead in different, transformational ways.

Mandatory Vaccination for Frontline Health and Care Staff
On 09 September 2021 the Government launched an open consultation seeking views on the proposal to mandate COVID-19 and Flu vaccinations for frontline health and care staff in England unless medically exempt. The consultation will run for a six-week period looking at whether requirements should apply for health and wider social care workers in contact with patients and people receiving care. Views will be gathered regarding any impact on staffing and safety such as reducing staff sickness absence. Staff, healthcare providers, stakeholders, patients, and their families are being urged to take part to have their views heard, with a final decision expected this winter. The consultation closes on 22 October 2021.

COVID Booster Vaccinations
Our Hospital Vaccination Hub will be restarting during the first week of October to provide booster doses of the COVID vaccination to health and social care staff. The hub is expected to be operational until mid-December.

Integrated Care Partnership Engagement Document
The Department of Health and Social Care published the Integrated Care Partnership (ICP) engagement document on 15 September 2021. The document expands on the role that ICPs will play within statutory arrangements for ICSs. This includes producing an integrated care strategy for their area, agreeing collective objectives, and facilitating joint action on health outcomes and the wider determinants of health. It positions ICPs as a critical part of ICSs and builds on NHSE/I's ICS design framework to provide more detail on the expectations of ICPs, as well as the timing of implementation.

The aim of the document is to assist systems in preparing to establish ICPs from April 2022 and consider what arrangements may work best in their area. This includes agreeing the ICP's resourcing, membership, and priorities. The expectation is for all system to have, at least, interim ICPs up and running for April 2022 with the hope that all ICPs will have built a stable membership by September 2022.

Integrated care board chairs are expected to ensure:

- The NHS and local authorities start the process this month of creating an ICP in preparation for legislation.
- NHS and local authority leaders agree how the ICP will be established, and a secretariat resourced at least during 2021/22.
- Statutory ICP partners come together as required to oversee ICP set up, including engagement with stakeholders, by November 2022.
- ICP chairs are appointed by a transparent decision-making process by February 2022. DHSC does not propose to set national expectations for the appointment, remuneration or person specification of the ICP chair.
- Key questions for the system to resolve are determined by April 2022.

Further detail is provided on how ICPs and place-based partnerships will work together to deliver their priorities, including the need for a mechanism to determine which issues are dealt with where in the system. ICPs should not overrule or replace existing place-based plans.

The document also explores the relationship between Integrated Care Boards and ICPs, including the importance of ensuring the governance is aligned, sharing intelligence, and considering how assurance can be provided to the ICP on delivery. It formally initiates a process of co-production and engagement with the health and care sector to identify examples of good practice for ICPs.

DCH Performance

Emergency Demand
The hospital continues to experience significant non-COVID emergency demand resulting in very high bed occupancy rates. This picture is mirrored across our system partners. South Western Ambulance Trust is consistently on the highest level of escalation and responding to unprecedented demand. System-wide Executive System Resilience meetings have been taking place. All our system partners are looking at additional measures to mitigate risks, however, all organisations are faced with significantly increased demand and workforce challenges. I am both proud of and thankful to our teams, both clinical and non-clinical, across the hospital who are working incredibly hard and demonstrating considerable resilience under this pressure. Staffing, particularly nursing remains challenging. Daily staffing meetings are continuing to ensure staffing levels in clinical areas are as safe as possible.

Pathology Laboratory Information Management System
August saw the 'go live' for our new Pathology Laboratory Information Management System (LIMS). This has been a significant project for the Pathology and IT teams and the outcome will be a joint system with our colleagues at University Hospitals Dorset, and later, across the wider South Six Pathology Network which includes Southampton, Hampshire, Portsmouth, Isle of Wight, and Salisbury. The benefits include improved flow of samples between laboratories and improved speed and accessibility of results.

Afghanistan
Dorset Council have been identified as a receiving authority for those coming to the UK from Afghanistan. I have been having conversations with colleagues at Dorset Council to establish how the hospital can support in terms of employment and accommodation. Given our challenges around accommodation the Council are looking for anyone who has a second home they are willing to offer to refugees from Afghanistan. In terms of employment, those coming from Afghanistan have been given 'vulnerable' status and so are able to work immediately on arrival. We will offer some dedicated recruitment fayres to see if we can match individuals to vacancies we have.

Strategic Outline Case
August saw a significant milestone in our Estates Master Plan. We received confirmation our Strategic Outline Case for our new Emergency Department, Intensive Care Unit, and Integrated Hub was approved by the Joint Investment Committee of the Department of Health and Social Care and NHS England. Thank you to everyone involved in this programme, particularly Nick Johnson, Deputy chief Executive, who has provided senior leadership.

Strategy and Transformation Senior Leadership Group Meeting
Following the finalising of the Trust Strategy the first meeting of the Strategy and Transformation Senior Leadership Group took place on 01 September. This specific SLG meeting has been established to oversee the delivery of the Trust Strategy and focus on strategic and transformation proposals and programmes. We are currently establishing the delivery mechanisms therefore the meeting heard about the draft three-year strategic delivery plan and the development of the enabling Clinical Strategy and People Strategy.

Wellbeing Walk Arounds
Staff wellbeing remains one of our top priorities. The Wellbeing Walkarounds have been reinstated to help staff feel supported, cared for, and ensure their voices are heard – prioritising Health and Wellbeing. The Walkarounds will visit departments across the hospital and consist of two to four staff members, led by Mental Health First Aiders. An Executive Director is joining the walkarounds once a month.

GEM Awards
Our Going the Extra Mile (GEM awards) were launched in August and closed earlier this month. The awards recognise both staff and volunteers who go over and above what is expected to make a difference to people's lives. Over the last 18 months everyone who works in the NHS has gone over and above to provide the best possible patient experience at a very difficult time and continues to do so as we respond to unprecedented demand for services. The GEM Awards 2021 will be a night of celebration to honour the dedication and commitment of staff and volunteers to DCH that colleagues, patients, their friends, and family feel have made a standout difference. The awards evening will also recognise those staff receiving their 25-year NHS Long Service Award. The awards ceremony is expected to take place on Friday 12 November 2021 at Kingston Mauward.

Patricia Miller
Chief Executive

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**29 September 2021**
Document Title:	**Performance Scorecard and Board Sub-Committee Escalation Reports**
Responsible Director:	**Executive Team**
Author:	**Abi Baker, Governance Support Officer**

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee (performance metrics)	21 September 2021	See committee escalations

Purpose of the Paper	To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance Scorecard** Key areas for operational standards in July 2021: The Trust did meet the standard for: • 52+ week wait trajectory • 31 Days for 1st treatment and subsequent treatment (drugs) The Trust did not meet the standards for: • Zero 52 week waits • Zero 104 week waits • RTT performance percentage • Diagnostic Waiting Times • ED, DCH only and Combined with MIU • All Cancers - 62 Day Referral to Treatment following an urgent GP referral • Two week wait from referral to first seen • Breast Symptomatic Two Week Wait from urgent GP referral to first seen • All Cancers - 31 Day Subsequent Treatment (Surgery) Looking forward to September 2021, it is anticipated that DCH will meet the standards for: • Cancer 31 days (except surgery) • 52+ week wait trajectory DCH will not meet the standard in September for: • RTT • The RTT waiting list size trajectory							

	• Diagnostic Waiting Times • ED – 4 hour standard combined with MIU • Cancer 62 day standard • Cancer two week wait standard • Cancer Breast symptomatic 2 week wait • Zero 52 week waits • Zero 104 week waits • Cancer- 31 day where treatment is surgery **Escalation Reports** The September Board sub-committees met as follows: Monday 20 September: People and Culture Committee Tuesday 21 September: Quality Committee, Finance and Performance Committee, Risk and Audit Committee. The attached reports detail the significant risks and issues for escalation to Board for action, key issues discussed, decisions made, implications for the Corporate Risk Register and Board Assurance Framework (BAF), and items for referral to other committees, arising from each of the Board sub-committee meetings.
Action recommended	The Board of Directors is requested to: 1. **NOTE** the performance data 2. **NOTE** the escalations from the Board sub-committees.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	N	
Impacts Strategic Objectives?	Y	Operational performance and corporate governance underpins all aspects of the Trust's strategic objectives.
Risk?	Y	Implications for the Corporate Risk Register or the Board Assurance Framework (BAF) are outlined in the escalation reports.
Decision to be made?	N	Details of decisions made are outlined in the committee escalation reports.
Impacts CQC Standards?	Y	Operational performance and governance underpins all aspects of the CQC standards.
Impacts Social Value ambitions?	Y	Operational performance and corporate governance underpins all aspects of the Trust's social value ambitions.
Equality Impact Assessment?	N	N/A
Quality Impact Assessment?	N	N/A

Metric	Threshold/ Standard	Type of Standard	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Q1	YTD	Movement on Previous Period	12 Month Trend
Safe												
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	**1 (0.1)**	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	Contractual (National Quality Requirement) 2019/20	2 (0.3)	4 (0.5)	**3 (0.4)**	**4 (0.5)**	**2 (0.2)**	**2 (0.2)**	**9 (0.4)**	**11 (0.3)**	↔	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	2	0	0	0	0	2	0	2	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	0	11	11	5	10	7	26	33	**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**	Local Plan	**2**	1	**2**	1	**3**	**3**	**6**	**9**	↔	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	1 (0.1)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	2 (0.2)	3 (0.1)	3 (0.1)	↓	
Emergency caesarean section rate			20.9%	22.3%	20.1%	26.2%	21.6%	17.5%	22.6%	21.9%	↑	
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)	96.0%	95.1%	100%	90.5%	N/A	N/A	N/A	94.6%	↓	
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)	95.7%	95.7%	96.0%	96.6%	**88.9%**	97.7%	92.6%	94.1%	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**57.9%**	**82.1%**	**83.3%**	**88.5%**	N/A	N/A	N/A	**86.4%**	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**84.2%**	94.6%	**84.2%**	**88.9%**	**88.0%**	**89.2%**	**87.5%**	**88.0%**	↑	
Effective												
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3**	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]	**≤1.14 (ratio between**	Contractual (Local Quality Requirement)	**1.14**	**1.14**	N/A	N/A	N/A	N/A	N/A	N/A	↔	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**107.3**	**106.3**	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**101.4**	97.6	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	B		N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	**70.5%**	**54.5%**	**59.8%**	**58.5%**	**56.4%**	**64.6%**	**58.3%**	**60.0%**	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	97.5%	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)	**88.0%**	**60.6%**	**83.3%**	**85.7%**	**60.0%**	90.9%	**80.9%**	**82.3%**	↑	
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	22	38	21	16	27	32	64	96	↓	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	**94.6%**	**94.9%**	**94.5%**	**93.9%**	**93.2%**	**94.2%**	**93.9%**	**93.9%**	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	89.7%	90.1%	88.0%	87.6%	85.4%	85.8%	86.9%	86.6%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**93.3%**	94.6%	**93.0%**	94.2%	**93.6%**	**91.9%**	**93.6%**	**93.2%**	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per**	Local Plan (2016/17 outturn)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	

Metric	Threshold/ Standard	Type of Standard	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Q1	YTD	Movement on Previous Period	12 Month Trend
Responsive												
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position)	**92%**	Contractual (National Operational Standard)	**50.5%**	**50.9%**	**51.5%**	**54.6%**	**56.4%**	**57.1%**	**56.4%**	**57.1%**	↑	
RTT Incomplete Pathway Waiting List size	**Trajectory July = 17711**		16,162	16,853	17,194	**17666**	**17928**	**18505**	**17928**	**18505**	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**76.0%**	**79.1%**	**69.1%**	**78.0%**	**56.0%**	**56.0%**	**67.0%**	**64.3%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**27.5%**	**29.3%**	**0.0%**	**3.7%**	**8.3%**	**9.4%**	**32.8%**	**5.6%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	**93.1%**	97.7%	96.7%	97.7%	**93.8%**	**94.1%**	96.1%	**95.6%**	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	**77.8%**	100.0%	**77.8%**	100.0%	100.0%	**93.9%**	94.6%	↔	
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)	-	-	-	-	-	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**67.7%**	**83.9%**	**81.0%**	**74.0%**	**74.2%**	**72.4%**	**76.5%**	**75.6%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	100.0%	**71.4%**	**62.5%**	**83.3%**	**57.6%**	**80.0%**	**32.8%**	**69.0%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**82.5%**	**79.9%**	**80.0%**	**80.4%**	**82.4%**	**85.4%**	**81.0%**	**82.1%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**79.2%**	**81.0%**	**80.7%**	**74.5%**	**71.1%**	**64.0%**	**75.2%**	**72.4%**	↓	
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)	**88.5%**	**90.3%**	**86.6%**	**82.6%**	**80.0%**	**76.9%**	**82.9%**	**81.3%**	↓	
Well Led												
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	**4.03%**	3.13%	3.08%	3.33%	**3.83%**	N/A	**3.4%**	**3.4%**	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	**76%**	**76%**	**77%**	**79%**	**78%**	**76%**	**78%**	**78%**	↓	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	7.7%	7.7%	7.7%	8.3%	8.1%	8.3%	8.0%	8.1%	↓	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,720.6	2,781.5	2,798.5	2771.36	2,801.8	2,765.2	2,790.6	2,790.6	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**5.7%**	**6.4%**	**6.6%**	**7.8%**	**7.7%**	**7.6%**	**7.4%**	**7.4%**	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**10,978.2**	**18,872.1**	**11,215.1**	**11,068.2**	**11,064.0**	**11,004.0**	**11,141.7**	**11,087.8**	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	2	0	2	2	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**87%**	**88%**	**87%**	**88%**	**88%**	**88%**	**88%**	**88%**	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584**		**1,865**	**2,434**	**2,012**	**2,185**	**2,284**	**2,134**	**6,481**	**8,615**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866**		**£1,468,667**	**£2,207,635**	**£2,027,512**	**£2,270,086**	**£2,431,382**	**£2,230,104**	**£6,728,980**	**£8,959,084**	↓	
Surplus/(deficit) (year to date)	**2021/22 = Breakeven**	Local Plan	(805)	387	**(502)**	**(693)**	**(717)**	**(602)**	**(717)**	**(602)**	**N/A**	**N/A**
Cash Balance	**2021/22 - M4 = 14,083**		29,286	17,698	17,900	16,319	15,841	17,527	15,841	17,527	↑	
CIP - year to date (aggressive cost reduction plans)	**No target for the first qtr of**	Local Plan	Yet to be decided	Yet to be decided	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	**N/A**
Agency spend YTD	**2021/22 = No Annual value**		8,985	**1,398**	**1,031**	**2,109**	**3,206**	**4,272**	**3,206**	**4,272**	**N/A**	**N/A**
Agency % of pay expenditure			**6.7%**	**6.7%**	**7.9%**	**8.4%**	**8.6%**	**8.4%**	**8.3%**	**8.3%**	↑	

Movement Key

Favourable Movement ↑
Adverse Movement ↓
No Movement ↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Jun-21	Jul-21
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)	**81**	2 (0.2)	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**16**	**2 (0.2)**	**2 (0.2)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	1	3
	SHMI - Rolling 12 months, 4 months in arrears (Oct-19 to Sep-20)	**<1.14**	**1.14**	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Nov-19 to Oct-20)	**100**	**106.3**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**56.4%**	**57.1%**
	RTT Incomplete Pathway Waiting List size	**Trajectory July = 17711**	**17,928**	**18,505**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**74.2%**	**72.4%**
	Maximum 6 week wait for diagnostic tests	**99%**	**82.4%**	**85.4%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**80.0%**	**76.9%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,431,382**	**2,230,104**
	Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M4 = £(310)**	**(717)**	**(602)**
	CIP - year to date (aggressive cost reduction plans)	**No target for the first qtr of the year**	N/A	N/A
	Agency spend YTD	**2021/22 = No Annual value YTD M4 = £2,142**	**3,206**	**4,272**

Rating Key

Metric	Threshold/ Standard	Type of Standard	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Q1	Q2	YTD	Movement on Previous Perior	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)	**1 (0.1)**	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	Contractual (National Quality Requirement) 2019/20	2 (0.3)	4 (0.5)	**3 (0.4)**	**4 (0.5)**	**2 (0.2)**	**2 (0.2)**	**5 (0.6)**	**9 (0.4)**	**7 (0.4)**	**16 (0.4)**	↓	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	2	0	0	0	0	2	0	0	2	2	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	0	11	11	5	10	7	0	26	7	33	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	0	0	0	**N/A**	
NRLS - Number of patient safety risk events reported resulting in severe harm or death	**10% reduction 2016/17 = 21.6 (1.8 per mth)**	Local Plan	**2**	1	**2**	1	**3**	**3**	**3**	**6**	**6**	**12**	↔	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	1 (0.1)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	2 (0.2)	0 (0.0)	1 (0.0)	2 (0.1)	3 (0.1)	↑	
Emergency caesarean section rate			20.9%	22.3%	20.1%	26.2%	21.6%	17.5%	N/A	22.6%	N/A	21.9%	↑	
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)	96.0%	95.1%	100%	90.5%	N/A	N/A	N/A	N/A	N/A	95.0%	↓	
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)	95.7%	95.7%	96.0%	96.6%	**88.9%**	97.7%	**89.5%**	92.6%	93.9%	93.2%	↓	
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)	**57.9%**	**82.1%**	**83.3%**	**88.5%**	N/A	N/A	N/A	N/A	N/A	**84.9%**	↑	
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)	**84.2%**	94.6%	**84.2%**	**88.9%**	**88.0%**	**89.2%**	100%	**87.5%**	93.5%	**89.9%**	↑	
Effective														
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	**1**	**1**	**1**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.14 (ratio between observed deaths and**	Contractual (Local Quality Requirement)	**1.14**	**1.14**	**1.16**	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)	**107.3**	**106.3**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**101.4**	97.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	B		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	**70.5%**	**54.5%**	**59.8%**	**58.5%**	**56.4%**	**64.6%**	**63.7%**	**58.3%**	**64.2%**	**60.7%**	↓	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	Contractual (Local Quality Requirement)	**88.0%**	**60.6%**	**83.3%**	**85.7%**	**60.0%**	90.9%	**85.7%**	**80.9%**	**88.0%**	**82.8%**	↓	
Caring														
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	22	38	21	16	27	32	48	64	80	144	↓	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	**94.6%**	**94.9%**	**94.5%**	**93.9%**	**93.2%**	**94.2%**	**92.5%**	**93.9%**	**93.4%**	**93.7%**	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	89.7%	90.1%	88.0%	87.6%	85.4%	85.8%	82.7%	86.9%	84.4%	85.9%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**93.3%**	94.6%	**93.0%**	94.2%	**93.6%**	**91.9%**	**92.8%**	**93.6%**	**92.4%**	**93.1%**	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	

Metric	Threshold/ Standard	Type of Standard	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Q1	Q2	YTD	Movement on Previous Period	12 Month Trend
Responsive														
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position)	**92%**	Contractual (National Operational Standard)	**50.5%**	**50.9%**	**51.5%**	**54.6%**	**56.4%**	**57.1%**	**57.2%**	**56.4%**	**57.2%**	**57.2%**	↑	
RTT Incomplete Pathway Waiting List size	**Trajectory Aug = 17812**		16,162	16,853	17,194	**17666**	**17928**	**18505**	**19089**	**17928**	**19089**	**19089**	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**76.0%**	**79.1%**	**69.1%**	**78.0%**	**56.0%**	**55.8%**	**44.1%**	**67.0%**	**49.2%**	**59.5%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**27.5%**	**29.3%**	**0.0%**	**3.7%**	**8.3%**	**9.4%**	**9.4%**	**32.8%**	**75.0%**	**6.1%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	**93.1%**	97.7%	96.7%	97.7%	**93.8%**	97.3%	97.2%	96.1%	97.3%	96.5%	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	**77.8%**	100.0%	**77.8%**	100.0%	100.0%	100.0%	**93.9%**	**75.0%**	96.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	-	-	-	-	-	-	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**67.7%**	**83.9%**	**81.0%**	**74.0%**	**74.2%**	**74.0%**	**71.2%**	**76.5%**	**72.6%**	**75.0%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	100.0%	**71.4%**	**62.5%**	**83.3%**	**57.6%**	**80.0%**	**68.8%**	**32.8%**	**75.0%**	**68.9%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**82.5%**	**79.9%**	**80.0%**	**80.4%**	**82.4%**	**85.4%**	**86.3%**	**81.0%**	**85.8%**	**82.9%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**79.2%**	**81.0%**	**80.7%**	**74.5%**	**71.1%**	**64.0%**	**61.0%**	**75.2%**	**62.5%**	**70.2%**	↓	
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)	**88.5%**	**90.3%**	**86.6%**	**82.6%**	**80.0%**	**76.9%**	**75.3%**	**82.9%**	**76.1%**	**80.1%**	↓	
Well Led														
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	**4.03%**	3.13%	3.08%	3.33%	**3.83%**	**4.18%**	NA	**3.4%**	**4.18%**	**3.6%**	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	**76%**	**76%**	**77%**	**79%**	**78%**	**76%**	**75%**	**78%**	**76%**	**77%**	↓	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	7.7%	7.7%	7.7%	8.3%	8.1%	8.3%	8.2%	8.0%	8.3%	8.1%	↑	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,720.6	2,781.5	2,798.5	2771.36	2,801.8	2,765.2	2,790.0	2,790.6		2,790.6	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**5.7%**	**6.4%**	**6.6%**	**7.8%**	**7.7%**	**7.6%**	**6.8%**	**7.4%**	**7.2%**	**7.3%**	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**10,978.2**	**18,872.1**	**11,215.1**	**11,068.2**	**11,064.0**	**11,004.0**	**11,385.9**	**11,141.7**		**11,147.4**	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	2	0	0	2	0	2	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**87%**	**88%**	**87%**	**88%**	**88%**	**88%**	90%	**88%**	**89%**	**88%**	↑	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**1,865**	**2,434**	**2,013**	**2,185**	**2,284**	**2,123**	**1,944**	**6,482**	**4,067**	**10,549**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£1,468,667**	**£2,207,635**	**£2,028,333**	**£2,270,086**	**£2,450,198**	**£2,318,694**	**£1,868,383**	**£6,748,617**	**£4,187,077**	**£10,935,694**	↓	
Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M4 = £(310)**	Local Plan	(805)	387	(502)	(693)	(717)	(602)	(570)	(717)	(570)	(570)	**N/A**	**N/A**
Cash Balance	**2021/22 - M5 = 13,496**		29,286	17,698	17,900	16,319	15,841	17,527	16,964	15,841	16,964	16,964	↓	
CIP - year to date (aggressive cost reduction plans)	**No target for the first qtr of the year**	Local Plan	Yet to be decided	Yet to be decided	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	**N/A**
Agency spend YTD	**2021/22 = No Annual value YTD M4 = £2,142**		8,985	**1,398**	**1,031**	**2,109**	**3,206**	**4,272**	**5,375**	**3,206**	**5,375**	**5,375**	**N/A**	**N/A**
Agency % of pay expenditure			**6.7%**	**6.7%**	**7.9%**	**8.4%**	**8.6%**	**8.4%**	**8.4%**	**8.3%**	**8.4%**	**8.3%**	↔	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Jul-21	Aug-21
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)	**81**	1 (0.1)	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	**2 (0.2)**	**5 (0.6)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	3	0
	SHMI - Rolling 12 months, 4 months in arrears (May-20 to Apr-21)	**<1.14**	**1.16**	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-20 to Mar-21)	**100**	**106.3**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**57.1%**	**57.2%**
	RTT Incomplete Pathway Waiting List size	**Trajectory Aug = 17812**	**18,505**	**19,089**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**74.0%**	**71.2%**
	Maximum 6 week wait for diagnostic tests	**99%**	**85.4%**	**86.3%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**76.9%**	**75.3%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,318,694**	**1,868,383**
	Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M4 = £(310)**	**(602)**	**(570)**
	CIP - year to date (aggressive cost reduction plans)	**No target for the first qtr of the year**	N/A	N/A
	Agency spend YTD	**2021/22 = No Annual value YTD M4 = £2,142**	**4,272**	**5,375**

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee (formerly Workforce Committee)

Date of Meeting: 16th August 2021

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	The committee: • Supported the Young Volunteers Strategy that reaffirmed the Trust's commitment to the Youth Charter and provided opportunities for young people that otherwise may not engage with the NHS; • Commended the work and outcomes within the disciplinary process and lived experience review that would be used to inform future policy; • Noted the relatively short period of shadowing and induction into the NHS for junior overseas doctors; • Noted the low Quarterly Staff Survey response rate; • Expressed concern at the number of staff leaving DCH within 12 months of joining the Trust.
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • People Performance Report and Dashboard • NHS People Plan tracker • Estates and Facilities Quality Update • Family and Surgical Services Divisional Report • Health and Wellbeing Activity Report • Education Report • Disciplinary Process and Lived Experience Report • Medical and Dental Local Negotiating Committee Escalation Report • ED&I Steering Group Escalation Report • There were no 'Red Flag' safe staffing incidents.
Decisions made by the Committee	• The Committee approved recommendations within the Dorset and Young People Strategy. • The Health Informatics Workforce Report was deferred until September.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Workforce risks noted arising from two key members of the Estates and Facilities small team • Risks arising from a predominantly older Estates and Facilities workforce approaching retirement.
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 17th August 2021

Presented by: Judy Gillow/Nicky Lucey

Significant risks / issues for escalation to Committee / Board for action	• The Quarter 1 Learning from Deaths Report was recommended to the Board for publication. • Sub-optimal performance in respect to pressure ulcers • Benchmarking activities in relation to falls incidents • Electronic Discharge and work in exploring alternative digital solution means ongoing delays in summaries to primary care until solution found. • SHMI deterioration and related coding delays

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting DCH's outlying position in respect to pressure ulcers
	• Noted the work being undertaken reference benchmarking falls.
	• Maternity Safety Update noting progress in delivering the Ockenden Action Plan and the learning from the Sheffield Maternity service review.
	• Quarter 1 Learning from Deaths Report noting a deterioration in the SHMI.
	• Transformation Update
	• Divisional Exception Report from
	  ○ Urgent and Integrated Care Division included a comprehensive deep dive on Stroke Services
	  ○ Family and Surgical Services Division
	• Chief Medical Officer's Update included
	  ○ Electronic Discharge Summaries noting the planned implementation of a new digital solution in March 2022
	  ○ National changes to the Dementia Screening requirement
	• Paediatric Peer Review Action Plan Update
	• Urgent and Emergency Care Survey results 2020
	• Inpatient Survey results 2020
	• Sub-Committee Minutes and Escalations from Infection Prevention and Control Group
	• Workforce Quality and Safety Indicator triangulation

Decisions made by the Committee	• The Learning from Deaths Quarter 1 Report was recommended to the Board for publication. • Updates on Stroke services would be provided quarterly going forward and any deterioration in performance / issues risks would be escalated in the interim as necessary • The Complaints / Patient Experience Annual Report was deferred to the September meeting. • Support for revised reporting format for the quality and safety performance report
Implications for the Corporate Risk	• Nil new

Register or the Board Assurance Framework (BAF)	
Items / issues for referral to other Committees	• Coding - impact being triangulated with Finance and Performance Committee

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 17th August 2021

Presented by: Stephen Tilton

Significant risks / issues for escalation to Board for action	• Increasing urgent and emergency care activity pressures arising from increasing demand and increasing patient flow difficulties with an associated negative impact on elective activity

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report noting:
	  ○ Continued and increasing pressures arising from non-elective activity and deteriorating emergency and ambulance standards subsequently;
	  ○ High bed occupancy rates were compounded by a significant number of patients remaining in hospital with no reason to reside despite maximising mitigations;
	  ○ The number of patients waiting 52 weeks and over had reduced;
	  ○ Work being undertaken to support timely Coding activity.
	• Elective Programme Management Group Update noting the increased threshold for Elective Recovery Funding that had not been achieved.
	• Finance Report noting the in month generation of a small surplus and a small reduction in Agency expenditure. The Year To Date position £0.3m behind plan.
	• Significant system and DCH Underlying Deficit positions.
	• Updated Capital Programme following system requested reductions and the inclusion of locally determined schemes following risk assessment.
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care noting that the Laboratory Information System had gone live that day concluding three years of work
	  ○ Family Services and Surgical Services noting action to maximise anaesthetic team capacity and recruitment activity
	• DCH Subco Escalation Report

Decisions made by the Committee	The following items were approved by the committee: • A proposal for future Outpatient Therapy provision proposal was approved and recommended to the Board for the purchase of a new off-site property. • Pathology MES Contract award (Lot 3) • Revised Capital Plan
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Increasing urgent and emergency care activity pressures arising from increasing demand and increasing patient flow difficulties with an associated negative impact on elective activity
Items / issues for referral to other	• Nil new

Committees	

Escalation Report

Executive / Committee: People and Culture Committee (formerly Workforce Committee)

Date of Meeting: 20th September 2021

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Extreme workforce and work load pressures within Digital teams.

Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports:
	• People Performance Report and Dashboard noting
	  ○ Plans to reopen the COVID Vaccination Hub for staff vaccinations in October;
	  ○ Increased levels of sickness absence
	  ○ Commencement of the newly appointed Freedom to Speak Up Guardian
	  ○ A review of reasons for staff leaving the Trust's employment
	• Health Informatics Workforce Report highlighting extreme pressures across the Digital teams
	• Urgent and Emergency Care Divisional Report
	• Staff Communication and Engagement Plan to promote greater participation in the national staff survey
	• Transforming People Practices Progress Update including:
	  ○ Updates on values based and inclusive recruitment approaches and ethical international recruitment
	  ○ Review of key HR policies that promote a 'Just' culture

Decisions made by the Committee	• None
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 21st September 2021

Presented by: Judy Gillow/Nicky Lucey

Significant risks / issues for escalation to Committee / Board for action	• The use of 'Socially Distant Bed Spaces' in extremis. • Staffing pressures across all disciplines of staff • Maternity divert due to staffing pressures • The infection Prevention and Control Annual Report is recommended to the Board.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Implementation of new Infection Prevention and Control metrics
	  ○ Changes to the Clostridium Difficile trajectory targets and system working to ensure antibiotic stewardship
	• Maternity Safety Update noting risks due to staff sickness absence, the need to escalate to divert and an increasing number of complaints.
	• A Review of the risk assessment for Socially Distance Beds
	• The Infection Prevention and Control Annual Report reflected the excellent work of teams across the hospital in maintaining standards and reducing outbreaks through a particularly difficult year.
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting that the Emergency Department remained within the top 10 for patient experience despite increased activity demands
	  ○ Family and Surgical Services Division noting increased need to use mixed sex accommodation
	• Complaints / Patient Experience Annual Report noting the increasing complexity of complaints over the reporting period and the planned introduction of a new complaints system across Dorset. Communication issues are a consistent theme.
	• Sub-Committee Minutes and Escalations from
	  ○ Clinical Practice Group
	  ○ Safeguarding Group
	  ○ Electronic Systems

Decisions made by the Committee	• Approved the use of socially distance beds in extremis, as per the risk assessment. • Approved the Infection Prevention and Control Annual Report
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 21st September 2021

Presented by: Ian Metcalfe (Vice Chair)

Significant risks / issues for escalation to Board for action	• The Winter Plan, outlining contingency proposals and plans to promote patient flows and release capacity, is recommended to the Board. The plan includes proposals to invest £213k to implement a Key Worker Programme. • Multi-storey Car Park Capital Departmental Expenditure Limit (MSCP CDEL) impact • The Anaesthetic Machine Replacement Programme is recommended to the Board for approval.

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report noting:
	  ○ Continued urgent and emergency care activity increases
	  ○ Continued pressure on waiting lists resulting from increased referral rated
	• Elective Programme Management Group Update noting
	  ○ Continued high bed occupancy rates and increasing patient acuity
	  ○ Ongoing inequalities review of waiting lists
	• Healthcare Tender Waiver
	• Finance Report noting
	  ○ £400k variance from plan year to date.
	  ○ Elective Recovery Fund – challenges to income
	  ○ Clinic coding update
	  ○ H2 planning guidance was expected imminently with a significant efficiency target expected
	• National Cost Collection Index Outcomes
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care noting continued good performance in the Emergency Department despite increased activity level and a high percentage of inpatients awaiting discharge
	  ○ Family Services and Surgical Services focus on elective recovery and maintaining cancer standards
	• Strategic Estates Master Plan Update
	• ED 15 Bi-Monthly Update noting potential risks arising from construction inflation and supply chain issues and increasing demand for the service over the winter period.
	• Multi-storey Car Park update noting consideration of further fire safety measures and the Capital Departmental Expenditure Limit (MSCP CDEL) impact

Decisions made by the Committee	The following items were approved by the committee: • KPI Health Tender Waiver • Winter Plan • Anaesthetic Machine Replacement Programme

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Risks are contained within the Risk Register
Items / issues for referral to other Committees	• Nil new

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 21st September 2021

Presented by: Ian Metcalfe

Significant risks / issues for escalation to Board for action	• Annual Emergency Preparedness, Resilience and Response (EPRR) self-assessment and Statement of compliance are recommended to the Board. • The Charity Risk Policy is recommended to the Trustees for approval. • The refreshed Policy for the Engagement of External Auditors in Non-Audit Services is recommended for approval • Further discussion by the Board in respect of cyber security risks – planned for part 2 Board, September 2021. • Policy for the Engagement of External Auditors in Non-Audit Services
Key issues / other matters discussed by the Committee	The committee received and noted the following reports: • Internal Audit Progress Report and follow up recommendations • External Audit Progress and Technical Updates and Benchmarking • Remaining Unfunded Capital Schemes noting explanation and complexity of the risk assessment process applied to decisions. • Annual EPRR Core Standards Self-Assessment and Statement • Charity Risk Policy • Policy for the Engagement of External Auditors in Non-Audit Services • Review of Effectiveness of External Audit – Internal and External Auditors were excluded from this discussion. • Information Governance Group noted priority areas of work to ensure compliance with the Data Saecurity and Protection Toolkit requirements.
Decisions made by the Committee	The committee approved the following: • Amendments to the Internal Audit Plan • Annual EPRR Core Standards Self-Assessment and Statement • Charity Risk Policy • Policy for the Engagement of External Auditors in Non-Audit Services
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Corporate Risk Register was discussed which challenged to the relatively low scoring of digital and cyber security risks and the timing for completion of mitigating actions • Discussion of the Board Assurance Framework (BAF) noted the need to more clearly articulate and define risks within the refreshed version of the BAF in line with the refreshed strategy.
Items / issues for referral to other Committees	• None

Meeting Title:	Board Meeting
Date of Meeting:	29 September 2021
Document Title:	**Benchmarking exercise against the CQC report for The Jessop Wing at Sheffield Teaching Hospitals**
Responsible Director:	Nicky Lucey, CEO
Author:	Jane Hall, Maternity Matron, presented by Jo Hartley, Associate Director of Midwifery and Neonatal Services

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	August 17th 2021	

Purpose of the Paper								
	Note (✓)	✓	*Discuss*		*Recommend*		*Approve (✓)*	✓
Summary of Key Issues	The CQC carried out an unannounced focused inspection following information that highlighted concerns about the safety and quality of the service at the Jessop Wing Maternity Unit in Sheffield. Following the inspection, under Section 31 of the Health and Social Care Act 2008 the CQC imposed urgent conditions on the registration of the provider in respect to the regulated activity; Maternity and midwifery services. The enclosed paper compares the areas of concern highlighted during the CQC inspection of the Maternity Unit – Jessop Wing Sheffield with the Maternity Service provided at Dorset County Hospital. Overall DCH benchmarked positively against the recommendations Areas that require further work for DCH maternity: • Mandatory training • Baby Abduction policy – no drill for >3 years • Checking of adult resuscitation trolley daily • PAT testing evidence on all appliances • Assurance that neonatal crash trolley checked daily • Introduction of formal triaging tool required • Women waiting too long to be seen in ANDAU • Unable to fully recruit into BR plus safe staffing recommendations • Documentation of drugs remains paper-based currentl							
Action recommended	The Trust Board is recommended to: 1. **NOTE** the report 2. **APPROVE** the contents							

Governance and Compliance Obligations

Legal / Regulatory	Y	Safety and quality in maternity services remains very high on the national agenda with several Trusts receiving critical CQC reports in the last few months and others under national scrutiny
Financial	Y	The refund of 10% of the CNST Incentive Scheme, if awarded will be assigned to the Maternity budget with a focus on improving safety
Impacts Strategic Objectives?	Y/N	
Risk?	Y	There are risks around safe staffing levels and mandatory training. The drill for baby abduction is planned for the Autumn.
Decision to be made?	N	
Impacts CQC Standards?	Y	As above
Impacts Social Value ambitions?	Y/N	
Equality Impact Assessment?	Y/N	
Quality Impact Assessment?	Y/N	

Report to benchmark the Maternity Service at DCH compared to the Maternity Service at The Jessop Wing at Sheffield Teaching Hospitals following their CQC assessment in March 2021.

The Jessop Wing Maternity Unit opened in 2001 with approximately 6,200 births every year. There is a 22 bed labour ward, one antenatal ward, an admission triage area, an advanced obstetric care unit. One of the postnatal wards specialises in women who have had a caesarean section.

The CQC carried out an unannounced focused inspection following information that highlighted concerns about the safety and quality of the service.

Following the inspection, under Section 31 of the Health and Social Care Act 2008 the CQC imposed urgent conditions on the registration of the provider in respect to the regulated activity; Maternity and midwifery services. This action was taken as the inspection team believed a person would be exposed to the risk of harm if they had not done so.

The overall ratings for the maternity service were inadequate:

Are services safe?	- inadequate
Are services effective?	- requires improvement
Are services responsive to people's needs?	– inspected but not rated
Are services well-led?	- Inadequate

The following table compares the areas of concern highlighted during the CQC inspection of the Maternity Unit – Jessop Wing Sheffield with the Maternity Service provided at Dorset County Hospital.

Heading	Reported for STH	DCH current position	Actions required	Owner of action	Anticipated completion date	RAG rating
Mandatory Training	73% of staff had completed mandatory training	Training at DCH is reported for each section -PROMPT-79% anaes - 79% midwives - 75% doctors BLS - 89.5% anaes - 100% obst drs -94% midwives -97% MSW K2fetal monitoring - 93% Drs - 98% midwives NLS 4yr accredited- for HB team & senior M/W -95%	Doctors to be rostered in advance to attend for PROMPT training to ensure yearly update as recommended	Nicky Trent is the Maternity Unit Training lead midwife.	Training is constantly being reviewed and updated.	
	PROMPT training stopped during COVID, restarted in January 2021 but delivered	PROMPT was only cancelled for 2 months in 20019 as had planned to have only 10 sessions. It		PROMPT facility meetings held every three months to		

	virtually	recommenced face-to-face in September 2019		review feedback and change content in line with national guidance		
	Anaesthetists not included in PROMPT training in line with best practise guidance	79% of the anaesthetic team have attended a face-to-face PROMPT course in the last year	Lead anaesthetic consultant for obstetrics has amended their roster to improve their attendance for the PROMPT day	Katherine Barr	September 2021	
	Staff unclear as to which CTG training package the Trust used.	K2 CTG package + monthly CTG monitoring session by CTG lead for DCH. 93% of doctors and 98% M/W have completed K2 in the last year. The monthly sessions are based on DCH cases, and learning shared with all staff.	Remind staff they need to redo their K2 if about to expire. Ensure that our CTG lead midwife is supported to continue with the excellent training she is providing.	Fetal monitoring lead – Nichola Coliandris		
	'Fresh eyes' approach only implemented in December 2020 and not yet embedded.	Fresh eyes has been successfully implemented in August 2018, we have a CTG lead midwife as recommended by the 'Saving babies lives care	Our CTG lead has successfully implemented ongoing training looking at a different local case each month.			

		bundle two'. She reviews CTG's along with the safety team when there has been an emergency LSCS or poor outcome. The CTG lead provides at least 6-7 online teaching sessions a month focusing on a different case each month for all staff to access.				
	Staff not interpreting, escalating or documenting CTG's appropriately.	2016 – NICE CTG interpretation tool attached to all the CTG machines for M/W to use, following this we produced CTG stickers based on NICE guidance to interpret CTG's, followed by a whole A4 size sheet to guide CTG interpretation in labour. Dawes/Redman interpretation for antenatal CTG's available on all our CTG machines	Guidance for CTG analysis and escalation is being constantly reviewed and updated. Our fetal monitoring lead attends national meetings so any changes in recommendations will be addressed during these.			
	Training provided not reflective of recommendations or themes identified from	There are a number of examples where training has incorporated themes from SI's or HSIB reports.		PROMPT local facility		

	serious incidents or HSIB reports	The Fetal Monitoring lead midwife bases the monthly sessions on themes identified in risks. The training team amend scenario's and provide community based PROMPT training in response to recommendations				
Environment and equipment	Two entrances to labour ward only one monitored by 24 hour reception, second entrance not visible from reception or midwives station	All entrances have security cameras so they can be viewed from the midwifery desk, secretary's office and maternity reception area.				
	Visitors and women can press a button to leave labour ward from either door unchallenged	Entrance and exit of the maternity unit through locked doors which have to be activated by reception staff during the day or midwifery staff at all other times. Therefore women and partners cannot exit without permission.				
	Baby abduction policy in place but not had a drill to test it.	We have an abduction guideline and have had 2 drills to test it, but not in	Another abduction drill needs to be organised	Jo Hartley	October 2021	

		the last year.				
	Baby tagging system implemented but tag only put on baby when leaving labour ward, so could be taken	We do not have a baby tagging system, however all our doors are locked and women and babies do not leave the unit when transferred between labour ward and postnatal ward.				
	Adult resuscitation trolley only check 16 out of a possible 190 occasions	Adult resuscitation trolley is part of the co-ordinators nightly checks. Months Jan 21-June 21 (6 months) out of 181 occasions checked 152 times	Ongoing action to ensure that the adult reses trolley is checked daily as per the Trust recommendations	Sarah Evans – Labour ward lead midwife and Jane Hall – Antenatal, Intrapartum & Screening Matron	Ongoing	
	Resuscitaires not being checked regularly – only 12 out of 30 occasions	Resuscitaires are part of the nightly checks as well as being checked after use. Review of the month of June 2021 – all checked 28 out of 30 days and most checked more than once a day	As above ongoing action to ensure that all the resuscitaires are checked and restocked a minimum of once a day	Sarah Evans – Labour ward lead midwife and Jane Hall – Antenatal, Intrapartum & Screening Matron	Ongoing	
	Portable Appliance Testing not evident on all equipment	PAT stickers are evident on the majority of equipment used in the maternity unit	Liaise with the estates and EBME departments to ensure that all the	Jo Hartley and Jane Hall	Annual	

			equipment used has been tested and is safe to use			
	Not enough resuscitaires on labour ward and all of the resuscitaires in the MLU had been decommissioned but no risk assessment completed	We have 4 resuscitaires available to cover the 6 labour ward rooms, one is based in theatre and another one based in the MLU. All were due to be replaced in 2021, however they have 6 monthly servicing and are still deemed fit to use for another year before needing replacement	No action at present. However need to ensure that they are replaced within the next 2 years.	Sarah Evans – Labour ward lead midwife and Jane Hall – Antenatal, Intrapartum & Screening Matron		
	The corridors were cluttered with equipment posing a risk if women needed to be transferred from the MLU to labour ward.	The maternity unit corridors are cluttered during the day time due to the cleaner's trolley and cones warning of wet floors. Equipment is not stored in the corridors- either kept in the store room, emergency equipment cupboards or in the delivery rooms.	Cleaning trolley and cones are both an Infection control and health and safety requirement. Corridors clear at all other times			
	The neonatal resuscitation trolley was	We have two neonatal emergency trolleys on	Jane Hall to speak to SCBU lead to	Dom Sheehy –	August 2021	

	checked by the neonatal team but there was no assurance for LW staff that it had been checked	the maternity unit. Both checked by SCBU staff but not clear to us that they have been checked.	ensure evidence that they have been checked is clear for maternity staff	SCBU Matron		
	Women were not risk assessed to prioritise who should be seen first on the labour ward assessment unit.	We do not have a labour ward assessment unit, however when women admitted the co-ordinator is informed and they are responsible for arranging a doctor review based on severity of admission symptoms.	Labour line looking at introducing a risk assessment tool similar to BSOTS to risk assess women to ensure that high risk women are prioritised when they are admitted to the unit.	Christine Grother	September 2021	
	The time that women had to wait to be seen was not monitored in the assessment unit and midwives uncertain how women were referred to the unit.	We are working towards introducing BSOTS once our day assessment unit has been moved to a larger area. At present every women who attends is written on an admissions board in DAU – with the reason and time arrived so women can be prioritised depending on risk	The plans to expand DAU and therefore provide not only more beds/space to see more women but to properly triage women when they arrive in DAU have been drawn up and money required to complete the building work. To present at next	Jane Hall James Male Louise Pride	October 2012	

			CAPSUG meeting to see if funding can be secured to move forward with the plans.			
Maternity Staffing	The chief nurse, nurse director and head of midwifery had not followed the birthrate plus report staffing recommendations of 90% registered midwives to 10% support workers. They were 85% midwives and 15% supports workers	Birthrate plus audit completed in April 2021. The audit identified that we needed 10.5% wte midwives. Funding for recruitment applied for from central budget, however as of July 2021 we have only received enough funding for 3.6 wte midwives	Advertise and recruit into the 3.6 wte midwives as soon as possible. Once further money is identified to recruit midwives we will need to submit a new proposal for the rest of the posts required	Jo Hartley	2021-2022	
	Labour ward co-ordinator was not always supernumerary they were counted in the numbers which gave an inaccurate picture of staff on duty.	Maternity Unit co-ordinators are classed as supernumerary as they need to oversee not only the labour ward but the whole unit. There are occasions when the co-ordinator may need to do some clinical work until extra staff that have been called into the unit to help is very busy have	Monthly senior midwives meetings (which is what co-ordinators are) provide an opportunity for issues and concerns to discussed in a safe and supportive manner. There are clear guidelines for	Sarah Evans – new band 7 labour ward lead started in post at the end of July 2021. Jane hall	Ongoing	

		arrived.	escalating when staffing is an issue. As the vast majority of our midwives work both in the unit and community we are able to ask midwives to come into the unit if it is particularly busy to ensure the co-ordinator can remain supernumerary.			
Records	Information was held on multiple systems – drugs prescribed on line but fluids documented on a chart making it difficult to have oversight of patient care.	We have just introduced the BadgerNet maternity digital programme which will enable the majority of information for a woman to be held all in one place. We will continue using paper based drug charts for a while longer until BadgerNet has been fully embedded, we will then introduce EPMA.	EPMA will be introduced once BadgetNet has been embedded into everyday use by the maternity staff. EPMA will require both a pharmacy and Maternity lead to introduce the programme to ensure a seamless introduction.	Chloe Mackenzie – digital lead midwife plus EPMA project lead identified by pharmacy	January 2022	
Drugs	Temperature of drugs	The drug fridges on the				

	fridge not always checked	unit are remotely monitored by pharmacy department using an electronic system. The treatment room where drugs are stored is also temperature monitored by the pharmacy department.				
	Missing controlled drugs checks, 17 missing days in a three month period.	Maternity unit CD are checked once a day and a signed sheet to prove this is available in the cupboard. Pharmacy undertakes drugs audits to ensure standards are maintained. Maternity unit had 100% in last audit.	Ongoing CD audits by the pharmacy department	Sarah Evans – Labour ward lead midwife and Jane Hall – Antenatal, Intrapartum & Screening Matron		
Incidents	Incidents not always managed well – delays in investigation and lessons learnt were not shared with staff in the unit.	All incidents reported via Datix. CTG issues reviewed by fetal monitoring lead with the safety lead and learning fed directly into the monthly monitoring sessions. All incidents are reviewed and if deemed a serious a 72 hour report is completed				

		followed by an RCA. The RCA findings are then presented at trust board level. If incident is a never event it is presented to the corporate panel where there is CCG representation. Learning is shared in a number of ways: Newsletter M&M meetings Fetal monitoring monthly sessions based on incidents within the maternity unit. PROMPT base some of their scenarios on learning from local incidents such as PPH in theatre.				
	Lack of transparency when grading incidents and investigating them which did not reassure the CQC that women were given a full explanation when things	The parents are always contacted by either the safety lead or head of midwifery. Duty of candour in place. All incidents requiring HSIB investigations have	Ongoing			

	went wrong.	been reported. If internal investigations carried out then the woman/couple are offered a meeting with the safety lead and head of midwifery to discuss the findings and any learning that has been identified.				
Patient Outcomes	MBRRACE report published in 2020 based on births in 2018 showed that the Trust perinatal mortality rates were 5% above the average for comparable Trusts.	The MBRRACE data for DCH 2018 perinatal mortality rate was– 1.8 compared to Trusts of a similar size which were 3.1	We continually submit data to MBRRACE and participate in the Dorset wide PMRT review and grading	Linda Deadman, Sophie Wilson, Liz Passells and Jane Hall		
	The Trust carried out a programme of repeat audits to check improvements made over time in the care and treatment of women using the service. However it was not clear that the managers shared and made staff aware of the learning and improvements identified through those audits.	We have an identified audit lead for the maternity Unit. The audits and outcomes are shared at the clinical governance meetings held monthly, maternity forum meetings which are held weekly, in the Maternity newsletter which is published monthly and emailed to all staff as well as being printed out for everyone		Kate Nicholson – audit lead for Maternity Unit		

		to read. Regular meetings with the head of midwifery.				
	MDT meetings to discuss and plan care for women however the minutes showed inconsistencies and plans were not followed up and updated every meeting	The maternity unit has an MDT meeting which is held approximately every two weeks to discuss all the high risk cases and update plans of care following scans or test results. The fetal abnormality referral guideline details this meeting				
	Women were not referred for mental health assessments when they showed signs of mental ill health,	We have a perinatal mental health team consisting of a perinatal mental health consultant, obstetrician, midwife and midwife psychotherapist which women are referred to.	Due to the increasing numbers of women with mental health issues we do not have enough appointments for women to be seen in a timely manner. It has been reported and is on our Maternity risk register	Consultant Miss A. Ryan. From September 2021 the number of Perinatal health clinic appointments will be increased as the clinic will be held weekly rather than every other week.		
	Staff survey results were not reviewed and at the	The staff survey results are sent to Jo Hartley	Ongoing every time a staff survey	Jo Hartley, Lindsey		

	time of the inspection there were no action plans in place to respond to areas highlighted as requiring improvement	who is the Associate Director of Midwifery & Neonatal Services. All areas are reviewed by the management team to ensure that areas requiring improvement have an action plan in place to address issues	is completed	Burningham and Jane Hall		
CQC Domain: Is the Service Well-led						
Governance	No clear process for how the trust board had oversight of the quality and safety of the Maternity service	All quality and safety issues are discussed at the weekly maternity forum meeting as well as the monthly clinical board meetings. As already noted				
	The risk register did not contain a date that it was reported or reviewed. There were a number of risks from 2017 which had not been reviewed and closed.	DCH maternity risk register is reviewed during every clinical governance meeting held at least 10 times a year. Risks are updated when actions have been completed or any new information/evidence available.	Monthly review of the units risk register and updates when new evidence available	Jo Hartley		
	The trust had a business	Maternity unit has a	All guidelines and	Christine		

	continuity and major incident plan but it was generic and did not provide specific instructions for the Maternity unit	specific escalation plan which contains guidance and proforma for staff to use when there are staffing or capacity issues. The unit has a major incident policy specific to the maternity unit.	policies are reviewed every three years or sooner if evidence available before the review date. Guidance written by the Maternity Unit Quality midwife	Grother		

Meeting Title:	Trust Board
Date of Meeting:	29th September 2021
Document Title:	**Safest Nursing and Midwifery Staffing**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Nicky Lucey, Chief Nursing Officer

Confidentiality:	**No**
Publishable under FOI?	**Yes**

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	Monthly	Regular updates on safest staffing position and approved safest staffing policy (February 2021)
Quality Committee	Monthly	Regular updates on workforce safest staffing impact on quality and safety
Risk and Audit Committee	B-Monthly	Nursing and Midwifery staffing risk on the corporate risk register

Purpose of the Paper	This paper is to brief the Board on the issues, impact and mitigations for safest staffing for nursing and midwifery staffing levels.							
	Note ✓		*Discuss* ✓		*Recommend*		*Approve*	
Summary of Key Issues	Safe staffing is calculated using recognised methodologies for Nursing and Midwifery staffing, taking account of patient acuity, dependency, activity and skill mix of staff. This creates the funded established staffing levels that are considered planned. In this funding there is allowance for normal sickness, annual leave and come study leave. Based upon this the roster for the department will have planned staffing numbers (Safe staffing levels) and then on the day actual staffing numbers (Safest staffing numbers), depending upon: vacancies; sickness; increased patient need; decreased patient need; temporary staff cover; cross cover. The Trust recognises that the provision of appropriate staffing levels is a critical element in the provision of safe, quality care. There are however occasions when maintaining planned staffing levels are challenged, for example in a major incident or pandemic. This document sets out how the Trust manages and governs staffing levels both as part of business as usual and in extremis. The Trust agreed a safest staffing policy In February 2021, to ensure mitigations and monitoring is in place to enable care to be as safe as possible in extremis. In the policy there is a term used called 'red flags' which is when safest staffing levels cannot be mitigated and managed and therefore creating a red flag concern shift. This situation has been raised and robustly discussed at the sub-board committees, with agreed actions and mitigations. This paper aims to pull together and brief the Board on: - the safest staffing situation and mitigations - the monitoring of the impact of this							

	- provide assurance of the mitigations in place
Action recommended	The Board is recommended to: 1. **NOTE** the briefing 2. **DISCUSS** the assurance of safest staffing

Governance and Compliance Obligations

Legal / Regulatory	Y	Care Quality Commission regulatory standards (18;9;12)
Financial	Y	Well-led use of resources
Impacts Strategic Objectives?	Y	Trust Strategy: People;;Partnership (including outstanding care)
Risk?	Y	BAF: Outstanding(Objective 1, risk 5); Corporate risk register risk:- Workforce (463); Constitutional Standards (709; 710; 450)/ High Volume of no-reason to reside patients (461)
Decision to be made?	N	
Impacts CQC Standards?	Y	See above
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	Covered in risk register risk assessment

TRUST BOARD
SAFEST NURSING AND MIDWIFERY STAFFING

Executive Situation Summary

The Trust recognises that the provision of appropriate staffing levels is a critical element in the provision of safe, quality care. There are, however, occasions when maintaining planned staffing levels are challenged, for example in a major incident or pandemic. This document is the brief the Board on the management, monitoring and escalations relating to the governance of safest levels both as part of business as usual and in extremis.

The Trust approved the safest staffing policy in February 2021, to ensure mitigations and monitoring was in place to enable care to be as safe as possible in extremis. In the policy there is a term used called 'red flags' which is when safest staffing levels cannot be mitigated and managed and therefore creating a red flag concern shift.

This situation has been raised and robustly discussed at the sub-board committees, with agreed actions, monitoring and mitigations.

The current pandemic and operational pressures has meant the safest staffing policy and daily extra safest staffing meetings have been in place since January 2021, aligned to escalating pandemic. These complement the bed meetings, where staffing is also discussed to ensure actions are taken for safety of all our people.

Current staffing pressures are due to:

- Vacancies
- Sickness (both covid related and non-covid)
- Certain leave (e.g. special leave, maternity leave, compassionate leave)
- Increased capacity constraints and demand, including acuity

Current impact of safest staffing is being monitored and managed by:

- In extremis escalation of capacity (with business continuity plans implemented)
- Extra support for nurse sensitive indicators for quality and safety (e.g. Tissue Viability support for skin integrity; patient safety nurse for falls bundle)
- Increased staff wellbeing rounds
- Sub-board committee oversight of outcomes and impact

Background

Nursing, Midwifery and Care Staff, working as part of a multidisciplinary team play a critical role in delivering safe high quality care to patients and service users. There is strong evidence from a range of recent reports (Hard Truths DOH 2013, Francis 2013, Keogh 2013, Berwick 2013) that having the right number of staff delivering care in the right place impacts positively on both clinical outcomes and patient experience. Addressing these issues ensures that we prioritize the safety and experience of our patients and staff.

Safe staffing is calculated using recognised methodologies for Nursing and Midwifery staffing, taking account of patient acuity, dependency, activity and skill mix of staff. This creates the funded established staffing levels that are considered planned. In this funding there is allowance for normal sickness, annual leave and come study leave. Based upon this the roster for the department will have planned

staffing numbers (Safe staffing levels) and then on the day actual staffing numbers (Safest staffing numbers), depending upon: vacancies; sickness; increased patient need; decreased patient need; temporary staff cover; cross cover. This is termed planned versus actual staffing.

Currently due to a number of factors safe staffing levels are being compromised and the Trust has implemented the safest staffing policy since January 2021, with increased pressures from the pandemic. Each day daily staffing meeting occur to look ahead and plan mitigations for safest staffing, alongside the reviews throughout the day at the Bed meetings. These meetings put in place mitigations, escalate for any further temporary staffing resources or action and highlight any red flags (events that prompt an immediate response where staffing cannot meet the safest staffing level).

Whilst to date there has not been any red flag incidents on safest staffing, mitigations have been put in place to avoid this, there have been very real challenges and responses as part of the escalations with many occasions staffing is on amber, such as:

- Special Care Baby Unit temporarily flexed being open and closed to new admissions
- Maternity unit has enacted their escalation plan and diverted once, with partner support
- Mixed sex accommodation occasions have been agreed on the grounds of safety by the Executive Directors
- Staff have been re-allocated to different wards/departments other than their normal place of work/team
- Extra temporary staffing has been sourced to support safest staffing
- Ongoing support for recruitment and expansion, funded by NHS England, for Healthcare Support Workers and International recruitment for Registered Nurses.
- Daily revision of acuity/dependency by the senior nurse/midwife with exercising of professional judgement to review the skill mix needed each shift

Assessment

The ongoing actions to support recruitment and retention are vital and the Trust has committed resources to this. In the meantime the impact of safest staffing for nursing and midwifery, with the mitigations in place, remains a concern.

The Trust collects nurse sensitive indicators to monitor the impact of safe and safest staffing, such as:

- Patient outcomes (e.g. falls, pressure ulcers, healthcare associated infections, malnutrition assessment compliance, maternity safety indicators)
- Patient and staff experience(e.g. Friends and Family Test, complaints)
- Workforce data (e.g. appraisal, retention, vacancy, sickness, staff feedback)
- Training and education (e.g. mandatory training, clinical training)

Due to the mitigations in place many quality and safety indicators are stable. There are some indicators where extra support has been proactively put in place to reduce the risk further as a slight trend has been identified. These are:

- Tissue Viability Specialist Nurse rounds to support pressure area care and reduce the risk of reportable pressure ulcers
- Patient Specialist Nurse support to the falls bundle work to reduce the risk of falls with harm
- Ongoing infection prevention and control rounds
- Refreshed the Deputy Chief Nursing Officer input into nutrition steering group to support actions for nutrition
- Volunteers support for clinical areas, where appropriate to aid with family communication and healthy stay activities for patients

There is very clear monitoring of the impact of safest staffing forms part of the sub-board committees reporting any escalations of any concerns as part of the sub-board reports to Board. The sub-board committees are to date assured on the actions being taken and has noted and escalated the ongoing safest staffing challenges and mitigations.

Recommendation

The Board is asked to receive this briefing of the situation, note the mitigations in place to ensure safest staffing for nursing and midwifery staffing and note that on occasions the normal high standards of care or access may be compromised with to the additional actions to mitigate the risk. The Board is asked to note and receive any concerns escalated to the Board from the sub-board committees.

The Board is therefore recommended to:

1. **NOTE** the briefing
2. **DISCUSS** the assurance of safest staffing for nursing and midwifery staffing

Name and Title of Author: Nicky Lucey, Chief Nursing Officer
Date: 24/09/2021

Meeting Title:	Board of Directors
Date of Meeting:	29th September 2021
Document Title:	**Trust Strategy Delivery Update**
Responsible Director:	Nick Johnson - Deputy CEO and Director of Strategy, Transformation and Partnerships
Author:	Ciara Darley – Programme Manager

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Strategy and Transformation SLG	1st September 2021	Strategy Delivery Plan discussed, update to be taken to next meeting
Risk & Audit Committee	21st September 2021	Board Assurance Framework

Purpose of the Paper	The purpose of the paper is to provide the Board with an overview of the key activities in progress following the refresh of the Trust's Strategic Objectives.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The updated Trust Strategy was approved by Trust Board in May 2021 and since then a number of related initiatives have commenced to support delivery of the strategy. This paper aims to provide an update on implementation and specifically around progress in the following areas: **Strategy and Transformation Senior Leadership Group (SLG)** A new Strategy and Transformation SLG commenced from the 1st September 2021 specifically to monitor implementation of the Trust Strategy and larger scale transformation programmes. **Strategy Delivery Plan and Dashboard** The Strategy Delivery Plan is in draft to be circulated to key leads for collaboration before the final draft is approved. Key metrics have been identified for the Dashboard; further engagement will be completed to ensure the right balance of measures. Both the Delivery Plan and Dashboard will be reviewed bi-monthly at Strategy and Transformation SLG and reported to Trust Board on a regular basis. **Update of the Board Assurance Framework (BAF)** The current BAF has been reviewed with risks realigned to the new strategic objectives for review by Risk Owners. A process for further review and update before approval of the updated BAF in November 2021 is in progress. **Alignment to the Well-Led Framework**							

	Update of the Trust Strategy and subsequent activity aligns to several key lines of enquiry included within the Well-Led Framework. This alignment has been identified and will be regularly reviewed. Each of the initiatives outlined within this report are key to the successful implementation of the Trust Strategy. Progress has been reported through associated committees with updates to date provided independently from one another. This report aims to provide an overview of each initiative, outlining progress to date and key interdependencies.
Action recommended	The Board of Directors is recommended to **NOTE** the report.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	N	
Impacts Strategic Objectives?	Y	*Positive impact, implementing updated strategic objectives.*
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Trust Board
Trust Strategy Delivery Update

Executive Summary

The Trust mission is to provide outstanding care for people in ways which matter to them. Updating the Trust Strategy provided a fresh opportunity to seek views from staff and representatives from our local communities to discover what is important to them, the people who will be central to delivering the strategy, and how we might achieve our aspirations in future.

The updated Trust Strategy was approved by Trust Board in May 2021 and since then a number of related initiatives have commenced to support delivery of the strategy. This paper aims to provide an update on implementation and specifically around progress in the following areas:

- Strategy and Transformation Senior Leadership Group (SLG)
- Strategy Delivery Plan and dashboard
- Update of the Board Assurance Framework
- Alignment to the Well-Led Framework

The Board of Directors is asked to **Note** this paper.

1. Progress on key strategic initiatives

Each of the initiatives outlined within this report is key to the successful implementation of the Trust Strategy. Progress has been reported through associated committees with updates to date provided independently from one another. This report aims to provide an overview of each initiative, outlining progress to date and key interdependencies.

1.1 Strategy and Transformation Senior Leadership Group

In order to successfully review the implementation of the refreshed strategic objectives, a new bi-monthly 'Strategy and Transformation' Senior Leadership Group (SLG) has been established which commenced on 1st September 2021. The purpose of this meeting is to support the delivery of the strategic objectives and will review the delivery plan, dashboard, enabling strategies and progress against wider strategic programmes. It will provide a forum to bring together all transformational change initiatives that are taking place across the Trust.

In addition, the Strategy and Transformation SLG will receive Business Cases aligned to the Strategy. This process will now be supported and made more robust through the establishment of a Working Group with representatives from across key areas of the Trust to ensure that proposals are adequately detailed and considered before decisions are made within the SLG meeting.

1.2 Development of the Strategy Delivery Plan

The Trust Strategy provides a view of what our Trust will look like in future and sets out the aims and actions which help us to achieve these ambitions. The delivery plan will provide the next layer of detail to enable Senior Leaders to view these aims together, alongside the key detail which will help to coordinate, manage, prioritise and resource them. A snapshot of the delivery plan has been provided in Appendix A, key details include:

- High level timescales for delivery
- Key metrics used to monitor implementation and benefits realisation
- The monitoring mechanism or key committee to monitor implementation
- The Executive Sponsor, accountable for the successful delivery of the initiative
- The Key Lead, responsible for successful delivery of the initiative

The draft delivery plan is in development and next steps include collaboration with Executive Sponsors and Key Leads to add further detail and clarity. The draft plan will be presented to the Strategy and Transformation SLG at the end of October 2021 for approval for use as a working document.
The plan will be reviewed bi-monthly as an iterative document to allow for developments for key interdependent initiatives, for example the outputs from the Clinical and People Strategies.

In the meantime, key strategic initiatives are in development or delivery, including but not limited to:

- Development of key enabling strategies including the People and Clinical Strategy
- Refresh of the Site Masterplan and delivery of the New Hospital Programme
- Development of the Health Inequalities Approach and Social Value Ambitions
- Review of Communication and Engagement approaches to embed co-production
- Implementation of the Quality Improvement Strategy and plans

<u>Strategy Measures and Dashboard</u>

As the above detail comes together, a strategy dashboard will be created to provide a comprehensive view of performance against the Strategic Objectives of People, Place and Partnerships. Several key metrics have been identified; these have been provided below. In collaborating with key Leads, it is anticipated that a number of softer metrics will also emerge to become part of the dashboard.

People	• Friends and Family Test • Workforce Race Equality Standard • Workforce Disability Equality Standard • Quality Improvement Metrics • Gender Pay Gap • Recruitment and Retention

Place	• Quality (CQC) • Reduced admissions per 100k population • Increased number of patients treated remotely • Increased clinical space available • Increased number of locally employed people and local spend • Reductions in health inequalities
Partnership	• Improving patient experience • Improving waiting times and access to planned services • Increasing productivity and efficiency measures • A thriving ICS

The dashboard will also be reviewed bi-monthly at the Strategy and Transformation SLG and reported to Trust Board on a regular basis.

1.3 Board Assurance Framework

The Board Assurance Framework (BAF) outlines the identified risks to delivery of the strategic objectives and mitigating actions. As such, approval of the new Trust Strategy brought the requirement to refresh the BAF. In the first instance, the current risks have been realigned to the new strategic themes and this Draft BAF has been shared with Risk Owners for feedback and comment. A SLG meeting will be utilised to provide an opportunity for Risk Owners to further review the content, mechanisms and structure of the report before the request for approval of the refreshed BAF in November 2021.

1.4 Alignment to the Well-Led Framework

Finally, the update of the Trust Strategy and subsequent activity aligns to several key lines of enquiry included within the Well-Led Framework. Key areas of alignment include:

KLOE	Evidence	Commentary
W1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?	1.4.6 – DCH Strategy	Trust Strategy update completed and delivery plan in progress with enabling People Strategy also in progress.
W2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities?	2.1.3 – Trust Strategy 2025 including vision, mission and strategic themes 2.1.4 - Values	Trust vision and values are widely promoted and visible across the organisation and have remained consistent through the strategy refresh. BAF refresh in progress following Strategy update.

	2.1.4 - Board Assurance Framework	
W2.2 Is there a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care?	Trust Strategy 2.2.3 - SLG Minutes	QI Strategy, People Strategy and Clinical Strategy development – engagement across organisation and to understand what the future of services should look like S&T SLG will support prioritisation and implementation
W2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?		Trust Strategy Refresh developed with engagement across Trust, multiple methods of communication and engagement, engagement with Your Voice Patient Group, engagement with governors, engagement with partners Refreshed communication materials produced.
W2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?		Facilitated and ongoing engagement across the organisation to support development of the enabling strategies to make the strategy/vision meaningful and achievable and help all staff understand their role in achieving them. Engagement via development of Clinical and People Strategy Development.
W2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?	2.5.4.- Strategic Programme	The Trust strategy was developed to be consistent with our local ICS and to align with the priorities of the NHS Long Term Plan and deliver social value.
W2.6 Is progress against delivery of the strategy and local plans monitored and reviewed, and is there evidence to show this?		New Strategy and Transformation SLG developed to monitor progress against the strategy. Dashboard and Delivery Plan in progress.

2. Progress and Next Steps

Upon completion of the Trust Strategy, the anticipated key milestones were also published on the Trust intranet. The below table outlines the key milestones and progress against them.

	Q1 2021/22	Q2 2021/22	Q3 2021/22

Strategy approval from Trust Board	✓ Delivered		
Develop materials to support and promote Trust Strategy		✓ Delivered	
Sign-off Strategic Delivery Plan (3 year rolling and 21/22)		→ In progress	
Launch Strategy and Transformation Senior Leadership Group		✓ Delivered	
Develop Strategy Dashboard			✓ On track
Refresh Board Assurance Framework			✓ On track
Engagement to embed within emerging Clinical and People Strategies			✓ On track
Develop Case Studies			→ Planning required

Moving forwards there are several key areas of focus between now and the end of the financial year, including:

- Continued review of the Key Lines of Enquiry from the Well-Led Framework to ensure that we are successfully embedding the Strategy
- Continued focus on the role of the Strategy and Transformation SLG
- Completion of the Strategy Delivery Plan and measures to monitor success
- Embedding the refreshed Board Assurance Framework
- To establish the strategic planning cycle, ensuring alignment to the corporate planning cycle

In addition, the importance of the strategic and corporate planning process has been recognised and demonstrated through the Trust creating and successfully recruiting to the Head of Strategic and Corporate Planning.

3. Recommendation

The Board is recommended to **NOTE** the update

Name and Title of Author: Ciara Darley, Programme Manager
Date: September 2021

Appendices
Appendix 1 – *Snapshot of Draft Strategy Delivery Plan*

APPENDIX A

Snapshot – Strategy Delivery Plan

WORKING DRAFT

Objective	Key Strategic Programmes/initiatives	YEAR 1 Q1	YEAR 1 Q2	YEAR 1 Q3	YEAR 1 Q4	YEAR 2 (2022)	YEAR 3 (2023)	Narrative	Key Metrics	Data Source	Monitoring Committee	SRO	LEAD
PEOPLE: Putting our people first to make DCH a great place to work and receive care													
PE1	**To develop a People Strategy which will outline how look after and invest in our staff**												
	Deliver People Strategy - first draft			x				Enabling Strategies Project Group established to develop and gain approval of People Strategy. Approach includes Trust wide engagement with clinical and non-clinical teams to form basis of strategies	Key metric for looking after and investing in staff: Staff Friends and Family Test	NHS Choices/PALS	Strategy Development: Strategy and Transformatin SLG	Dawn Harvey	Emma Hallett
	Deliver People Strategy - final draft				x			Final draft subject to approval from SLG and Board					
	Develop Delivery Plan for People Strategy					x		Following approval of People Strategy document					
	Identify Projects/Programmes from People Strategy and develop necessary Business Cases					x		Following production of delivery plan					
PE2	**To create a culture of openness, innovation and learning**												
	SEE PL1 (below) QI Strategy revision approval/implementation							Paused to due vaccination project					
	Culture Review Programme							Culture review launched 2020	Staff Friends and Family	NHS Choices/Pals	Workforce Committee	Dawn Harvey	Julie Barber
	HR Policy Review, e.g. disciplinary policy, recruitment and appraisal							Identified within Trust Strategy, TBC whether this will be included within the people stratgegy or HR project.	Number of policies reviewed	HR	Workforce Committee	Dawn Harvey	TBC
PE3	**To create an environment where everyone matters through improving decision making and training managers**												
	ED&I Strategy & Programme							Recruitment for Inclusion Lead initiated	WRES/WDES Data	HR	Equality, Diversion and Inclusiuon Group	Dawn Harvey	Julie Barber
	Inclusive Leadership Training					x		4 Cohorts (A-D) underway, 4 more cohorts (E-H) have been communicated with staff.	Leadership training uptake	Leadership Administration Team	Education and Training Group	Dawn Harvey	Leadership Administration Team
	Decision Making Process Review to include Support Services and AHPs					x		Strategy. Support Services and AHPs included within the development of the People Strategy	TBC	Strategy and Transformation SLG	TBC	Nicky Lucey (TBC)	TBC
PE4	**Develop recruitment and retention approaches**												
	Establish career development pathways							Identified within Trust Strategy - TBC	Vacancy Rate/ Recruitment and retention	Integrated scoredcard	Workforce Committee/Workforce Resources Strategy Group	Dawn Harvey	TBC
PE5	**To improve staff wellbeing through building on the offer and putting wellbeing and development at the heart of appraisals**												
	Enhance and improve staff wellbeing offer							Identified in Trust Strategy - many wellbeing offers and opporutnities already available to staff with additional support during Covid 19 pandemic. TBC action plan to sustain/enhance offer.	National Quarterly Pulse Survey Appraisal completion rate	HR	Health and Wellbeing Steering Group	Dawn Harvey	Julie Barber
	Appraisal review							Identified in Trust Strategy - putting wellbeing at the heart of appraisals			Workforce Committee		Emma Hallett

The above snapshot provides a view of the developing Delivery Plan and has been circulated to key leads for accuracy checks and collaboration. The full delivery plan includes similar sections for each strategic objective of People, Place and Partnership and subheadings based on the aims outlined within the Trust Strategy Document.

Title of Meeting	Board of Directors
Date of Meeting	29th September 2021
Report Title	Emergency preparedness, resilience and response (EPRR) annual assurance 2021-22
Author	Tony James, Head of Emergency Planning & Resilience
Responsible Executive	Inese Robotham, Chief Operating Officer, Accountable Emergency Officer (AEO)

Purpose of Report (e.g. for decision, information
To update the Board on the Trusts Emergency Preparedness, Resilience and Response (EPRR) Assurance process and outcome for 2021-22.

Summary
The Trust, considers itself as fully compliant against 89-99% of the relevant NHS EPRR Core Standards meaning an overall rating of 'Substantial Compliance'

Paper Previously Reviewed By:
- Accountable Emergency Officer (COO).
- Emergency Planning & Resilience Group

Strategic Impact
Robust systems for EPRR ensure that the Trust complies with relevant provisions of the Civil Contingencies Act (2004) and the NHS Act 2006 as amended by the Health and Social Care Act 2012

Risk Evaluation
An update on the 2021/22 partially compliant domains and the identification and embedding of learning through an appropriate process.

Impact on Care Quality Commission Registration and/or Clinical Quality
CQC Regulations 12: Safe care and treatment. 'To make sure that people who use services are safe and any risks to their care and treatment are minimised, providers must be able to respond to and manage major incidents and emergency situations'.

Governance Implications (legal, clinical, equality and diversity or other):
The Trust needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This is underpinned by legislation contained in the CCA 2004 and the NHS Act 2006 (as amended).

Financial Implications - None

Freedom of Information Implications – can the report be published?	No
Recommendations	The Board is recommended to approve a 'Substantially Compliant' EPRR assurance rating for 2021-22

Title of Meeting	**Trust Board Meeting**
Date of Meeting	**29th September 2021**
Report Title	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Submission 2021-22**
Author	**Tony James, Head of Emergency Planning & Resilience**

1. Introduction

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

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

2. Relevant legislation and guidelines

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

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

3. EPRR annual assurance process

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

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

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

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

4. Core Standards for EPRR domains

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

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

Further detail can be found in Appendix C.

5. NHS EPRR Core Standards 2021-22

5.1 The Trust was notified on 22nd July 2021, by NHS England & NHS improvement of the process for the 2021-22 EPPRR assurance process. The letter, from Stephen Groves, National Director of EPRR, included the latest version of the Core Standards which have omitted some standards to accommodate this year's assurance process given the events in 2020.

5.2 Organisations are asked to undertake the self-assessment, against individual core standards and rate their compliance for each as fully compliant, partially compliant, or non-compliant. See definition below:

Compliance Level	Definition
Fully compliant	Fully compliant with core standard.
Partially compliant	Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months.

Non-Compliant	Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

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

6. Assurance Deep Dive 2021-22

6.1 Each year NHS England use the core standards assurance process to undertake a 'deep dive' to look at a specific topic relating to emergency preparedness, resilience, and response. This year's topic focussed on Oxygen, to better understand the resilience of internal piped oxygen systems.

7. NHS EPRR Core Standards Self-Assessment

7.1 As part of NHS England's EPRR assurance process for 2021-22, Dorset County Hospital was required to self–assess against a total of 46 applicable core standards.

7.2 The self-assessment was completed by the Trust's Head of Emergency Planning & Resilience and Chief Operating Officer (Accountable Emergency Officer).

7.3 The outcome of the self-assessment showed that of the 46 applicable standards the trust was:

- Fully compliant with 45 of the 46 standards
- Partially compliant with 1 of the standards
- Non-compliant with 0 of the standards.

7.4 The results of the 2021-22 self-assessments enable the Trust to provide **'substantial' compliance** to NHS England and Dorset Clinical Commissioning Group with respect to its emergency preparedness, resilience and response arrangements.

8. EPRR Work Programme

8.1 To accompany the EPRR core standards self-assessment, the Trust is required to submit an Action Plan detailing how it plans to address the 1 standard for which full compliance has yet to be achieved. See Appendix A

8.2 The Core Standards Action Plan has been added to the EPRR Work Programme 2021-22 which is overseen by the Trust's Accountable Emergency Officer and the Emergency Resilience & Planning Group.

9 Next Steps

7.1 The next steps for the assurance process are:

- The Trust Board to approve the 'Statement of Compliance' and Action Plan following the recommendation ratified by the Risk and Audit Committee on 21st September 2021.
- The Trusts Accountable Emergency Officer and Emergency Planning Lead met with Dorset CCG's Accountable Emergency Officer and NHS England and NHS Improvement - South West EPRR representative to discuss the Trust EPRR assurance submission and agree a compliance position.
- Following the submission of the final system assurance statement, the CCG will represent Dorset providers at a confirm and challenge meeting with NHS England and NHS Improvement regional EPRR Team. Statements of assurance will subsequently be presented to the Local Health Resilience Partnership (LHRP) Executive Group for discussion and approval during the November meeting.

10 Conclusions and Recommendations

10.1 During the past 12 months, the Trust has not only responded to the COVID-19 Pandemic but also several concurrent incidents, through which the resilience of the Trust has been exceptional.

10.2 Our ability to respond so effectively is a direct result of dedicated focus on Emergency Preparedness which has resulted in the Trust being able to provide 'substantial compliance' to NHS England and Dorset Clinical Commissioning Group with respect to emergency preparedness, resilience, and response for 2021-22

10.3 The Trust Board is asked to approve the EPRR Statement of Compliance and Action Plan for 2021-22.

Appendix A: Statement of Compliance and Action Plan

Emergency Preparedness, Resilience and Response (EPRR)

Statement of Compliance 2021-22

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

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

As part of the national EPRR assurance process for 2021-22, Dorset County Hospital NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 46 of the core standards, 45 (98%) are fully compliant and 1 partially compliant. Therefore, Dorset County Hospital NHS Foundation Trust is submitting an overall compliance rating of substantial compliance.

In response to the 2021-22 deep dive for Oxygen, Dorset County Hospital is fully compliant with all 7 standards.

I. Robotham

Inese Robotham
Accountable Emergency Officer

September 2021

NHS EPRR Core Standards 21/22 Action Plan - Version 1.0 **September 2021**

Dorset County Hospital NHS Foundation Trust has assessed itself against the NHS Core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2021-22. This action plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance. This is a live document and it will be reviewed and updated as actions are completed. The plan will be monitored by the Trusts Emergency & Resilience Planning Group and NHS Dorset Clinical Commissioning Group.

Ref	Domain	Standard	Detail	Evidence Required	RAG	Action to be taken	Timescale
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Our major incident response involves pre-prepared major incident packs. These are currently in the process of being reprinted. These will be automatically numbered in sequential fashion eg likely to be formatted as either RBDM001, RBDM002, etc OR RBD001M, RBD002M. This allows us to have all of our paperwork up and running immediately and does not rely on electronic systems which could of course be affected in an incident. It also allows us to quickly spot if a patient is missing and needs to be located. These pre-printed packs will be allocated on arrival to both identity known and unknown patients. These will be pre-printed using randomly generated phonetic names, and as patients are registered if they can identify themselves the phonetic name will be changed to their real name. In this way, the 'unknown identity' patients will in all likelihood have non-sequential numbers.		Exercise to be carried out to test the patient identification system.	October 21

Appendix B: Organisational Assurance Ratings

Overall EPRR assurance rating	Criteria
Fully compliant	The organisation is 100% compliant with all core standards they are expected to achieve.
Substantial compliant	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non Compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Appendix C: Core Standards for EPRR domains

1. **Governance**

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

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

2. **Duty to risk assess**

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

3. **Duty to maintain plans**

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

4. **Command and control**

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

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

5. **Training and exercising**

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

Planning arrangements must be exercised through a:

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

6. **Response**

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

7. **Warning and informing**

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

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

8. **Cooperation**

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

9. **Business continuity**

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

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

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

Meeting Title:	**TRUST BOARD**
Date of Meeting:	**29 September 2021**
Document Title:	DCH Charity Annual Reports and Accounts period ended 31/03/21
Responsible Director:	Paul Goddard, Chief Financial Officer
Author:	James Claypole, Deputy Financial Controller

Confidentiality:	
Publishable under FOI?	**Yes**

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Charitable Funds Committee via email in May 2021	May 2021	Annual Report and Accounts reviewed and supported by members of the Charitable Funds Committee via email in May 2021

Purpose of the Paper	Approval of 2020/21 Annual Report and Accounts for the Charity following review by Charitable Funds Committee and final Audit review meeting on 09/09/21.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	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 June 2021 with the follow up meeting between Ian Carrington from Edwards & Keeping and Paul Goddard (Chief Financial Officer) took place on 9 September 2021. There were no changes requested by External Audit to the 2020/21 Annual Report and Accounts.							
Action recommended	a) Review the 2020/21 Charity Annual Report and Accounts. b) Approve the Charity Annual Report and Accounts as Corporate Trustee.							

Governance and Compliance Obligations

Legal / Regulatory	Y	The Charity is regulated by the Charity Commission and it is a statutory requirement to prepare and produce an Annual Report and Accounts.
Financial	Y	The Fund Balances as at 31 March 2021 are: £1,411,000. The Charity spent £300,000 in 2020/21. £1,142,000 of the Fund Balances are held within restricted funds.
Impacts Strategic Objectives?	Y	The Annual Report and Accounts summarises the activity of the charity for 2020/21 and demonstrates compliance with the objects of the Charity in preparation for completing the Final Annual Report and Accounts in April 2021.
Risk?	N	The Annual Report and Accounts were independently audited using a risk based audit approach. The Charity Auditors met with the Chief Financial Officer to report on the conduct and outcome of the audit, after the audit had been completed, with no issues arising.
Decision to be made?	Y	To approve the 2020/21 Charity Annual Report and Accounts
Impacts CQC Standards?	N	N/A
Impacts Social Value ambitions?	Y	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.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Dorset County Hospital NHS Foundation Trust Charitable Fund

Annual Report and Accounts

for the year ended 31 March 2021

Registered Charity No. 1056479

Dorset County Hospital NHS Foundation Trust Charitable Fund

Annual Report and Accounts for the year ended 31 March 2021

Contents

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 2021

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 2021.

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 in October 2019.

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

As the new Chair, I welcome you to our annual report for the year ended 31 March 2021. The Charity's purpose is to raise and receive funds to enhance patient care and staff welfare at Dorset County Hospital; providing support that is above and beyond the NHS budget.

This has been an unprecedented year. The COVID-19 pandemic has presented a very challenging environment for Charity fundraising. For our Charity this has amounted to a 28% reduction in income compared to the preceding year and a 43% reduction against the charitable income target we had set for this year, a scale mirrored across much of the charitable sector. Nonetheless, we have been heartened by the extraordinary level of support received from our community, particularly towards the welfare of our staff. The majority of our income, as well as numerous donated gifts, this year have been received in response to the pressures faced by the NHS, reflecting a generosity of spirit in support of this effort. We have also received valuable support from the NHS Charities Together COVID-19 Appeal, providing grants for staff well-being initiatives and patient welfare. I would like to thank all the individuals, organisations, businesses, community groups, volunteers and our hospital staff who have donated and fundraised in support of Dorset County Hospital during these challenging times.

I would also like to thank my fellow Charitable Fund Committee Members and the volunteers who assist Dorset County Hospital Charity. 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 continue to enhance patient care and staff welfare at Dorset County Hospital.

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

- Launch of the DCH COVID-19 Appeal raising nearly £150,000 to support our dedicated staff during and beyond the pandemic.
- Grant funding from NHS Charities Together COVID-19 Appeal in support of staff well-being initiatives and patient welfare.
- Steady continuation of the DCH Chemotherapy Appeal to redevelop the Hospital's existing Chemotherapy Unit.
- Raising the Charity's profile and income through virtual fundraising and use of social media.
- Securing major grants from local trusts and charities.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

- Funding a range of initiatives and projects to support staff well-being, their resilience and recovery from the impact of the pandemic.

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. 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 253215 or send an email to: charity@dchft.nhs.uk

With many thanks and appreciation,

David Underwood, Chair .

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (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; as well as supporting staff welfare, especially since the impact of the pandemic.

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 Charity & Social Value; together with Rachel Cole, Fundraising and Communications Manager, Kitz Clifford, Fundraising Officer, Jodi Hibbard and Individual Giving Manager (new post). DCHFT Arts in Hospital programme is also now managed by DCH Charity supported by Suzy Rushbrook, Arts Advisor.

If you would like more information about supporting the Charity, please contact Simon Pearson, Head of Charity & Social Value 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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (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 five designated, unrestricted funds: Cardiac, Stroke, Urology, Diabetes, Critical Care, Emergency Department, Ophthalmology, Dermatology Fund, Kingfisher Ward, Purbeck Ward, DCH Research, Ridgeway Ward, Dementia Fund, Forget-me-not Suite, Maud Alexander Ward, Colorectal and Lower GI, Breast Care, Lulworth Ward, Hinton Ward, Prince of Wales Ward, DCH Therapies, Haemodialysis, Barnes Ward, COVID-19 Appeal and DCHC Christmas Appeal Fund. 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
Overall the COVID-19 pandemic has had a significant impact on the Charity's targeted income for 2020/21. Income has primarily been COVID-19 related fundraising and donations in support of the NHS. The charity launched its COVID-19 Appeal in March 2020 to support staff well-being and patient welfare. The appeal raised nearly £150,000, driven by virtual fundraising and donations. In addition, NHS Charities Together Stage 1 grants were received; with notification of Stage 2/3 grant funding rounds. During the year, the Charity's Chemotherapy Appeal, raising £850K funds for redevelopment of the hospital's existing Chemotherapy Unit, continued with a lower profile and by year end had neared its target. Ward and speciality charitable funds continued to receive donations specifically for charitable activities within those areas.

It has been a very tough year for charity operations up and down the country, as fund raising activities were hugely curtailed, and the ability of people to donate was much reduced by the financial pressures they faced. Against that backdrop the generosity of local people has been amazing but nonetheless at Dorset County Hospital Charity we have felt it important to make savings in the administrative overhead to reflect the reduced income. We will continue to do whatever we can to contain costs, whilst recognising that we need a strong base from which to launch the Charity's work with renewed vigour as we come out of the national lockdown.

Development of the Charity
It has been a challenging year for fundraising, though the Charity adapted to the prevailing environment. Digital fundraising techniques were prioritised to support virtual fundraising, with the Charity Team working remotely for most of the year. Plans were developed during the year, focused on maintaining financial sustainability and generating new fundraising opportunities, to build back as we move through and beyond the pandemic.

The Charity has undertaken the following key activities:

a) Launch of the DCH COVID-19 Appeal, responding to the situation and groundswell of support for the NHS and its staff. This required the Charity to rapidly develop and deploy digital fundraising and increased use of social media to promote the appeal.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

b) Grant applications and receipt of NHS Charites Together COVID-19 Appeal Stage 1 grants focused on staff welfare. DCH Charity is also the lead Charity for NHSCT Stage 2 Community Partnerships funding for Dorset ICS region; managing this process and working with other NHS Charities, NHS bodies and community organisations. This funding will be applied for in 2021/22. DCH Charity has also been notified of NHSCT Stage 3 grant allocation for which a funding application for recovery focused projects at the hospital will be applied for in 2021/22.

c) The DCH Chemotherapy Appeal continued to receive individual donations and some community fundraising support. Work continued on securing major grants. During the year the appeal has neared its £850K target and is expected to conclude in early 2021/22.

d) The Charity ran a digital Christmas Appeal to help enhance the hospital environment and raise the morale of staff and patients in the hospital at Christmas during the pandemic.

e) Development of the Charity's new fundraising campaign – 'The Power of Giving', which will underpin the Charity's annual fundraising programme raising funds across DCH specialist care areas. This will be launched in early 2021/22.

f) The Charity commenced planning for its next major appeal. This will be aligned to the hospital's plans to build a new ED and ICU over the next few years. The major appeal will fundraise to support enhancements to both facilities. The appeal's initial phase is expected to commence during 2021/22.

g) Development of the Charity's new website, working with NHS Creative. The new website will be launched at the start of 2021/22.

h) Planning for the introduction of its new donor database CRM (Donorfy) which will transform the Charity's ability to integrate its digital fundraising, marketing and donor communications.

i) Management of DCH Arts in Hospital programme and appointment of a new DCH Arts in Hospital Manager.

j) DCH Charity developed its new five year Strategy 2021-25 and Business Plan 2021/22 during the year. The new strategy will focus on maintaining the Charity's financial sustainability within the context of the challenging economic environment; whist capitalising on new fundraising opportunities with its 'Power of Giving' campaign; digital fundraising and a new major appeal from 2021/22.

k) The Charity's Head of Charity & Social Value has lead on development of DCHFT's new Social Value programme, working with the DCH Social Value Programme Group. DCH recognises its role as an anchor institution in delivering social value, contributing to the wider social, economic and environmental well-being of the community it serves.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

Significant Projects
With the tremendous support from our supporters and grants from NHS Charities Together it has enabled the Charity to support the staff at Dorset County Hospital throughout the COVID-19 pandemic. This has included:

- **Staff Welfare £59,000**:
  Initially funding supported a range of short-term initiatives to directly support DCH staff working under very difficult circumstances. This included practical items to support well-being such as water bottles, nutritional snacks and handcreams and a range of items which made an immediate difference to our staff. COVID-19 charitable funding has also supported the provision of the on-site counselling service for DCH staff.

- **Improving staff facilities £18,000**
  This saw the purchase of furniture and fittings for staff areas including microwaves, installation of water coolers, introduction of coffee pod machines and pods among many other items. Current projects include the refurbishment of The Terrace as a staff rest and well-being area.

- **Improving NHS services for staff and patients £37,000**
  This saw the commitment made to establish a clinical psychologist post and a commitment for an inclusion co-ordinator post at Dorset County Hospital. This funding will also fund longer-term projects to support the mental health, wellbeing and resilience of staff at DCH

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 including:

- £9,750 funding from Fortuneswell Caner Trust enabled the Charity to purchase a Scalp Cooler for cancer patients at Dorset County Hospital.

- £9,400 funded the purchase of a bladder scanner for Radiotherapy at the Robert White Centre at Dorset County Hospital.

- £6,000 funding from the Friends of Dorset County Hospital facilitated the introduction of patient WIFI to allow patients at Dorset County Hospital to access the internet and keep in touch with family and friends.

- The Charity also supported non-mandatory training courses to enhance staff knowledge and support better patient care.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

Thanking our Supporters

In a very challenging year, Dorset County Hospital NHS Foundation Trust has more reason than ever to thank all those who supported Dorset County Hospital Charity through donations, fundraising, grants, in memoriam collections, legacies and the donation of gifts in kind.

Their generosity and dedication enables the Charity to continue to fund equipment and special projects which directly enhance care for patients and staff welfare at Dorset County Hospital.

The Charity's COVID-19 Appeal was launched in March 2020 as a direct result of the pandemic. This appeal received immediate and significant support from the public, who made hundreds of donations to support staff welfare and patient care. In addition many individuals, families and community groups held inspirational fundraising events, in line with the prevailing restrictions, to raise funds for the appeal. These included swimming the equivalent of the English Channel in a back garden and completing virtual marathons and long distance cycling challenges. Many businesses also supported the COVID-19 Appeal and the hospital, donating many products and care items in the form of gifts in kind.

Further support was received for the Chemotherapy Appeal, as well as for wards and units across Dorset County Hospital and for our Christmas Appeal. Dorset County Hospital Charity was also fortunate to receive three generous legacies for the benefit of the Renal Unit and the Chemotherapy Appeal.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

DCH Charity would like to thank all supporters for their generosity and valued commitment to the work of our Charity. Our thanks to the following for their significant contributions this year:

- NHS Charities Together
- Virtual Quayfest
- Calebrations Roadshow
- West Dorset Scrubbers
- Kitson Trotman
- Battens Solicitors
- Bebb Charitable Trust
- District 1200 Rotary Clubs
- Lions Clubs
- DCH Staff fundraisers
- Community events across our region

Thanks are also due to the many organisations and networks which helped promote the work of the Charity and raise its profile in the local community. These include:

Dorset Echo
Bridport News
BBC Radio Solent
Wessex FM
Greatest Hits Radio
Marshwood Vale Magazine
Blackmore Vale Magazine
Poundbury Magazine
Air FM
Keep FM
And many other publications and organisations

DCH Charity would like to express its sincere gratitude to all its supporters and donors including staff fundraisers, volunteers, community supporters, trusts and local businesses; and the many other organisations who freely give their time and effort to help the Charity; and those who increase levels of recognition and awareness by sharing our news and promoting our events. Without the ongoing and valued support of all these groups DCH Charity would not be able to fulfil its purpose of enhancing patient care at Dorset County Hospital.

Dorset County Hospital NHS Foundation Trust Charitable Fund

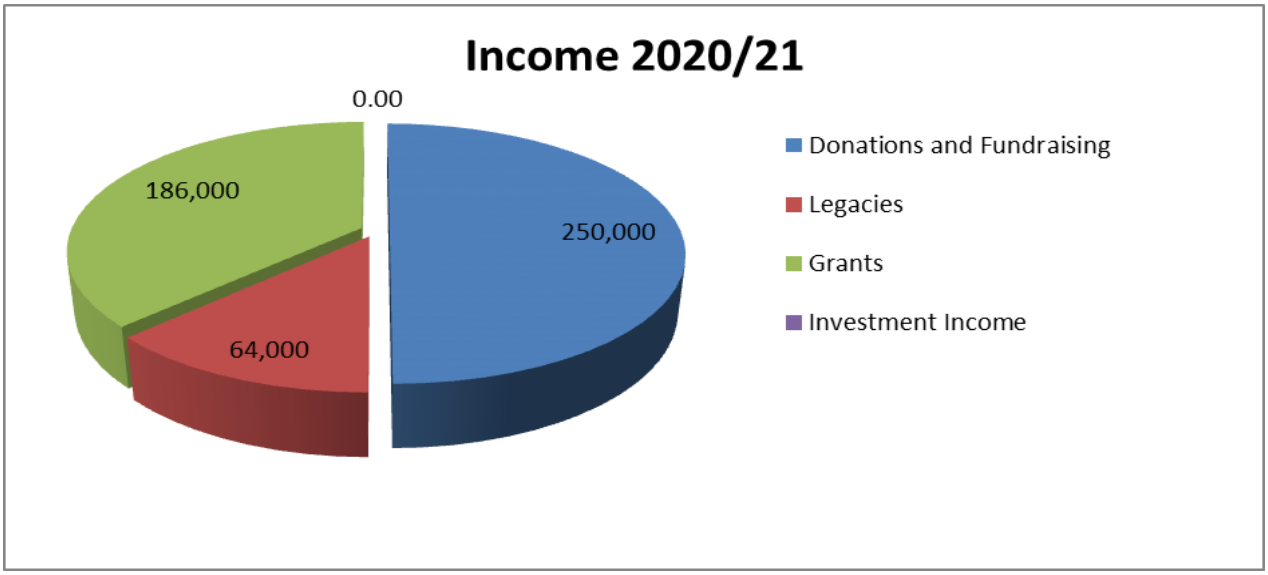
Trustee's Annual Report for the year ended 31 March 2021 (continued)

Financial Review

A review of our finances, achievements and performance
The net assets of the Charitable Fund as at 31 March 2021 were £1,411,000 (2020: £1,211,000).

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

Income
Total income was £500,000 (2020: £695,000) which was a decrease of £195,000 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 £500,000 (2020: £687,000) – 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 £186,000 (2020: £484,000) – The Charity received £156,000 from NHS Charities Together COVID-19 response along with grants for medical equipment for the benefit of patients at Dorset County Hospital.

- The outpouring of support for the NHS through 2020/21 with the lockdowns has been amazing. We were inundated with donations of flowers, food and care packages that distributed immediately to our staff and patients. These are not reflected in our accounts but we estimate that these gifts had a value of about £55,000.

- Legacies £64,000 (2020: £37,000) – 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.

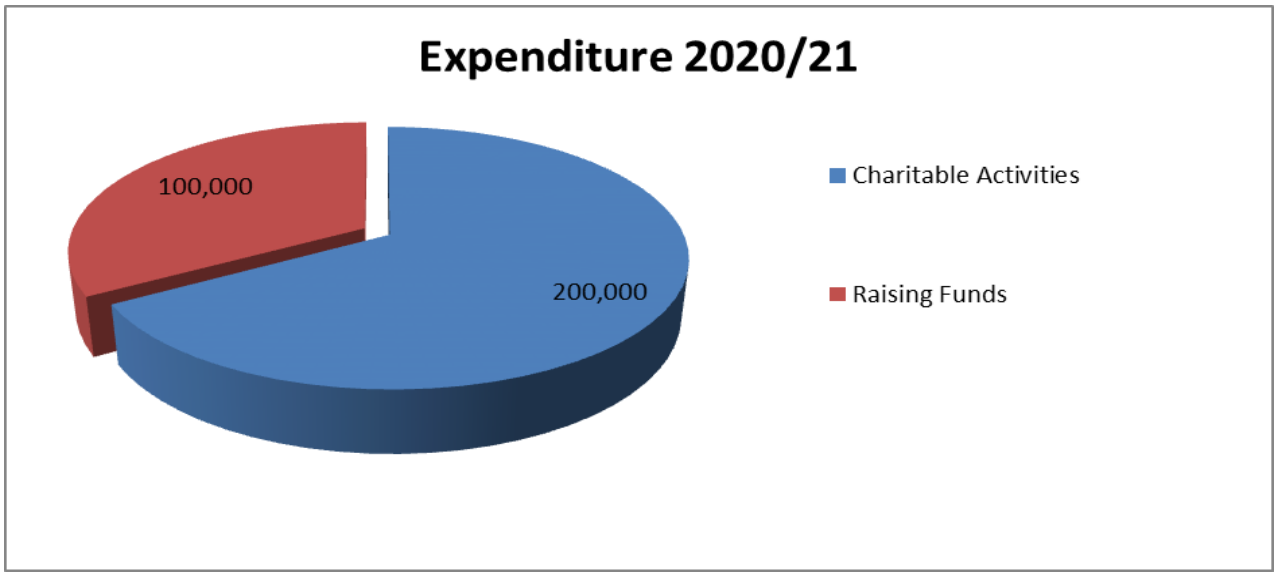
- Donations and fundraising £250,000 (2020: £166,000) saw an amazing response from our supporters towards the COVID-19 Appeal, which raised £134,000. The rest of our donations and fundraising comes from collecting boxes and personal donations to fundraising events in

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

the community. We are fortunate to receive generous donations for the benefit of the patients at Dorset County Hospital.

Expenditure
Of the total resources expended of £300,000 (2020: £566,000), expenditure on direct charitable activity was £200,000 (2020: £376,000) across a range of programmes. The pie chart shows that our largest area of spend was on charitable activities:



Raising funds expenditure of £100,000 (2020: £190,000) related to the cost of the fundraising office (including fundraising staff) and fundraising events.

Charitable activities expenditure of £200,000 included the Charity donating to Dorset County Hospital NHS Foundation Trust assets of £54,000 (2020: £256,000). These covered contributions to building schemes and medical and surgical equipment. It also donated furniture and fittings of £40,000 (2020: £27,000), artwork expenses of £3,000 (2020: £Nil) and staff welfare and amenities of £69,000 (2020: £15,000). Patients' welfare and amenities were £34,000 (2020: £78,000). Support costs for charitable activities totalled £44,000 (2020: £28,000) and this relates to the support and governance charge to support compliance requirements and these charitable activities. The allocation of these support costs against each charitable activity is detailed in Note 8 in the Accounts on page 32.

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.

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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

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 £1,584,000 (2020: £1,408,000) of which £1,583,300 (2020: £1,407,500) was held in an interest earning account with the Government Banking Service. £700 was held as Petty Cash at the end of March 2021.

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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

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.

The Corporate Trustee reviewed its policy on setting a reserve balance for the charitable funds; and adopted a revised policy at its meeting in December 2020. 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 December 2020, to set the target reserves balance at £200,000 to cover costs of administration, fundraising and support costs of the Charity.

Total funds at 31 March 2021 were £1,411,000 of which £1,142,000 related to restricted funds. Whilst unrestricted funds totalled £269,000 the Charity is not including the COVID-19 Appeal Fund of £99,000 as part of its reserves allocation. The Reserves (unrestricted funds) were therefore £30,000 below the target reserves. The Trustee is confident that the shortfall against the reserves policy is within a tolerance that does not require any further action at this time.

As at 31 December 2019 China had alerted the World Health Organisation (WHO) of several cases of an unusual form of pneumonia in Wuhan. This was identified as coronavirus or COVID-19, which only came to light in early 2020 which resulted in a worldwide pandemic during financial year 2020/21.

The COVID-19 pandemic has had an impact on the Charity's general fundraising income in 2020/21 although this has been partially offset by the COVID-19 Appeal launched by the Charity in March 2020. The Charity has received grants from NHS Charities Together for COVID-19 and has received a fantastic response from Donors to the appeal. As a grant making charity, the reduction in general fundraising income will impact on the new grants that can be made in the short term rather than affecting the Charity's ability to continue to operate.

In the longer term, the implementation of the Dorset County Hospital Charity Fundraising Strategy 2021-2025 will establish the strategic framework, key themes and the approach that will underpin the development of the Charity. The implementation of the Dorset County Hospital Charity Fundraising Strategy 2021-2025 is moving forward.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

Our future plans

The Corporate Trustee has committed to a long term role for the Charity. The Charity has developed its Business Plan for 2020/21 as part of its longer term Charity Strategy 2021-25. The key activities for 2020/21 will include;

- We will publicise and celebrate the successful achievement of the Charity's major £850K Chemotherapy Appeal.
- We will launch our new website and digital fundraising strategy to increase our social media activity, improve our digital fundraising capability and increase supporter engagement.
- We will develop our plans for our next major appeal. This will fundraise in support of the hospital's new ED/ICU build providing enhancements to both facilities. The appeal's initial phase is expected to commence during 2021/22.
- We aim to grow the contribution Individual Giving makes to our annual income.
- We will develop our donor stewardship plans and activities to build relationships with our supporters to generate further support year on year.
- We will implement further planned fundraising communications and marketing activities to continue to increase our profile and facilitate income growth.
- We will continue to fundraise and receive funds in support of our wards and specialist care areas to enhance patient care and staff welfare across our hospital
- We will implement plans for the organisational development of the DCHFT Arts in Hospital programme including securing new funds for our Arts in Hospital Fund. We will organise new exhibitions and arts-related projects to continue to enhance well-being for our patients, staff and visitors.
- We will continue to review the mix of skills and experience required in our fundraising team to provide the capacity required to deliver our Charity's growth forecasts in line with our new strategy.
- The work of DCH Charity will align to DCHFT's Social Value programme, contributing to the wider health and well-being of our community.

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 2021, the Charity comprised 40 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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

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.
- 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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

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 £500,000 against an original plan of £875,000. We fell short of our plan because our main fundraising activities slowed or stopped during the year due to the pandemic. Our overall income was primarily comprised of COVID-19-related fundraising and grants, including the DCH Charity COVID-19 Appeal supported by the public in the early days of the pandemic and the stage 1 and second wave grants from NHS Charities Together. We hope to restart face to face fundraising events from summer of 2021 onwards. However, digital fundraising techniques will now remain a key source of income generation. We have reviewed our pre-pandemic plans and developed a new five year strategy for the Charity, together with our Business Plan 2021/22 revising down our annual fundraising target accordingly.

We benchmark our fundraising activity with our peers through the NHS Charities Together financial comparison survey and monitor the comparative success of campaigns and overall fundraising cost to income ratios. We continue to perform well with an average cost to income ratio compared with our peers.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (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 2020/21 and up to the date this report and accounts were approved and signed were:

Mr M Addison	Chairman
Mr M Rose	Non-Executive Director (until 16th June 2020)
Ms V Hodges	Non-Executive Director (until 30th September 2020)
Ms M Blankson	Non-Executive Director (from 1st January 2021)
Ms J Gillow	Non-Executive Director
Prof S Atkinson	Non-Executive Director
Mr I Metcalfe	Non-Executive Director
Mr D Underwood	Non-Executive Director (from 1st March 2020)
Mr S Tilton	Non-Executive Director (from 1st June 2020)
Ms P Miller	Chief Executive Officer
Mr P Goddard	Chief Financial Officer
Prof A Hutchison	Chief Medical Officer
Mrs I Robotham	Chief Operating Officer
Mr M Warner	Director of Organisational Development & Workforce (until 31st October 2020)
Ms D Harvey	Chief People Officer (from 1st April 2021)
Ms N Lucey	Chief Nursing Officer
Mr N Johnson	Deputy Chief Executive and Director of Strategy, Transformation and Partnerships,
Mr S Slough	Chief Information Officer

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 2021; 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 2021 (continued)

Name	Position	24 June 2020	19 Oct 2020	21 Dec 2020	24 Feb 2021
Mr M Addison	Chairman and Non-Executive Director. Chair of Charitable Fund Committee until 30 June 2020)	✓	✓	✓	✓
Mr D Underwood	Chairman and Non-Executive Director. Chair of Charitable Fund Committee from 1 July 2020	✓	✓	✓	✓
Mr P Goddard	Chief Financial Officer	✓	✓	✓	-
Mrs I Robotham	Chief Operating Officer	✓	✓	✓	-
Ms N Lucey	Chief Nursing Officer	✓	✓	✓	✓
Mr N Johnson	Deputy Chief Executive	✓	✓	✓	-
Ms V Hodges	Non-Executive Director (until 30 September 2020)	-	-	-	-
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 the Foundation Trust's Council of Governors following the recommendations made by an appointments panel comprising the Chair of the Foundation Trust, representatives of the Nomination and Remuneration Committee of the Council of Governors, and the Foundation Trust's Chief Executive and Director of Organisational Development and Workforce. The Foundation Trust's Non-Executive Directors appoint the Chief Executive, subject to the approval of the Council of Governors. Other Executive Directors are appointed by the Chief Executive, Chairman and Non-Executive Directors of the Foundation Trust. Members of the Board of Directors and the Charitable Funds 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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2021 (continued)

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

David Underwood
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 2021 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 2021, 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

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 (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 18], 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.

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 (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 2021

	Note	Unrestricted funds £000	Restricted funds £000	Total funds 2021 £000	Total funds 2020 £000
Income from:					
Donations and legacies	4	229	271	500	687
Investments	6	-	-	-	8
Total income		229	271	500	695
Expenditure on:					
Raising funds	7	83	17	100	190
Charitable activities	8				
Medical and surgical equipment		54	-	54	256
Furniture and fittings		28	12	40	27
Artwork expenses		-	3	3	-
Patients' welfare and amenities		(8)	42	34	78
Staff welfare and amenities		3	66	69	15
Total expenditure		160	140	300	566
Net income / (expenditure)		69	131	200	129
Transfers between funds		-	-	-	-
Net movement in funds for the year		69	131	200	129
Reconciliation of funds					
Funds brought forward at 1 April 2020		200	1,011	1,211	1,082
Funds carried forward at 31 March 2021	18	**269**	**1,142**	**1,411**	**1,211**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Balance Sheet as at 31 March 2021

	Note	Unrestricted funds £000	Restricted funds £000	Total funds 2021 £000	Total funds 2020 £000
Current assets					
Debtors	14	2	2	4	10
Cash and cash equivalents	15	313	1,271	1,584	1,408
		315	1,273	1,588	1,418
Liabilities					
Creditors: amounts falling due within one year	16	(46)	(131)	(177)	(207)
Net current assets		269	1,142	1,411	1,211
Net assets		**269**	**1,142**	**1,411**	**1,211**
The funds of the charity					
Restricted income funds		-	1,142	1,142	1,011
Unrestricted funds		269	-	269	200
Total funds	18	**269**	**1,142**	**1,411**	**1,211**

Signed
Paul Goddard, Chief Financial Officer
Dorset County Hospital NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Charitable Fund

Statement of Cash Flows for the year ended 31 March 2021

	Note	Total funds 2021 £000	Total funds 2020 £000
Cash flows from operating activities:			
Net cash provided by operating activities	17	176	185
Cash flows from investing activities:			
Interest received	6	-	8
Net cash provided by investing activities		-	8
Change in cash and cash equivalents in the year		176	193
Cash and cash equivalents at 1 April 2020	15	1,408	1,215
Cash and cash equivalents at 31 March 2021	15	**1,584**	**1,408**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021

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 in October 2019, the Charities Act 11 and UK Generally Accepted Practice as it applies from 1 January 2019.

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 in October 2019 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. The COVID-19 pandemic has had an impact on the Charity's fundraising income although this is partially offset by restricted income from the NHS Charities Together national appeal. As a grant making charity with few on-going commitments, this will impact on the new grants that can be made in the short term rather than affecting the charity's ability to continue as a going concern. It is expected that the amount of grants that can be made will be reduced in 2021/22. However, there are no material uncertainties affecting these accounts.

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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

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.

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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

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.
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) Gifts-in-kind

Gifts in kind, such as food and care packages are not accounted for when they are accepted and immediately distributed unless a single donation is material.

i) 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.

j) 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.

k) 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.

l) Debtors

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

m) 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.

n) 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.

o) Pensions

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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

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 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2021 is based on valuation data as 31 March 2020, updated to 31 March 2021 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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (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 manages.

2a Statement of Financial Activities for the year ended 31 March 2020

	Unrestricted funds £000	Restricted funds £000	Total funds £000
Income from:			
Donations and legacies	232	455	687
Investments	8	-	8
Total income	240	455	695
Expenditure on:			
Raising funds	35	155	190
Charitable activities			
Medical and surgical equipment	172	84	256
Furniture and fittings	19	8	27
Artwork expenses	-	-	-
Patients' welfare and amenities	61	17	78
Staff welfare and amenities	10	5	15
Total expenditure	297	269	566
Net income / (expenditure)	(57)	186	129
Transfers between funds	-	-	-
Net income / (expenditure)	(57)	186	129
Reconciliation of funds			
Funds brought forward at 1 April 2019	257	825	1,082
Funds carried forward at 31 March 2020	**200**	**1,011**	**1,211**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

2b Balance Sheet as at 31 March 2020

	Unrestricted funds £000	Restricted funds £000	Total funds £000
Current assets			
Debtors	10	-	10
Cash and cash equivalents	309	1,099	1,408
	319	1,099	1,418
Creditors: amounts falling due within one year	(119)	(88)	(207)
Net current assets	200	1,011	1,211
Net assets	200	1,011	1,211
Total funds	**200**	**1,011**	**1,211**

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 £200,000 (2020: £376,000) is detailed in note 8. At 31 March 2021 the Charity had made £147,000 (2020: £153,000) of grant commitments to the Foundation Trust which had not yet been paid. The Foundation Trust did not charge the Charity for financial services administrative expenses in 2020/21 due to the finance team supporting the hospital with additional COVID-19 NHS reporting requirements (2020: £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 £157,000 (2020: £146,000).

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 2021 (continued)

4. Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total funds 2021 £000	Total funds 2020 £000
Donations and fundraising	198	52	250	166
Legacies	1	63	64	37
Grants	30	156	186	484
	229	**271**	**500**	**687**

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.

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6. Investment income

	Unrestricted funds £000	Restricted funds £000	Total funds 2021 £000	Total funds 2020 £000
Cash on deposit	**-**	**-**	**-**	**8**

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. With the zero interest rates in 2020/21 no investment income was realised.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

7. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2021 £000	Total 2020 £000
Fundraising office*	10	(29)	(19)	45
Fundraising events	-	-	-	-
Support costs	73	46	119	145
Total	**83**	**17**	**100**	**190**

*Includes reversal of prior year commitment that was unrealised.

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 2021 £000	Total funds 2020 £000
Medical and surgical equipment	33	21	54	256
Furniture and fittings	27	13	40	27
Artwork expenses	3	-	3	-
Patients' welfare and amenities	33	1	34	78
Staff welfare and amenities	60	9	69	15
	156	**44**	**200**	**376**

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

	2021 £000
Opening balance at 1 April 2020 (see note 16)	202
Additional commitments made less unused amounts reversed during the year (see note 8)	156
Amounts paid during the year	(187)
Closing balance at 31 March 2021 (see note 16)	**171**

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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

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. The Charity was not charged for this in 2020/21 by Dorset County Hospital due to the Finance Team having to support the additional COVID-19 Reporting requirement.
- Fundraiser – allocated between raising funds and charitable funds based on time split of 75% raising funds and 25% charity funds.
- Bank Charges - allocated directly to charitable activities and then apportioned across funds using fund balances.

	Raising funds £000	Charitable activities £000	Total funds 2021 £000	Total funds 2020 £000
Governance costs				
Audit fees	-	5	5	5
	-	**-**	**-**	**5**
Other support costs				
Financial services	-	-	-	22
Fundraiser	119	38	157	145
Insurance	-	-	-	-
Bank charges	-	1	1	1
	119	**44**	**163**	**173**

	Unrestricted funds £000	Restricted funds £000	Total funds 2021 £000	Total funds 2020 £000
Raising funds	73	46	119	145
Charitable activities	30	14	44	28
	103	**60**	**163**	**173**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (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

	2021 £000	2020 £000
Salaries and wages	132	123
Social security costs	13	12
Employers pension contribution	12	11
Total	157	146

The average headcount during the year was 3.96 (2020: 3.98) with four employees plus as and when bank support involved in fundraising with a 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 (2020: none).

13. Auditor's remuneration

The auditor's remuneration of £4,680 (2020: £4,680) related solely to the audit with no additional work being undertaken (2020: nil).

14. Analysis of current debtors

	2021 £000	2020 £000
Trade debtors	-	-
Accrued income	4	10
	4	10

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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

15. Analysis of cash and cash equivalents

	2021 £000	2020 £000
Cash in hand	1,584	1,408

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

	2021 £000	2020 £000
Creditors falling due within one year		
Trade creditors	1	-
Accruals for grants owed to NHS bodies	171	202
Other accruals	5	5
	177	**207**

17. Reconciliation of net income/ (expenditure) to net cash flow from operating activities

	2021 £000	2020 £000
Net income / (expenditure) for the year (as per the statement of financial activities)	**200**	**129**
Adjustments for:		
Interest receivable	-	(8)
Decrease in debtors	6	31
Increase / (Decrease) in creditors	(30)	33
Net cash provided / (used in) by operating activities	**176**	**185**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2021 (continued)

18. Funds

	At 1 April 2020 £000	Income £000	Expenditure £000	Transfers £000	At 31 March 2021 £000
Unrestricted funds					
General Purpose*	23	39	(46)	-	16
Staff General Purpose*	1	-	-	-	1
Patients General Purpose*	-	-	-	-	-
Emergency Department	2	4	(1)	-	5
Cardiac	29	2	(5)	-	26
Critical Care	13	10	(9)	-	14
Diabetes	2	2	(2)	-	2
Stroke	29	1	(9)	-	21
Urology	6	-	(1)	-	5
Kingfisher Ward	27	4	(8)	-	23
Purbeck Ward	3	1	(2)	-	2
DCH Radiotherapy Fund	12	5	(11)	-	6
Dermatology Fund	1	-	-	-	1
Ilchester Integrated Assessment Unit	1	-	-	-	1
Ridgeway Ward	4	-	(1)	-	3
Dementia Fund	-	1	-	-	1
Forget-me-not Suite	6	2	(2)	-	6
Maud Alexander Ward	5	-	(3)	-	2
Colorectal and Lower GI	7	1	(2)	-	6
Breast Care	1	-	-	-	1
Lulworth Ward	2	-	-	-	2
Hinton Ward	2	-	-	-	2
Prince of Wales Ward	8	1	(2)	-	7
DCH Therapies	5	-	-	-	5
Haemodialysis	5	1	(1)	-	5
Barnes Ward	3	-	-	-	3
Ophthalmology	3	1	(1)	-	3
COVID-19 Apppeal	-	149	(50)	-	99
DCHC Christmas Appeal	-	5	(4)	-	1
	200	**229**	**(160)**	**-**	**269**
Restricted funds					
Children's Services Trust*	12	6	(1)	-	17
Art in Hospitals*	3	2	(3)	-	2
Cancer Services*	18	7	(2)	-	23
West Dorset Cancer Centre Campaign	542	42	(9)	-	575
Post Graduate Education & Research*	-	-	-	-	-
The Lillian Martin Ophthalmology Fund*	-	-	-	-	-
Special Care Baby Unit*	41	2	(1)	-	42
Renal Fund*	395	56	(18)	-	433
Diabetic Fund*	-	-	-	-	-
COVID-19 NHS Charities Together	-	106	(56)	-	50
NHS Charities Together Emergency	-	50	(50)	-	-
	1,011	**271**	**(140)**	**-**	**1,142**
Total funds	**1,211**	**500**	**(300)**	**-**	**1,411**

*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 2021 (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 were no transfers between funds during 2020/21.

20. Contingency Assets

The Charity was notified via Nantes Solicitors on 15 October 2020 of a residual beneficiary legacy for the General Purpose Charitable Fund at Dorset County Hospital but the value could not be reliably measured at 31 March 2021 when the solicitors were collecting the assets and liabilities of the Estate.

The Charity was notified via Smee & Ford legacy notification service on 31st March 2021 of a residuary beneficiary legacy for the Kingfisher Ward Fund at Dorset County Hospital but the value could not be reliably measured at 31 March 2021 when the solicitors were collecting the assets and liabilities of the Estate.

21. Events after the Reporting Period

There were no events after the reporting period.

Title of Meeting	**Board of Directors**
Date of Meeting	**29 September 2021**
Report Title	**Guardian of Safe Working Interim Report**
Author	**Mr Kyle Mitchell, Guardian of Safe Working**
Responsible Executive	**Alastair Hutchison, Medical Director**

Purpose of Report (e.g. for decision, information) For information	
Summary The Guardian of Safe Working is required to report to the Board to provide evidence of compliance with the safe working elements of the 2016 Junior Doctors Contract. This report covers the period April 2021 – Sept 2021. This period has included times of exceptionally high inpatient numbers and unplanned attendances, with ongoing impact from Covid-19 at the same time as some lifting of restrictions promoting the numbers of holiday makers in the local area. There are ongoing efforts to return to pre-pandemic levels of planned activity but persisting challenges in the discharge of patients who do not need acute hospital care.	
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 Junior Doctors Contract outlines the employer's requirement to ensure training opportunities and a safe working environment.	
Risk Evaluation Analysis of the data summarised within this report may 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 include those associated with additional payments due to excess hours worked; Guardian's fines designed to discourage specific unsafe working practices; and a loss from the Trust of trainees allocated by the postgraduate medical deanery.	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	**a) The Trust continues to support Exception Reporting as a worthwhile venture beneficial to the Trust; to doctors; and to patients.** **b) Divisional leadership continues to take seriously any Immediate Safety Concerns expressed by junior doctors and supports relevant clinical leadership in reviewing and responding to such concerns.** **c) The ongoing transition to a new medical rostering system is used as an opportunity to optimise the Trust's response to short notice medical staffing absences.**

Title of Meeting	**Trust Board**
Date of Meeting	**29 Sept 2021**
Report Title	**Interim Guardian Report of Safe Working report: Doctors in Training (April 2021 – Sept 2021)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Junior doctors are a vital part of the workforce at Dorset County Hospital NHS Foundation Trust ("the Trust"). All eligible doctors in training at the Trust between April 2021 and September 2021 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract") and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW).
- All work schedules provided to doctors in training within the Trust between April 2021 and September 2021 complied with contractual commitments under the 2016 Contract.
- During the peaks of the Covid-19 pandemic exception reporting was at a low level. This may have reflected changes in working patterns, with more hands-on support from non-training grades, but may also have reflected a tendency to under-report.
- The GOSW, the Director of Medical Education and the Executives recognized the importance of encouraging appropriate reporting and promoted this at junior doctor induction, Junior Doctor Forum, with posters in junior doctor working areas.
- Exception reporting has significantly increased since the junior doctor rotation in August 2021.
- Junior doctors have also chosen to escalate some Exception Reports as being of *Immediate Safety Concern*. These have been escalated to divisional leadership and are subject to ongoing consideration.

- Short notice absences contribute to challenges in ensuring a safe working environment for doctors in training. Historic mechanisms to fill short notice absences had inherent inefficiencies. The adoption of a new electronic system for medical rostering provides an opportunity to redesign the mechanism used to fill short notice absences.

- The provider of the electronic platform used to submit Exception Reports within the Trust is changing in coming months. The Guardian of Safe Working will oversee this transition.

2. Introduction

This is an interim report covering the period of April 2021 – September 2021. As agreed at the time of discussion of the Guardian's Annual Report in May 2021, an interim report would be provided at a six month interval.

3. High level data

Number of doctors- / dentists-in-training posts (total):	187	(166 in 2020/21)
Number of doctors in training post (total):	159.2	(156.5 in 2020/21)
Average vacancies across this period	16.9	(9%, 7.2% 20/21)

4. Data summary

The appendices to this report contain summary data as per the nationally agreed outline for Guardian of Safe Working Reporting.

5. Key issues arising

a. Underutilization of the exception reporting system

The rate of submission of Exception Reports was at its lowest level during the Covid-19 pandemic and 2020/21 saw fewer than half the reports submitted compared to 2019/20 (see Appendix 6). Exception reporting provides information useful to Trust and divisional leadership, demonstrating where the greatest challenges exist in ensuring safe medical staffing and allowing refinement of staffing models without relying on adverse events. Under-reporting of work schedule breaches hampers this process.

b. Immediate safety concerns

Within Trauma and Orthopeadics ("T&O"), 4 Exception Reports submitted since August 2021 were highlighted as representing Immediate Safety Concerns (ISCs). These ISCs highlighted the high volume of orthopaedic

inpatients; the conflicting clinical demands placed on senior colleagues that inevitably effect accessibility of support, especially out of hours; some uncertainty regarding responsibilities of junior doctors across surgical specialties; challenges in communication between regular in-hours and out-of-hours clinical teams; and possible deferral of activity that could be taken in-hours that may increase activity out-of-hours.

c. **Redesign of mechanisms used to fill short-notice absences in medical staffing**
   Short notice absences (<48hrs of a shift) represent a challenge in ensuring safe medical staffing. Whilst there is a contractual obligation of junior doctors to step in to fill such short notice absences, when "safe and able" so to do, historically, it has been difficult to know who is in the pool of doctors able to cover a shift; how best to contact them especially out of hours; and how to appropriately remunerate junior doctors for stepping in to short notice gaps. Junior doctors have highlighted the challenges of dealing with pressure to working extra shifts. Both doctors and managers have highlighted the lack of formalized guidance on remuneration. Failure to identify an appropriate junior doctor to fill a gap can result in unnecessary reliance of expensive external agency locum cover; internal consultant "acting down" with associated loss of elective activity; and/or a direct risk to the delivery of safe patient care.
d. **Transition to new platform provider for Exception Reporting**
   Allocate Software have, to date, provided the platform for Exception Report submission. The trust is implementing a new medical rostering platform provided by HealthRota as part of a pan-Dorset project. This includes an exception reporting tool and this will replace the Allocate system. In order to maintain contractual commitments, it is vital that there is no loss of opportunity for junior doctors to submit exception reports.

6. **Action taken to resolve issues**
   a. **Underutilization of the exception reporting system**
      This has been discussed at each of the Bi-monthly Junior Doctors Forums held during the pandemic. The Guardian of Safe Working, supported by the Trust Executives in attendance, agreed that there was a risk that failure to report work schedule breaches may become ingrained in junior doctor working. The August 2021 junior doctor change-over, which sees most junior doctors change jobs and many change employers, was identified as representing an opportunity to reinvigorate the exception reporting process. The Guardian, DME and Medical Director spoke to rotational doctors at clinical induction sessions and promoted the benefit of exception reporting to both Trust and doctor. Junior doctor BMA representatives and the BMA's local Industrial Relations Officer have also promoted these efforts, with posters highlighting the opportunity to exception report displayed in junior doctor working areas. Ongoing trends in reporting will provide evidence of the effectiveness of these efforts.
   b. **Immediate safety concerns**

These reports were immediately escalated to divisional leadership and the Director of Medical Education and the Clinical Lead for T&O provided the Guardian of Safe Working with clarification of aspects of the reports. Uncertainties regarding the responsibilities of FY1 doctors within T&O, included a perceived role within ENT Surgery, were clarified by the service manager and all relevant FY1 doctors are now clear of their out-of-hour responsibilities. The College Tutor for Surgery is aware of this issue and this will be clarified at future induction meetings. The other aspects highlighted in these ISCs are subject to ongoing consideration by relevant clinical leadership.

c. **Redesign of mechanisms used to fill short-notice absences in medical staffing**
The implementation of a new medical rostering system provides the opportunity to formalize a protocol for response to short-notice absences. An App-based "push" notification will facilitate communication with relevant doctors. Decisions regarding remuneration for short notice absence remain with the on-call Executive at the time, but the Guardian has asked divisional leadership to consider how guidance can be provided to facilitate arrangements. Contractual obligations will be discussed at upcoming Junior Doctors Forum.

d. **Transition to new platform provider for Exception Reporting**
The Guardian sits on the project team for implantation of the HealthRota system and will report on the transition with has been planned for January 2022.

7. Other Information:

a. Guardians fines.
There were no fines levied during this period.
.

8. Conclusion

APPENDICES - TRUST BOARD PAPER SEPTEMBER 2021

INTERIM 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 carried over from last report that remain open	No. exceptions raised April-Sept	No. exceptions closed April-Sept	No. exceptions outstanding
Paediatrics	0	0	1	1	0
Obstetrics & Gynaecology	0	0	3	3	0
Orthopaedics	0	0	16	10	6
Anaesthetics	0	0	1	1	0
A&E	0	0	1	1	0
Acute Medicine	0	0	2	1	1
Elderly Care	0	0	13	11	2
Cardiology	0	0	4	4	0
Respiratory	0	0	10	9	1
Gastroenterology	1	0	11	3	9
General Surgery	0	0	12	4	8
Total	**1**	**0**	**74**	**48**	**27**

Exception reports by grade					
Grade	No. exceptions carried over from last report	No. exceptions carried over from last report that remain open	No. exceptions raised April-Sept	No. exceptions closed April-Sept	No. exceptions outstanding
F1	0	0	57	39	18
F2	1	0	7	4	4
CT1-2/ST1-2	0	0	6	1	5
ST3-8	0	0	4	4	0
Total	**1**	**0**	**74**	**48**	**27**

Exception reports by rota					
Specialty	No. exceptions carried over from last report	No. exceptions carried over from last report that remain open	No. exceptions raised April-Sept	No. exceptions closed April-Sept	No. exceptions outstanding
Paediatrics ST3-8	0	0	0	0	0
Paediatrics FY2/GPVTS	0	0	1	1	0
Obstetrics & Gynaecology FY2/ST1-2	0	0	0	0	0
Obstetrics & Gynaecology ST3-8	0	0	3	3	0
General Surgery FY2/CT/GPVTS	0	0	4	0	4

General Surgery ST3-8	0	0	0	0	0
Orthopaedics ST3-8	0	0	0	0	0
Anaesthetics CT1-2	0	0	0	0	0
Anaesthetics ICU CT1-2	0	0	0	0	0
Anaesthetics ICM FY2	0	0	0	0	0
Anaesthetics ST3-8	0	0	1	1	0
Haematology ST3-8	0	0	0	0	0
Histopathology ST1-2	0	0	0	0	0
A&E FY2/GPVTS	0	0	0	0	0
General Medicine FY2/CT1/2/GPVTS	0	0	3	3	0
CMT/GPVTS Cardiology	0	0	0	0	0
CMT – FW Clinical Oncology	0	0	0	0	0
General Medicine ST3-8	0	0	0	0	0
ST3+ Cardiology	0	0	0	0	0
IMT Medical	0	0	1	0	1
GPTS – ED	0	0	1	1	0
FY2 General Practice (AHAH – Med On Call)	0	0	0	0	0
FY2 AHAH	0	0	0	0	0
FY2 GP – Med On Call	0	0	0	0	0
FY2/CT Gastro	1	0	4	1	4
FY1 CAMHS (Gen Adult)	0	0	0	0	0
FY1 Geriatric/Stroke	0	0	4	4	0
FY1 Respiratory	0	0	4	3	1
FY1 Renal	0	0	0	0	0
FY1 Medical	0	0	15	15	0
FY1 Cardiology	0	0	2	2	0
FY1 Gastroenterology	0	0	7	2	5
FY1 Surgical	0	0	13	6	7
FY1Urology	0	0	4	4	0
FY1 ENT	0	0	0	0	0
FY1 Breast/Vascular	0	0	0	0	0
FY1Orthopaedic	0	0	9	7	2
Paediatric FY1	0	0	0	0	0
FY1 Adult	0	0	0	0	0

Psychiatry (Surgical on call)					
FY1 Child & Adolescent Psychiatry (Orthopaedic On call)	0	0	0	0	0
Total	**1**	**0**	**74**	**38**	**27**

Standard Exception Reports - response time			
	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	15	23	15
F2	3	1	4
CT1-2 / ST1-2	1	0	5
ST3-8	0	4	0
Total	**29**	**44**	**24**

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	0	1	3
F2	0	0	0	0
CT1-2 / ST1-2	0	0	0	0
ST3-8	0	0	0	0
Total	**0**	**0**	**1**	**3**

Appendix 2 – Work schedule reviews by grade and department

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

Work schedule reviews by department	
General Surgery	1
Trauma & Orthopaedics	1
Total	**2**

Appendix 3 – Trainee Vacancies within the Trust

Speciality	Grade	Apr	May	Jun	Average Q1	July	Aug	Sept	Average Q2
Paediatrics	ST3	0.3	0.3	0.3	**0.3**	0.3	0.3	0.2	**0.3**
Paediatrics	ST4+	1.2	1.2	1.2	**1.2**	1.2	1.2	1	**1.1**
O&G	ST1	0	0	0	**0**	0	0	0	**0.0**
O&G	ST3+	0.6	0.6	0.6	**0.6**	0.6	0.6	0.6	**0.6**
ED	ST3+	0.4	0.4	0.4	**0.4**	0.4	0.4	0.4	**0.4**
Surgery	CT1	0	0	0	**0**	0	0	0	**0.0**
Surgery	CT2	0	0	0	**0**	0	1	1	**0.7**
Surgery	ST3+	1	1	1	**1**	1	1	1	**1.0**
Orthopaedics	ST3+	0	0	0	**0**	0	0	0	**0.0**
Anaesthetics	CT1/2	1.2	1.2	1.2	**1.2**	1.2	1.2	1.2	**1.2**
Anaesthetics	ST3+	0.4	0.4	0.4	**0.4**	0.4	1.2	1.2	**0.9**
Medicine	CT1/2	2.2	2.2	2.2	**2.2**	2.2	3	3	**2.7**
Medicine COE	ST3+	0	0	0	**0**	0	0	0	**0.0**
Medicine Diab/Endo	ST3+	0	0	0	**0**	0	1	1	**0.7**
Medicine Gastro	ST3+	0	0	0	**0**	0	0	0	**0.0**
Medicine Resp	ST3+	0	0	0	**0**	0	1	1	**0.7**
Medicine Cardio	ST3+	0	0	0	**0**	0	1	1	**0.7**
Medicine Renal	ST3+	0.1	0.1	0.1	**0.1**	0.1	0.1	0.1	**0.1**
Heamatology	ST3+	0	0	0	**0**	0	0	0	**0.0**
Med/Surg	FY1	0	0	0	**0**	0	0	0	**0.0**
Med/Surg	FY2	0	0	0	**0**	0	0	0	**0.0**
GPVTS	ST1	5	5	5	**5**	5	0.8	0.8	**2.2**
GPVTS	ST2	0.8	0.8	0.8	**0.8**	0.8	1.6	1.6	**1.3**
GPVTS	ST3	0	0	0	**0**	0	0	0	**0.0**
Orthodontics	ST3	0	0	0	**0**	0	0	0	**0.0**
Total		13.2	13.2	13.2	**13.2**	13.2	15.4	15.1	**14.57**

Trainee vacancies outside the Trust overseen by the LET guardian:

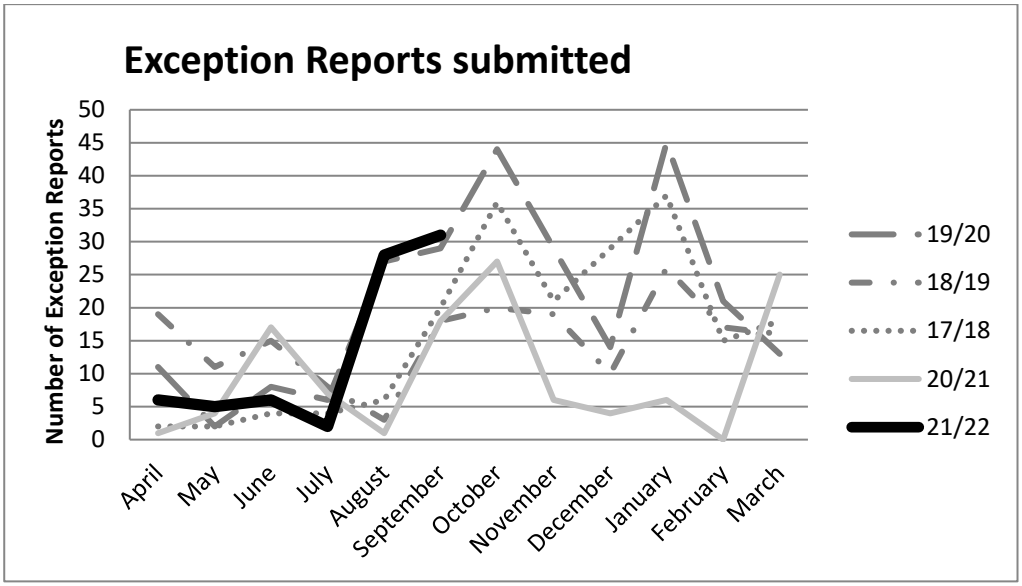
Speciality	Grade	Apr	May	Jun	Average Q1	July	Aug	Sept	Average Q2
General Practice	ST3	4	4	4	1	4	1	1	2.3
Public health trainees	ST4+	0	0	0	0	0	0	0	0
Total	ST1	1	1	1	1	1	3	3	2.3

Appendix 5 – Fines levied by Division and Cumulative Total

Fines by department		
Division	Number of fines levied	Value of fines levied
A	0	0
B	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

Appendix 6 – Exception Reports submitted by month since implementation of 2016 Contract



	17/18	18/19	19/20	20/21	21/22
April	2	19	11	1	6
May	2	11	2	4	5
June	4	15	8	17	6
July	4	8	6	7	2
August	6	3	27	1	28
September	20	18	29	18	31
October	36	20	44	27	
November	21	19	29	6	
December	29	10	14	4	
January	37	26	45	6	
February	15	17	21	0	
March	18	16	13	25	
	194	182	249	116	

Meeting Title:	**Board of Directors**
Date of Meeting:	**29.9.21**
Document Title:	**Education Update**
Responsible Director:	**Chief Medical Officer**
Author:	**Audrey Ryan, DME**

Confidentiality:	*If Confidential please state rationale:*
Publishable under FOI?	yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Medical Education Committee	20.09.2021	Departmental action plans and sharing of good practice
College Tutors, Education Leads, Divisional Directors and Managers	Through August and September 21	Departmental action plans and sharing of good practice

Purpose of the Paper	To receive and note for information and assurance.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	*The GMC survey of 2021 shows that areas previously causing concern have created an improvement in training. Areas have been identified where work is needed to change the experience of trainees and trainers, particularly where this impacts on patient safety.* *DCH has never had as many learners before, and further expansion in numbers is proposed; this will have benefits but will require planning and investment.*							
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the presentation 2. **APPROVE** the actions							

Governance and Compliance Obligations

Legal / Regulatory	Y	Health Education England and the GMC expect us to note the findings of the GMC Survey and to respond to areas of concern.
Financial	Y	Expansion in learner numbers will have an impact due to need for workspace, Supervision and accommodation
Impacts Strategic Objectives?	N	
Risk?	Y	Patient safety impacts outlined
Decision to be made?	N	
Impacts CQC Standards?	Y	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Director of Medical Education Overview

September 21

Miss Audrey Ryan FRCOG

Outstanding care for people in ways which matter to them

- 2021 GMC Survey of doctors in training
- Progress from previous surveys and from the GMC Visit
- Medical staffing update
- Future developments in Education

Staffing update

- Recognition of the impact of gaps in rotas
- Opportunities through Covid: F3s, Medical Support Workers
- IMGs, LEDs
- Wellbeing – session at induction for all new doctors, facilitated groups for our most junior doctors, peer mentor training, Deanery-funded evening seminars

Our doctors

- A mix of consultants, doctors in training (almost exclusively from Wessex Deanery), and Locally Employed Doctors (LEDs: Staff Grades, Specialty Doctors, Trust Doctors, ‘F3s’, Associate Specialists, Fellows); and now Medical Support Workers
- Deanery trainees are here for between 6 months and 2 years
- Rotas are designed around a certain number of doctors but lower levels of doctors training in some specialties around the nation plus increased numbers of LTFT (less than full time) working mean rotas are not filled

Overall results, highlights and hotspots

- All trainer and trainee scores overall are in line with national averages
- Questions are asked in 10 categories, giving rise to the ‘overall satisfaction’ score.
- Results are only published if at least 3 responses
- ‘Above’ outliers (top 5% nationally) within Trainers and Trainees in Anaesthetics; trainees in T&O, and GP trainees in Emergency Medicine
- ‘Below’ outliers (bottom 5% nationally) in O and G
- Good experiences and practice also highlighted in Surgery, Medicine for Older People, Paediatrics, Renal Medicine
- Concerns also raised in Urology, General Surgery and Foundation level Medicine

Concerns relating to patient safety

- In Obs and Gynae, and in Medicine out-of-hours: taking consent when not trained to do so; coping with problems beyond competence/experience; being supervised out-of-hours by someone not competent to do so
- In Urology: strong disagreement with the statement ‘if I had concerns I would know who to talk to in confidence’
- In one of the Medical specialties, in ED and in General Surgery, trainers (consultants) flagging concerns about handover of patients between departments. ED and Gen Surgery also concerned about handover between shifts.
- In Paediatrics, trainers (consultants) flagging daytime workload concerns, with all respondents working beyond rostered hours and half feeling sleep-deprived as a result

Progress from previous years

- Workload in ED – (2019: 100% working beyond rostered hours weekly, with 60% feeling short of sleep as a result) - responses have changed significantly
- ‘Below’ outliers in Foundation Surgical posts – this has improved
- O&G results had improved overall, but 2021 shows a downturn again

GMC Visit February 2018

- ‘Trainees and Trainers are well supported as both clinicians and educators at DCH, with Senior members of the organisation being visible, identifiable and approachable. All groups said they would recommend working at DCH, and Undergraduate education was highly rated’
- Raised serious concerns about clinical supervision of F2s in Surgery at nights, with a requirement to review and monitor out-of-hours supervision for F2 trainees and ensure F2s working at night in the specialty for the first time are appropriately supported
- Asked that we continue to develop clear and transparent systems to monitor how educational resources are allocated and used.
- Review local induction, LTFT training and systems for granting annual and study leave

Over the last 6 years…

- ED recognised as a site for Emergency Medicine training
- Significant increase in medical staffing, mostly in LED group; appointment of consultant lead for LEDs
- DCH has never had as many learners as now; use of other posts to work alongside doctors- PAs, ANPs, Specialist nurses
- Involvement of junior doctors in management decisions – rota design, induction planning, redeployment
- Exception reporting, with results driving change
- SuppoRTT scheme; appointment of consultant lead for SuppoRTT and LTFT training
- Joined up thinking around medical staffing in DCH and across Dorset working with Recruitment, DME, Business Managers, Chief Medical Officer

The future?

- Action plans in areas of concern; areas of good practice asked to share the learning
- £60K Recovery funding – Simulation, Local teaching sessions, Teaching clinics, AV kit
- Continuing work on LEDs
- Expansion of Medical Student and Junior Doctor numbers, meaning an increased requirement for Supervision, appraisal, space and accommodation
- Ongoing focus on Wellbeing and support
- Continuing involvement of junior doctors in management

Thankyou

For your ongoing commitment to teaching, training and supervising

Meeting Title:	**Board of Directors meeting – part 1**
Date of Meeting:	29th September 2021
Document Title:	**Board Assurance Framework**
Responsible Director:	Nick Johnson – Director of Strategy, Transformation & Partnerships. Deputy CEO.
Author:	Ciara Darley – Programme Manager, Transformation & Improvement

Confidentiality:	*Not Confidential*
FOI Publishable?	*Yes/~~No~~*

Prior Discussion							
Job Title or Meeting Title		**Date**		**Recommendations/Comments**			
Risk and Audit Committee		21/09/2021		Recommend to Board			
Purpose of the Paper							
Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

Summary of Key Issues

Summary

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

The principle risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix. The summary position of the BAF continues to highlight the Outstanding Services and Sustainable strategic objectives as the two which are most at risk of delivery. All Executives were asked to review and provide updates where appropriate to the relevant BAF items.

The refreshed Trust Strategy was approved in May 2021 and three new strategic themes have been identified: People, Place and Partnership. Work has commenced to realign all identified risks to the new strategic themes and Risk Owners have been contacted for feedback. Whilst this transition stage is still in progress, the previous template has been submitted for the Committee.

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

- **Objective 1** - Outstanding: Delivering outstanding services everyday.
  - **Risk 5.** Not having the appropriate workforce in place to deliver our patient needs
    Control: Workforce supply and retention is at the heart of the NHS People Plan and this will be mirrored in the refreshed People Strategy (presently being drafted). The Trust will also be moving to a Workforce Business Partner model with a focus on workforce planning and redesign. This will ensure that each division has a workforce model linked to the clinical model. The Trust is working with the Dorset system on both national and international recruitment streams. Vacancy and turnover rates are reviewed monthly at People and Culture Committee

	and are a focus at monthly divisional performance management meetings.
	
	• **Objective 4** Enabling, empowering staff.
	  • **Risk 1**. Not achieving a staff engagement score in the top 20% nationally.
	  Control: People are at the heart of the NHS People Plan and the refreshed DCH People Strategy will reflect this. The Trust undertook a three-step cultural review (Discover, Diagnose, Design) to better understand and engage the whole workforce. An OD function was created (leadership & management development, Health and wellbeing, Inclusion, Freedom to Speak Up). Health and Wellbeing champions are active within all divisions to ensure local action plans developed and discussed. A suite of staff networks have been launched. The results from the 2020 staff survey are showing important improvements. July saw the implementation of the national quarterly staff engagement pulse check, which provides regular, timely feedback on engagement levels to support action to address. The updated EDI Roadmap of culture transformation is on track. The refreshed People Strategy is in development. (R1)
	  Reporting Mechanism: Staff survey results and pulse check results are reported to the People and Culture Committee and Board. A new 'people performance dashboard' is in place reporting on a suite of metrics and qualitative data linked to staff experience and inclusion. The Equality, Diversity and Inclusion steering group review results and actions. The Health and Wellbeing Steering Group has transformed to the People Recovery steering group to support action as a result of the data. Overall oversight is provided by the People and Culture Committee.
	  • **Risk 2.** Not benefitting from the successful delivery of our People Strategy
	  Control: Linked to the new Trust strategy the enabling clinical and people strategies are in development via an organisation wide engagement approach. This is due for sign off in November/December (R2)
	
	• **Objective 5** Sustainable: Productive, effective and efficient
	  • **Risk 1**. Not returning to financial sustainability, with an operating surplus of 1% and self-sufficient in terms of cash
	  Risk Score: Reduced from 20 to 10

Action recommended	The Board is requested to: • review the Board Assurance Framework; and • note the high-risk areas

Governance and Compliance Obligations

Legal / Regulatory	Y/~~N~~	
Financial	Y/~~N~~	The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.

Impacts Strategic Objectives?	Y/~~N~~	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?	Y/~~N~~	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.
Decision to be made?	~~Y~~/N	
Impacts CQC Standards?	Y/~~N~~	It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Impacts Social Value ambitions?	~~Y~~/N	
Equality Impact Assessment?	~~Y~~/N	
Quality Impact Assessment?	~~Y~~/N	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: September 2021

Summary Narrative

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

We may not have the appropriate workforce in place to deliver our patient needs. We continue to experience increasing dependency on the use of temporary clinical staff and the failure to maintain spend within the regulator ceiling for agency staff. The current COVID-19 Pandemic is putting severe strain on the Trust in the short term which may have consequences for the longer term achievement of the Strategic Objectives. However, it is too early to determine this.

There is also a high risk in ensuring we are SUSTAINABLE. The Trust has submitted a plan for the first six months of 21/22 which predicts a breakeven but this is more consequential of the financial regime rather than the underlying income base. The Trust is likely to return to a reported deficit in the second half of the year unless it can delivery significant CIP's during this period. The strength of control and assurance however remains the same.

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

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

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

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

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

A) Principle RISKS					
REF	**RISK**	**Exec Lead**	**Consequence Score**	**Likelihood Score**	**Risk Score**
R1	Not achieving an outstanding rating from the Care Quality Commission within next two years (2021)	NL	3	**4**	**12**
R2	Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality can lead to reduced confidence in the organisation from the public and other bodies.	NL	3	4	**12**
R3	Not achieving national and constitutional performance and access standards	IR	4	4	**16**
R4	Not having effective Emergency Preparedness, Resilience and business continuity plans	IR	3	2	**6**
R5	Not having the appropriate workforce in place to deliver our patient needs	DH	4	5	**20**
R6	Failing to improve the Trust SHMI index	AH	4	3	**12**

B) We will CONTROL these risks by...		**Strength**	**C) The REPORTING MECHANISM...**	**Strength of Delivery**
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	CQC action plan and management of CQC Provider Information Collection (PIC) data every quarter alongside Quarterly CQC meetings (reviewing evidence/assurance information alongside staff and patient feedback focus visits). ICS quality surveillance Group monitors and scrutinises safety and quality with the system and the regulator. (R1)	G	Quality Committee reports on CQC, CQC Provider Information Collection & Insight data, CQC quarterly meetings. Dorset Quality Surveillance meeting in place that reviews hard and soft intelligence remain in 'Routine Surveillance' with acknowledgement to planned waiting list RTT risk.	G
C2	Performance monitoring and management of key priorities for improvement in quality and safe care (R2)	G	Divisional exception reporting and monitoring of quality improvement plans, SHMI and KPIs via The Quality Committee, alongside safety visits (NEDs) and back to floor time for Executive Directors to triangulate data with direct observations of care quality and safety. National NHSI /CCG and CQC reporting . Select number of KPIs not at standard being managed as Quality Improvement programmes (MUST/VTE) with investment required for Dementia team to address Dementia. Reductions seen in Patient experience relating to planned admission and cancelled operations - related to access constitutional standards - gap in assurance and reduced strength in delivery	A
C3	Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement (R3)	G	Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee	G
C4	Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - triggers for intervention/support (R3)	A	Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board).	G
C5	Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE (R4)	G	Reporting from EPRR Committee to Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership.	G
C6	Workforce supply and retention is at the heart of the NHS People Plan and this will be mirrored in the refreshed People Strategy (presently being drafted). The Trust will also be moving to a Workforce Business Partner model with a focus on workforce planning and redesign. This will ensure that each division has a workforce model linked to the clinical model. The Trust is working with the Dorset system on both national and international recruitment streams. Vacancy and turnover rates are reviewed monthly at People and Culture Committee and are a focus at monthly divisional performance management meetings. (R5)	A	We review safe staffing through Board reports; junior doctor workforce issues through the GOSW reports; vacancy levels through the People and Culture Committee and Board workforce reports; develop strategic solutions through the Resourcing Operations Group.	A
C7	People Strategy published May 2018. Refreshed People Strategy presently being drafted. (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 has increased, through the introduction of the Workforce Planning Team. Plan to strengthen this further via the introduction of the Workforce Business Partner model. Dorset Workforce Action Board partner and joint working to mitigate and collectively tackle Dorset workforce issues.	A
C7	Scrutinising other care quality indicators to assure standards of care (R6)	A	Regular reports to Hospital Mortality group , Quality Committee and Board. The latest figure of 1.11 is the best it's been since Dec 2014	G
C8	Poor data capture drives patient coding which effects SHMI (R2)	A	Internal audit of sample of 1000 patient notes and national benchmarking undertaken by PWC	A
Overall Strength		A		G

D) We have actually received these POSITIVE ASSURANCES...		
	Add actual assurances received that a control has remained effective e.g. internal audit reports; metrics demonstrating compliance.	
CONTROL	**ASSURANCE**	**EVIDENCE**
C1	November 2018 CQC rating as 'Good', remain on Routine Surveillance at system and regulator level through Quality Surveillance Group (QSG). Quarterly review with Regulators review of KPIs (CQC; NHSI/E). Maternity safety surveillance enhanced as a result of national Ockenden report with added south west regional perinatal quality and safety surveillance and Dorset safety surveillance.	CQC report. QSG notes. Other benchmark datasets via internal KPIs. National patient surveys. South West Regional NHS England/Improvement Perinatal Quality Safety Surveillance Group (PQSSG) minutes.
C2	National benchmarked datasets such as RCEM, ICNARC, HQIP, Surveys	Quality Committee and Divisional Reports
C3	CCG assurance visits and contract monitoring	CCG assurance reports
C4	Internal performance reports	Board and FPC reports
C2	External auditors - Quality Account (transparency and accuracy of reporting)	Board and QC reports
C5	Internal Audit of systems and processes; and CCG assurance of the EPRR standards	Audit Committee and Board
C1	External review of Divisional Governance Structures and the PWC Well Led Review	Quality Committee and Board
C6	Monthly workforce reports detailing vacancies and trajectories.	Strategic Resourcing Group, Workforce Committee
C8	NHSE/I regular scrutiny and support (R6)	Ongoing NHSI/E reviews

E) We have identified these GAPS IN CONTROL/NEGATIVE ASSURANCES...		
	E.g. No surgical safety checklist in place (gap in control) or hand hygiene audits demonstrate less than 50% compliance (negative assurance), these should be recorded, together with the actions to rectify the gap or negative assurance. These should be linked to the relevant control.	
ISSUE 1		**ACTION**
C1	CQC inspection process being redefined as it progresses due to global COVID-19 pandemic, which may result in some services not being reviewed to enable an 'outstanding' rating within the time frame of the Trust strategy.	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. To undertake our own review in 2021 to outline where we have triangulated evidence against CQC regulatory standards as a overview of the Trust position, whilst pending any inspection. UPDATE: no triggers from CQC for an inspection. Cancer system review - no issues raised for DCH.
ISSUE 2		**ACTION**
C2	Significant resource constraints to deal with increased demand for both Elective and Emergency services.	System wide working on changes to care models and capacity and demand analysis to identify areas for additional investment. Escalation via Elective Care Board, Urgent Emergency Care Board, OFRG and SLT. Revised Phase 3 recovery plan submitted to Region and CCG as part of the recovery from COVID-19
ISSUE 3		**ACTION**
	Uncertainty over no deal Brexit and associated impact on procurement, staffing and charging of overseas patients.	Receiving regular briefings from regional team, participation in national data submissions, task and finish group reporting to Audit Committee.
C3	COVID-19 new virus that requires responsiveness to new guidance and ERPP planning	COVID-19 Incident Management Team in place with a steering group overseeing all actions and planning. Responsiveness to changes in national guidance daily with assurance reports on actions in place.
ISSUE 4		**ACTION**
C4	Inconsistent application of the Performance framework within the Divisions leading to failure to pick up early warnings of deteriorating performance	
ISSUE 5		**ACTION**
C5	Late visibility in junior doctor gaps from Deanery rotations	Regular communications with the Deanery, and profiling of historic gaps. "At risk" recruitment to F3 posts in anticipation of gaps - particularly at ST1 level.

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

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

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Emergency Department admissions continuing to increase per 100,000 population	IR	4	5	**20**	9
R2	Occupied hospital beds days continue to increase per 100,000 population	IR	3	4	**12**	9
R3	Having stranded patients	IR	3	4	**12**	9
R4	Not achieving an integrated community health care hub based on the DCH site	IR	4	4	**16**	6
R5	Not achieving a minimum of 35% of our outpatient activity being delivered away from the DCH site	IR	2	1	**2**	6

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

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

Add actual assurances received 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 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
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		A
		Strength of assurance		G

A) Principle RISKS

REF	RISK	Exec Lead	Consequence Score	Likelihood Score	Risk Score	Target score
R1	Failing to deliver services which have been co-designed with patients and partners	NL	3	3	**9**	6
R2	Not being at the centre of an integrated care system, commissioned to achieve the best outcomes for our patients and communities	PM	3	3	**9**	6
R3	Failure to play an integral role to MDT working leading to unsustainable services and poor outcomes	AH	3	2	**6**	6
R4	Workforce planning consequences across the system are not fully considered which de-stabilises individual organisation's workforce	DH	3	2	**6**	4
R5	Not achieving a Dorset wide integrated electronic shared care record	SS	**2**	**3**	**6**	9

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	Patient and Public engagement as part of transformation framework, with Trust Transformation lead and team trained in service improvement; plus Patient Experience lead in place; Communications team link with CCG for public consultations and engagement events where relevant (R1)	A	Senior Management Team (SMT), Executive Management Team (EMT), Patient Experience Group (PEG) - via CCG , Health Oversight and Scrutiny Committee, Healthwatch, special interest groups	A
C2	CEO Leadership role in SPB, SRO for UECB and broader membership of SLT meetings including SRO for the Dorset ICS with respect to Health Inequalities The SW region has just prioritised the expansion of ED as their top priority. CEO Poole/RBCH and DCH have agreed that when appointments are reviewed for clinical leads at a specialty level to lead the transformation work, there needs to be balance between the East and West.	A	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	A
C3	All improvement programmes (Elective Care Recovery and Sustainability Programme) (R2)	G	SMT (Transformation) meeting minutes and updates to Board via Strategy Update	G
C4	Divisions supported by the Transformation Team (DCH) integral part of Locality and service redesign meetings (R3)	G	SMT Meeting updates and escalation to Execs and Board where applicable	G
C5	Investment in DCH workforce planning team has occurred. DWAB resourced Dorset wide workforce planning capacity has also been implemented to co-ordinate system work. The implementation of the Workforce Business Partner model will help us to better assess our own workforce needs and ensure we are appropriately represented externally, assisting the coordinated Dorset approach. (R4).	G	Regular reports considered at Dorset People Committee and escalated to People and Culture Committee	G
C6	Dorset Care Record project lead is the Director of Informatics at Royal Bournemouth Hospital. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director. (R5)	G	Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	A
Overall Strength		G		G

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

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

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

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

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

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

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

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

A) Principle RISKS

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

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	**CONTROL**	**RAG**	**REPORTING MECHANISM**	**RAG**
C1	People are at the heart of the NHS People Plan and the refreshed DCH People Strategy will reflect this. The Trust undertook a three-step cultural review (Discover, Diagnose, Design) to better understand and engage the whole workforce. An OD function was created (leadership & management development, Health and wellbeing, Inclusion, Freedom to Speak Up). Health and Wellbeing champions are active within all divisions to ensure local action plans developed and discussed. A suite of staff networks have been launched. The results from the 2020 staff survey are showing important improvements. July saw the implementation of the national quarterly staff engagement pulse check, which provides regular, timely feedback on engagement levels to support action to address. The updated EDI Roadmap of culture transformation is on track. The refreshed People Strategy is in development. (R1)	A	Staff survey results and pulse check results are reported to the People and Culture Committee and Board. A new 'people performance dashboard' is in place reporting on a suite of metrics and qualitative data linked to staff experience and inclusion. The Equality, Diversity and Inclusion steering group review results and actions. The Health and Wellbeing Steering Group has transformed to the People Recovery steering group to support action as a result of the data. Overall oversight is provided by the People and Culture Committee.	A
C2	Linked to the new Trust strategy the enabling clinical and people strategies are in development via an organisation wide engagement approach. This is due for sign off in November/December (R2)	G	Workforce committee originally established to consider and report progress against People Strategy. Workforce Committee was extended to become the People and Culture Committee in January 2021.	G
C3	Better Value Better Care Group provides model hospital overview. Regular feedback loops planned for support services to test satisfaction. (R3)	A	Performance and satisfaction measures for support services reported to IMT and SLG. Informal feedback indicates high degree of satisfaction	A
C5	Strong clinical research and innovation programme (R4)	G	Reports to the Quality Committee	G
C6	Medical training activity and issues reviewed by the Director of Medical Education at the Medical Education Committee. Escalation through to the Resourcing Operations Group, and People and Culture Committee as necessary. (R5)	G	Medical Education update provided at People and Culture Committee. GMC junior doctor survey presented to board annually.	G
C7	Ensure a clinical leadership program is in place and appropriate delegates attending. (R6)	G	Both the Divisional Directors have very competent deputies and all other leadership posts are filled. Recent recruitment has produced at least 2 other consultants who could step up if required.	G
Overall Strength		G		A

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	Appointment now in place. Staff survey promoted appropriately and launch of staff recognition scheme. Quarterly staff engagement pulse check implemented. (R1).	Confirmation of appointment. First Pulse Check circulated to all staff.
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 such as ERIC returns will assist with assurance (R3).	Benchmarking information
C5	Recognition via nominations and awards within Research networks (R4)	Wessex CRN awards 2019

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

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

ISSUE 1		**ACTION**
C1	Poor responses to the quarterly Staff Family and Friends test do not provide assurance of staff engagement (R1).	Focus on annual staff survey action plans. Review current people strategy.
ISSUE 2		**ACTION**
C2	Medical engagement continues to be hard to gauge. Recently formed Medical Engagement Forum too early to assess impact (R2).	Review effective 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).	Ensure regular feedback and assurance sought from service users and complaints dealt with promptly.
ISSUE 4		**ACTION**
C6	Gap in workforce reporting to highlight medical leadership vacancies (R6)	Include clinical leadership as part of talent management review

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

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

A) Principle RISKS

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

B) We will CONTROL these risks by...		Strength	C) The REPORTING MECHANISM...	Strength of Delivery
We have the following processes and procedures in place in order to control the risks listed above. Include the Principle Risk reference in (brackets) after the control		green amber red	Where will you get your assurances from throughout the year that this control is effective?	green amber red
REF	CONTROL	RAG	REPORTING MECHANISM	RAG
C1	The Board approved a financial sustainability strategy in Sept 17. The CFO is leading on the implementation of the strategy with the rest of the ICS. The Transformation Team is supporting the delivering of key work streams in the strategy. (R1)	R	The Better Value Better Care Group oversee the implementation of the financial savings. The Senior Management Team receive regular updates on the Transformation Programme. Regular reports received by the Finance and Performance Committee and the Board.	R
C2	Model hospital metrics accessible to service areas. Regular reports and opportunities identified by the Better Value Better Care Group (R2)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	G
C4	Commercial Board reviews income against metrics, overseen by Better Value Better Care Group (R3)	G	Financial reporting mechanisms at commercial board and the Better Value Better Care Group	A
C3	Model hospital will provide information on the efficient use of our estate. (R4)	G	Reports on opportunities and risk discussed by the Better Value Better Care Group and reported up to the Senior Management Team and the Finance and Performance Committee.	A
C5	Estates team look at compliance with statutory requirements and identify risks and mitigating actions (R4)	A	The Authorising Engineers which the Trust appoint, are independent and ensure that safe systems of work and inspection regimes are in place and carried out in accordance with the legislative requirements	G
C6	Six facet survey undertaken in Q2 of 19/20 to identify backlog maintenance levels and investment requirements. (R4)	A	Capital Planning Group review the 6 facet survey and capital investment required. This is reported to the Senior Management Team, Finance and Performance Committee and Board of Directors for approval.	A
C7	The Trust is part of the Dorset Finance Collaborative Agreement to ensure that funds and control totals are amended across the system (R5)	A	Formal reporting of Dorset wide position to the Dorset Operations and Finance Reference Group.	G
Overall Strength		A		R

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

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

CONTROL	ASSURANCE	EVIDENCE
C1	Internal audit reports on financial controls. (R1) and (R2).	BDO audit reports
C2	Model hospital information and RCI index provides the information on our level of efficiency. (R2)	Model Hospital & national RCI index
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 Risk and Audit 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) complaint 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 breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches 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

Meeting Title:	Board of Directors meeting Part one
Date of Meeting:	29 September 2021
Document Title:	**Corporate Risk Register**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Mandy Ford, Head of Risk Management and Quality Assurance

Confidentiality:	*n/a*
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated,
Risk and Audit Committee	21/09/2021	

Purpose of the Paper	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 by the Service Manager and Division. The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*	✓	*Approve (✓)*	
Summary of Key Issues	The most significant risks which could prevent us from achieving our strategic objectives are detailed in the tables within the report. All current active risks continue to be reviewed with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.							
Action recommended	The Board is recommended to: • review the current Corporate Risk Register • note the Extreme and High risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances before recommending to the Board							

Governance and Compliance Obligations

Legal / Regulatory	Y	*Duty to ensure identified risks are managed*
Financial	Y	*Failure to manage risk could have financial implications*
Impacts Strategic Objectives?	Y	*Failure to manage risk will impact on the strategic objectives*
Risk?	Y	*Links and mitigations to the Board Assurance Framework are detailed in the individual risk entries.*
Decision to be made?	Y	*Movement of two workforce related risks to managed or tolerated within risk appetite.*
Impacts CQC Standards?	Y	*This will impact on all Key Lines of Enquiry if risk is not appropriately reported, recorded, mitigated and managed in line with the Risk Appetite.*
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Audit and Risk Committee
Corporate Risk Register as at 31.08.2021

Executive Summary
The Committee will note that the highest risks are associated with the impact of delayed patient treatment due to suspension of services as a result of COVID 19 pandemic control, and the recruitment and retention of staff. There has been some impact on services as a result of staff absence linked to Covid-19.

1. Introduction

1.1 This report provides an update from the report presented to the May 2021 Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 31.08.2021 unless otherwise stated and is reflective of the operational risks.

1.2 This report is to provide the Committee with assurance of the continued focus on the identification, recording and management of risks across the Trust at all levels. These are managed in line with the Trust's Risk Management Framework. The Corporate Risk Register is an amalgamation of the operational risks that require Trust level oversight. The Corporate Risk Register items are the overarching cumulative risks that cover a number of services and the divisions where individual risk elements are being actively managed.

1.3 It should be noted that in this report, only those risks that are scored as High or Extreme are detailed within the report. As agreed at the Committee in July 2021, the whole Corporate Risk Register will be presented to the November 2021 meeting. This report will include those items scored as Low and Moderate

1.3 Presented to the Committee at Appendix 1 is a heat map of those items currently on the Corporate Risk Register with Appendix 2 providing the detail.

- Heat Map (detailed in Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)

1.4 For information, the risks identified below remain as 'managed/tolerated within risk appetite', as agreed at previous committee meetings. For assurance these have been discussed with the risk leads monthly to review status, mitigations and actions to ensure that these can remain as tolerated within risk appetite. Should this change on review, the risks will be re-opened.

- Financial sustainability (449)

  This is likely to remain at current status and risk score (LOW RISK – 6) until November 2021. This risk will be reviewed again 31.10.2021 to ensure that the status and score remain correct.
- Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff (463); and Recruitment and retention of Medical staff across specialities (468)

Trust continues to review our recruitment processes and recruitment drives, working in line with the People Plan, to try and ensure that vacancies are recruited to. We have looked at different models to try and encourage applications. However, it should be acknowledged that across many health care professions, at all levels and in all specialities, there are national shortages. Any staff shortfalls have been mitigated by reallocating staff from wards to other areas to provide support and ensure patient safety, bank staff and agency staff. Whilst staffing remains extremely challenging high quality safe care is still being delivered.

2. Updates

2.1 **704 – Brexit – UK leaving the EU without a deal.**

(This is managed/tolerated within risk appetite but is under bi-monthly review)

2.1.1 The update remains unchanged from the previous report.

2.1.2 Family Services and Surgical Division

472 Community Paediatric Long Waits for Autism Spectrum Disorder (ASD) patients. Scored as 20 (Extreme) (Major (4) x Certain (5))

This has been reported as an emerging risk in previous RAC reports.

It should be noted that this is not a new issue and that this has been a longstanding risk within the service since September 2018. Various workshops have been held across the system have been held with the aim to ensure that the pathway is correct for patients with ASD.

However the demand for this service has increased, and the waiting list, and therefore the risk, increased further with the onset of the pandemic. Following revision and review of the risk, and despite the mitigations and actions in place, the waiting list cannot be managed with the service capacity that we have.

Additional clinics are currently running from phase 3 monies which has slightly reduced the backlog, however waits continue to be extremely long for patients, some of which are in excess of 1 year. Funding has just been approved to continue with ASD clinics post September. The service have gone out to advert for a Specialist Grade clinician which is a new National medical post that was introduced from April 2021.

The ASD options paper is due to be reviewed within the department following changes in management. The paper will then be presented to the Senior Leadership Group (SLG) for consideration.

For information, as at 24 August 2021, there are currently 320 on the waiting list and the service are able to see 14 patients a week currently.

2.1.3 **Cybersecurity**

Queries have been raised at the two previous meetings in relation to why cybersecurity is not on the Corporate Risk Register. Therefore, an update is provided to this meeting for information.

There are a number of risks on the Corporate Risk Register that do not get reported to the Committee, as the report focuses on any extreme or high risk items. In addition to these, the Trust has a number of other risks recorded as 'moderate or low risk' items.

For information only, Cybersecurity is currently scored as moderate and the details are as below:-

690 - Malicious attack - Cyberattack on the NHS / Internal ICT failure. Scored as 12 (Moderate) (Major (4) x Possible (3)).

This risk sits on the corporate risk register and is linked to the ICT and Emergency Planning risk register. In addition to the risk detailed above, there are other risks linked to this risk which are specific to the Trust infrastructure and Firewalls. There are full mitigations and actions in place, and these risks are reviewed monthly.

To support the risk score as moderate, there have been no incidents reported in relation to any cybersecurity breaches or loss of systems due to a cyberattack which would increase the likelihood score, which in turn would then escalate the risk score.

For items on the Emergency Planning Risk register, we routinely link and review these in line with the National risk register, and we note the national risk score for information within our risk register. Currently, nationally the risk of a cyberattack is scored as a 'Medium to low' risk, which is in line with our local risk score.

2.2 New to the Corporate Risk Register

2.2.1 **840 - Paediatric Diabetes Service Staffing** (agreed from escalation to the Corporate Risk Register from emerging risks in previous reports). **Scored as 20 (Extreme) (Major (4) x Certain (5))**

The current PDSN establishment is unable to meet the demands of national guidelines (NICE Guidance, Paediatric Diabetes Best Practice Tariff (BPT) and National Children and Young People's Diabetes (NCYPD) Quality Programme). This significantly increases the risk of diabetes related complications both in the short and long term, resulting in poor patient outcomes, workforce burnout and increased cost to the NHS.

Confirmation from the Divisions that funding has been agreed for additional staffing from Oct 2021.
Band 7 PDSN – 0.5 wte
Band 6 PDSN – 1.0 wte
Paediatric Diabetes Specialist Dietician band 6 – 1.0 wte

Once these staff are appointed and have commenced at the Trust, the risk severity should be reduced and this should move back to Divisional and service level.

3. Top Themes:

3.1 **Covid 19**

- 919 – Covid 19 (Extreme 20 (down from 25))

3.1.1 Covid-19 (data from the Dorset LRF Covid-19 COP 10/8/21 (Common Operating Picture)

After a short period of seeing case rates fall in our local area, they have begun to increase again over the past week. At 510.1 per 100,000, the Bournemouth, Christchurch and Poole Council case rate is above the England average of 283.7 and the South West average of 307.2. Dorset Council's case rate is also rising and is now 282.0. The number of people in hospital in Dorset with COVID-19 continues to rise slowly, and sadly we are seeing a small number of COVID-related deaths.

NHS England publish weekly data on the number of COVID-19 vaccinations given by local area. As of 1 August, 1,075,493 doses of the COVID[1]19 vaccination had been administered in Dorset.

As of 16 August 2021 the government has changed the requirements to self-isolate following a positive COVID-19 contact. Local guidance has been amended to reflect these changes. Masks are still required to be worn on the hospital site and social distancing is still being adhered to.

3.2 Constitutional standards

- 709 - Failure to achieve constitutional standards (elective care) (Extreme 20)
- 710 - Follow up waiting list backlog (Extreme 20)
- 450 - Emergency Department Target, Delays to Care & Patient Flow (Moderate 12)

3.2.1 The access team are continuing to contact patients on the waiting lists during. Patients are being called in clinical priority with consultants having oversight of the lists.

3.2.2 Currently 709 and 710 remain as 'Extreme' due to the potential impact on patient safety and delay in treatment that could potentially lead to harm. (This is being mitigated by reviewing patients based on clinical need and any changes in presentations). There may be financial implications if constitutional standards are met and there may be an increase in litigation if patient harm has been caused due to delays caused by Covid 19.

3.2.3 ED performance continues to be impacted by increased attendances and ambulance conveyances. There is also an increase of patients experiencing a 12 hour delay in ED due to the volume of patients and the lack of available hospital beds.

3.3 Mortality

- 641 – clinical coding (High 15)
- 464 – Mortality Indicator (Moderate 12)

3.3.1 Both of these items are discussed and reviewed regularly at the Hospital Mortality Group chaired by the Chief Medical Officer. There is no change to the update provided in the previous report. Dr Foster data was not discussed at the August meeting to the presenter of the report being unavailable. This will be discussed at the September report and the risks updated.

4 Divisional Emerging Risks (Details in Appendix 3)

4.1 <u>Urgent and Integrated Care</u>

- 461- High volume of patients with no reason to reside (scored as 20 (Extreme) (Major (4) x Certain (5))

Previously reported to Committee as 'Inpatient length of stay (Scored as 15 (High) (Moderate (3) x Certain (5))'

4.1.1 This risk has been on the register since October 2018. The risk has recently been reviewed and reframed to ensure that it is reflective of the situation as it stands currently.

Having a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed is impacting on the patients well-being and the flow of patients. Predominantly, this cohort of patients are awaiting for some form of care package, or placement within a residential or nursing home setting. Some patients are delayed by legal processes, such as Court of Protection, where there is some dispute over placement, or the patient's capacity to make a decision on their care.

Clinical teams are reporting incidents for patients that have no reason to reside due to the impact on their physical and mental well-being, whilst this is difficult to evidence fully, we are aware that delays in discharge are affecting patients. As their condition deteriorates, their care needs increase, which means the assessment and brokerage process has to be recommenced.

As at 09.09.2021, we have 59 patients with no reason to reside, mitigations and actions have been reviewed and updated and are detailed below:-

- Home First Programme (internal)
- External support from NHSE/I to implement Criteria to Reside (Ilchester commenced already)
- Increasing Volunteers support to mitigate serious issue with care capacity
- Improved EOL fast track processes
- Appointed a Discharge Lead (therapy background – commenced in post late August 2021)
- Daily escalation meetings in place with SPA leads/discharge team
- Supporting the work of Impower (ICS strategic partner) to design and implement a new model for hospital discharge
- Working with the discharge team to review internal processes and practice
- Working with Risk Management to look at legal options to support patients on DOLS or COP to ensure these patients are placed in appropriate care settings in a timely manner
- Looking at the MCA process to streamline, and to eliminate discrepancies in its application across the Trust and agencies involved.

4.2 <u>Family Services and Surgical Division</u>

- 866 - External Multiagency delays resulting in delayed discharge of complex paediatric patients (Scored as 16 (High) (Moderate (4) x Certain (4))

4.2.1 This is currently sitting at Divisional level where mitigations are in place. The score is currently being reviewed by Division as we have had a lower volume of incidents reported.

4.3 These risks are being highlighted to the Committee again, as they continue to have the potential to impact on patient flow through the hospital, and could potentially cause patients harm by prolonged admissions or failure to undertake the necessary tests. These are not new issues but have become more prevalent during the pandemic management due to the requirement of flow and bed capacity. It should also be noted that space is an issue across the Trust and for many services.

5. Conclusion

Risks continue to be regularly reviewed and updated in line with the Risk Management Framework and is linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place.

The Risk team are in the process of reviewing all open and active entries on the live risk register with the service managers and relevant staff to ensure that scoring is correct and that risks are being reviewed and appropriately followed up and actions being followed through.

In addition, regular monthly meetings between the Head of Risk Management and the Chief Nursing Officer are being held where the registers are reviewed and challenged.

6. Recommendation

The Audit and Risk committee is recommended to:

- review the current Corporate Risk Register ; and
- note the Extreme and High risk areas and actions
- consider overall risks to strategic objectives and BAF
- request any further assurances before recommending to the Board

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 06.09.2021

Appendices

Appendix 1 – Heat map
Appendix 2 - Corporate Risk Register
Appendix 3 – Emerging Divisional Risk Details

Heat Map

Appendix 1

		Likelihood Score				
score		**1**	**2**	**3**	**4**	**5**
		Rare (this will probably never happen 1x year)	**Unlikely (Do not expect it to happen but it is possible 2 x year)**	**Possible (might happen occasionally - monthly)**	**Likely (will probably happen - weekly)**	**Certain (will undoubtedly happen – daily)**
Consequence Score	**5 Catastrophic**	**5**	**10**	**15**	**20** (472,1084)	**25**
	4 Major	**4**	**8**	**12** (450,466, 1000)	**16** (474, 979)	**20** (709, 710, 840, 919)
	3 Moderate	**3**	**6**	**9** (470)	**12** (464)	**15** (641)
	2 Minor	**2**	**4**	**6**	**8**	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**
	KEY	**(↓number)** Risk score has decreased since previous report **(↑number)** Risk score has increased since previous report **Please note that no arrow indicates no change to previous risk score.**				
	Closed/Managed/Tolerated risks	449 Financial Sustainability remains in 'managed' status at the start of 2021/22 financial year. 463 Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff; and 468 Recruitment and retention of Medical staff across specialities				

Corporate Risk Register **Appendix 2**

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

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Catastrophic Likelihood: Likely Reviewed: 17.08.2021
919	Covid- 19	Previous Rating	Extreme (25)
This will impact on all of our strategic objectives.		Lead Executive	Inese Robotham
How this risk has been scored: **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Tony James
Current position/Progress/ Mitigation As at 06.09.2021 (data correct as at 06.09.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible undetermined
• After a short period of seeing case rates fall in our local area, they have begun to increase again over the past week. At 510.1 per 100,000, the Bournemouth, Christchurch and Poole Council case rate is above the England average of 283.7 and the South West average of 307.2. Dorset Council's case rate is also rising and is now 282.0. The number of people in hospital in Dorset with COVID-19 continues to rise slowly, and sadly we are seeing a small number of COVID-related deaths. • NHS England publish weekly data on the number of COVID-19 vaccinations given by local area. As of 1 August, 1,075,493 doses of the COVID[1]19 vaccination had been administered in Dorset. • As of 16 August 2021 the government has changed the requirements to self-isolate following a positive COVID-19 contact. Trust guidance has been amended to reflect the changes. • During September, the Government will undertake a review to assess the country's preparedness for autumn and winter, which will consider whether to continue or strengthen public and business guidance The Prime Minister urged the public to remain vigilant and exercise caution. Current modelling suggests that COVID-19 cases will continue to rise as restrictions are eased. Hospitalisations, serious illness and deaths will also continue, albeit at a much lower level than before the vaccination programme. The		Next review date	30.09.2021

government is keeping in place a number of key protections including guidance for individuals, businesses and the vulnerable, border quarantine, testing and encouraging and supporting businesses and large events to use the NHS COVID Pass in high risk settings. The Health and Social Care Secretary also announced the plans to Parliament. • It has been advised by NHSE&I that Hospital Hubs that closed in March will re-open in September for 15 weeks to administer booster vaccines and flu jabs at the same time. • The DCH IMT were meeting once a week on a Wednesday. ICC is in place to be stood up if required as per the Level 3 requirements. DCH IMT has been stepped up again as at 01.09.2021. • National Daily COVID-19 SitRep reporting has been stood down to five days a week. • DCH remains at Major Incident Stand-by status along with the other Dorset acute hospitals. • No issues with Mortuary capacity at DCH or within the other Dorset acute hospitals • PPE levels remain good within the Trust with at least 2 weeks supply and no issues with ordering further supplies.		

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 31.08.2021
709	Failure to achieve constitutional standards (elective Care)	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : **Outstanding:** Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards Strategic Objective 3 Not achieving a 96% score on our friends and family test, Not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities **Strategic Objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Inese Robotham
Current position/Progress/Mitigation As at 06.09.2021 (data correct as at 06.09.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Covid- 19 impacted on services – this is being reviewed as part of the start-up work. • This is coded as extreme due to the potential impact on patient safety and delay in treatment that could potentially lead to harm – this is being mitigated by reviewing patients based on clinical need and any changes in presentations. • The 2021/22 planning guidance requests the trust to deliver 85% of our 2019/20 activity volumes by July 2021. The Trust is achieving 86% in April 2021 and is forecasted to be achieving 100% or above by July 2021. This returns the trust to pre-COVID levels of activity. The trusts has an elective recovery programme which is tasks with delivering above this level, as such levels of activity will not be enough to reduce the backlog of patients. A large scale insourcing and outsourcing programme has commenced to support this. • Diagnostics – Recovery plans and trajectories are in place and being monitored by the Elective Performance Management Group to return the trust to achieving the required standard. Use of insourcing and outsourcing providers is underway. • Cancer – The Trust has recovered cancer performance to pre-COVID levels as per the 2021/22 guidance; with an improved 104 day backstop position. The required standard is still not being met and a trajectory to achieve this by the		Next review date	30.09.2021

end of the year is in place. • ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average.		
OTHER RISK REGISTERS LINKED TO RISK 709	**Current rating following local review**	**Target rating following completion of all actions**
450 Emergency Department Target, delays to care and Patient flow	Moderate	Moderate
473 Failure to meet 6 week diagnostic targets for paediatric and adult audiology	Low Risk	Low Risk
531 Same day emergency care mandated activity	Moderate	Low risk
554 Non-compliance with QS33 Rheumatoid arthritis in over 16s	Low Risk	Very low risk
555 Partial non-compliance with NG100 – rheumatology	Low Risk	Very low risk
Numerous incidents reported in relation to cancellation of clinics and increase in complaints regarding treatment delays.	Potential for litigation due to patient harm	

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 31.08.2021
710	Follow up waiting list backlog	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	All services
Current position/Progress/Mitigation As at 06.09.2021(data correct as at 06.09.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Robust reporting arrangements are in place to allow the services to oversee and manage all of the patients on their waiting lists. • Follow up waiting list numbers and profile of the waiting list is routinely reported to FPC. • Patient initiated follow ups are being launched in 3 specialities in 2021/22. This will reduce the volume of non-value adding appointments, releasing capacity to address the backlog. • Where clinically appropriate, virtual appointments are now offered, either via video consultation or via telephone. Virtual appointments are more efficient and result in higher volumes of patients being seen per clinic.		Next review date	30.09.2021

OTHER RISK REGISTERS LINKED TO RISK 709	Current rating following local review	Target rating following completion of all actions
462 Lack of ophthalmology service capacity to meet demand	Moderate	Low risk
472 Community paediatric long waits for ASD patients	Extreme	Moderate
505 Volume of patients on the gastroenterology follow up outpatient waiting list	Low risk	Low risk
557 Surveillance colonoscopy patients waiting greater than 6 months from their due date	Moderate	Very low risk
561 Volume of patients on the orthopaedic admitted list	Extreme	Low risk
581 Volume of patients on the dermatology outpatient waiting list	High	Low risk
777 Long waiting list for outpatient orthotic appointments	Low risk	Low risk
956 Excessive sleep diagnostic waiting times	Low risk	Very low risk
991 Increasing waiting list for paediatric dietetic outpatients	Moderate	Very low risk
1003 Ambulatory EEG waiting list	High	Low risk

Movement on Risk Register: 	Risk Statement PACS Storage **Date added to Risk Register 22.04.2021**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 05.05.2021
1084	The issue is that the new CT scanner takes a more in depth picture that is therefore larger and takes up more storage. Unfortunately the increased storage requirements weren't factored in at the time, but there has been a change in the consumption forecast.	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	Simon Brown
Current position/Progress/Mitigation As at 06.05.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING Target date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 31.03.2022
Mitigation: • ICT produce the summary report to Radiology monthly to evidence consumption • the monthly reports are working well to enable a reasonably accurate forecast on consumption • The mitigation would be to purchase additional storage, we do not believe this is a capital pressure until next financial year (2022/23)		Next review date	30.09.2021

Movement on Risk Register: 	Risk Statement Community Paediatric Long Waits for ASD Patients **Date added to Corporate Risk Register 09.06.2021** **Opened by Service 10.09.2018 – reviewed monthly** **Escalated to Division 08.06.2021 request to escalate to Corporate**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 24.08.2021
472	There has been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 3: Collaborative** Joining up our services. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	Catherine Abery-Williams
Current position/Progress/Mitigation As at 06.09.2021 (data correct as at 06.09.2021)		POST MITIGATION RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 19.01.2022
Mitigation: • The ASD options paper was reviewed within the department following the changes in management. It was presented to SMT for consideration. • Additional clinics currently running from phase 3 monies which has reduced the backlog, however waits continue to be extremely long for patients in excess of 1 year. Currently 320 on waiting list and see 14 a week. Risk remains as extreme. • Funding has just been approved to continue with ASD clinics post September. Have gone out to advert for Specialist Grade which is a new National medical post introduced from April 2021.		Next review date	30.09.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 17.07.2021
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Sue Eve-Jones
Current position/Progress/Mitigation As at 06.09.2021 (data correct as at 06.09.2021)		POST MITIGATION RATING (Target) Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31/03/2022
There is a certain amount of uncoded data / backlog in coding which is affecting the SHMI figures. Data submitted by Trust as SUS data but then goes on to become the national HESS data. If the primary diagnosis is missing or invalid when the data is submitted they are put in R69X as part of the HESS data cleaning. This pushes all uncoded activity into the residual codes unclassified diagnosis group. Current figures are based on data up to February discharges which the Trust would of submitted the middle of March. This shows a large amount of activity predominantly siting in December 20 and January and February 21. A lot of super spells and a high volume of deaths are sitting in this group. Generally speaking the residual codes unclassified diagnosis group have a low risk of mortality but when fully coded the risk of mortality will change and the overall expected number of deaths would go up and the SHIMI would come down. This data is now fixed as the Trust had until the middle of May to refresh and re-submit data for each financial year. The Chief Medical Officer noted the coding activity was diverted to get the elective data coded to gain the financial enhancements based on performance. This was the focus of the coding department, this work is now complete.		Next review date:	30.09.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	High (16) Consequence: Major Likelihood: Likely Reviewed: 08.09.2021
979	Removal/reduction of education funding from HEE commencing April 21.	Previous Rating	Moderate (12)
Impact on Strategic Objectives		Lead Executive	Nicky Lucey covering
Strategic objective 1 : Outstanding Not having the appropriate workforce in place to deliver our patient needs **Strategic objective 4: Enabling** Failure to deliver flexible and appropriate service models**,** Loss of training status for junior doctors **Strategic objective 5:** Sustainable **How this risk has been scored:** **Consequence: Moderate** **Patient safety** – event that impacts on a small number of patients, increase length of stay by 4-16 days **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Likelihood:** Certain		Local Manager	Elaine Hartley
Current position/Progress/Mitigation As at 08.09.2021 (data correct as at 09.09.2021)		POST MITIGATION RATING (target) Target date	Low Risk (6) Consequence: Minor Likelihood: Possible 31.03.2022
We have submitted our request for funding to the Dorset ICS in July. Our request is based on the TNA scope for 21/22 and incorporates all requests for health care science, pharmacy and non clinical. We are yet to receive a confirmation of the funding we will get and we have had to go at risk for some staff to continue on programs which are longer than 12 months. We are hoping to receive confirmation by the end of Q3.		Next review date	31.12.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 01.06.2021
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 5: **Sustainable :** Not using our estate efficiently and flexibly to deliver safe services **Mitigation:** Discussion at SMT 15.01.2020 Electrical work is now underway Data is back and work will commence on this before financial year end Tender will be out shortly for new installation work - this will fall in to the new financial year. **UPDATED PROGRESS:** Electrical installation 30% complete. Data out to tender. To be complete by 31MAR21. New system install specification nearing completion. Roll out anticipated end Q1 FY20/21 **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Don Taylor
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 14.07.2021)		POST MITIGATION RATING (TARGET) Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31/03/2022
Completion of power installation adjusted to end of FEB 2021. Project delayed to FY21/22 Tender with procurement and almost ready for release to procure the replacement system which is currently planned to commence early new financial year, powers supply enabling works now nearing completion Scope complete. Now with Procurement for tender**.**		Next review date	31.07.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:17.07.2021
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective 1: Outstanding : Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit -** non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity -** National media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position/Progress/Mitigation As at 17.07.2021 (data correct as at 06.09.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2022
The trend is still downwards but has shown a slight increase over the last 3 months. Upper limit is 1.13 DCH currently are 1.1295. Our observed deaths continue to come down which may be due to the month of January when COVID deaths were not included and the expected deaths also reduced and went down faster than observed deaths. However, the mean depth of coding has continued to increase which is a positive. The figure for latest year is slightly above the UK average for non-elective admissions. Our HSMR is stable at 106 and within expected range. HSMR is similar to SHIMI but only looks at specific diagnosis not all deaths and only inpatient deaths.		Next review date	30.09.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (Following review)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 29.09.2020
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible**		Local Manager	Samantha Hartley
Current position/Progress/Mitigation As at 28.02.2021 (data correct as at 09.03.2021)		POST MITIGATION RATING Target date:	Moderate (12) Consequence: Major Likelihood: Possible 31.03.2022
Mitigation: Liaison Service on site. Increase in activity is being managed with IMT ED area increased during pandemic to assist with flow and capacity. Building works commenced to enlarge ED 2021 ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average. UPDATE: Minor service has relocated to Weymouth UCC 28 June 2021 to assist with patient flow and attendances at ED		Next review date	30.09.2021 (annual review)

OTHER RISK REGISTERS LINKED TO RISK 450	**Current rating following local review**	**Target rating following completion of all actions**
1060 ED Footprint not fit for purpose 1061 Workforce requirements for new ED 709 – Failure to achieve constitutional standards.	Low risk Moderate risk	Very Low risk Very Low risk

Movement on Risk Register: **NEW**	Risk Statement **This risk was added to Datix on (it looks like 09.10.2019), with a review date of 09.01.2020. It was marked for quarterly review 27.11.2020 and weekly review from 30.03.2021.** **It was marked as service specific on 03.12.2020, escalated to Division at that point and to Corporate for consideration via Division on 16.03.2021.** **Risk score allocated to this by the service between 18.12.2019 and 07.10.2020 was scored as 12 (moderate), this was reviewed and rescored 19.10.2020 to 15 (high) and then 20 (Extreme) following the review on 26.11.2020** **Agreed for addition to Corporate Risk Register 01.05.2021**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 18.08.2020
840	Paediatric Diabetes Service Staffing	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Inese Robotham
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic Objective 3: Collaborative** Failing to deliver services which have been co-designed with patients and partners Failing to be an integral part of full system multi-disciplinary teams **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Certain**		Local Manager	Anna Ekerold
Current position/Progress/Mitigation As at 18.08.2021 (data correct as at 06.09.2021)		POST MITIGATION RATING Target Date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 06.12.2021
Mitigation: • Band 5 LM previously seconded from Kingfisher covering 23hrs per week now permanent. • New Band 6 PDSN ED began employment in June 2021.		Next review date	31.10.2021

• Band 7 PDSD to increase hours from 0.5 to 1 WTE with effect from 01/10/2021. • 1.4 WTE Band 6 PDSN posts currently out to advert. • 1 WTE Clinical Psychology awaiting advertisement. • 2 PA's Consultant time currently covered by Speciality Doctor SZ, however long term plan for Consultant PP to cover this role. • Urgent & Integrated Care Division successful for funding for transition service. Recruitment underway. • Confirmation from Division is that funding has been agreed for additional staffing from Oct 2021. **Once these staff are in place, the risk severity should be reduced**		

Emerging Divisional Risks

Appendix 3

Movement on Risk Register: 	Risk Statement External Multiagency delays resulting in delayed discharge of complex paediatric patients **It was added to the service risk register 24.12.2019 reviewed 11.05.2020, 07.10.2020 and escalated to the Divisional Risk Register 22.12.2020**	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 08.07.2021
866	Increasing amount of children and young people are requiring the local authority to provide accommodation on discharge from Kingfisher Ward. These children often have emotional or mental health issues but do not require mental health inpatient admission but require a safe, nurturing environment away from the family home for their own safety and/or the safety of family/siblings. There are often delays in processes and locating appropriate placements resulting in prolonged hospital admission in an inappropriate environment. Additionally the Trust have seen a significant increase in patients admitted with Eating Disorders, requiring specialist input and / or inpatient bed. This has been highlighted both locally and nationally.	Previous Rating	Low Risk
Current position/Progress/Mitigation As at 08.07.2021 (data correct as at 14.07.2021)		POST MITIGATION RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.03.2022
Mitigation: • Weekly escalation though Division B updating with progress of patients. • Weekly reporting of incidents involving these patients to Dorset Healthcare to the Head of Mental Health Services • Formal escalations are happening when required between multiple agencies involved with patients. • Children all discussed at Weekly ILM meetings. • 1:1 support for patients being sought when appropriate for safety. Risk reports entered locally to evidence delays. • Training provided by DHCFT to support staff in restraint techniques • DHCFT providing staff (either from their own bank or agency) to support the staff on Kingfisher • Legal support and advice requested and provided in complex cases to try and assist with the correct placement being found for the children • Continued working with the Local Authority and DHCFT to find appropriate placement for the children. • Possibility of a safe room within the unit being explored.		Next review date	02.09.2021

Movement on Risk Register: 	Risk Statement **It was added to the service risk register 29.10.2018 reviewed 19.01.2019, 14.01.2020 and escalated to the Divisional Risk Register 14.01.2020**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 09.09.2021
461	High volume of patients with no reason to reside	Previous Rating	High Risk
Current position/Progress/Mitigation As at 08.09.2021 (data correct as at 09.09.2021)		POST MITIGATION RATING Target date:	Moderate (10) Consequence: Minor Likelihood: Certain 31.03.2022
Mitigation: As at 09.09.2021 : We currently have 59 patients with no reason to reside, mitigations are:- • Home First Programme (internal) • External support from NHSE/I to implement Criteria to Reside (Ilchester commenced already) • Increasing Volunteers support to mitigate serious issue with care capacity • Improved EOL fast track processes • Appointed a Discharge Lead (therapy background) • Daily escalation meetings in place with SPA leads/discharge team • Supporting the work of Impower (ICS strategic partner) to design and implement a new model for hospital discharge • Working with the discharge team to review internal processes and practice • Working with Risk Management to look at legal options to support patients on DOLS or COP to ensure these patients are placed in a timely manner • Looking at the MCA process to streamline, and to eliminate discrepancies in its application across the Trust and agencies involved.		Next review date	31.10.2021

Meeting Title:	Board of Directors
Date of Meeting:	29 September 2021
Document Title:	**Recovery Overview**
Responsible Director:	Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships
Author:	Natalie Violet, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Chief People Officer, Chief Operating Officer, and Deputy Chief Executive and Director of Strategy, Transformation and Partnerships	22/09/2021	Approved

Purpose of the Paper	The purpose of the report is to provide the Trust Board with an overview of progress against the Trust's Recovery Framework following the COVID-19 pandemic.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	Highlights include: • Development of a new People Dashboard with measures to track recovery aligned to the National NHS People Plan, presented monthly to the People and Culture Committee. • The first People Recovery Steering Group convened this month. • Continued wellbeing initiatives and the reintroduction of wellbeing walkarounds. • The Transforming People Practices work, aligned to the Inclusive Leadership Programme, continues. • The organisation achieved the required ERF thresholds for the first three months of the year. • NHS England and NHS Improvement announced the threshold required to qualify for ERF would increase to 95% from 01 July 2021. The organisation did not achieve this for July or August. • Non-COVID emergency demand remains high resulting in elective cancellations. • Performance against the ERF gateways is positive, however further work is required to analyse waiting times for ethnic minority patients and patients from deprived areas. • Work is underway to improve ethnicity data collection. • The waiting list size is growing faster than expected with referral rates sitting 8% above 2019/20 levels. • The waiting list profile has reduced in patients waiting between 52 and 77 weeks. 52+ week waiters are reducing faster than the planned trajectory. Since the peak in March 2021, the Trust has reduced the number of 52+ week waiters by 1,075. • Insourcing and outsourcing activity has been utilised in most surgical specialties with Maxillo-facial commencing this month. A specialty particularly challenged with 52+ week waiters. • The organisation has successfully secured capacity within local community hospitals without incurring additional rental costs from Dorset Healthcare.							

Action recommended	The Trust Board is recommended to: 1. **APPROVE** the Trust's Recovery Framework.

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to monitor progress against the Trust's Recovery Framework could result in further deterioration of standards. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus.
Financial	Y	Failure to monitor progress against the Trust's Recovery Framework could result in further deterioration of standards. Ensuring the Trust Board has oversight of the recovery ensures they are sighted on those areas that are outside of our control and those which require focus.
Impacts Strategic Objectives?	Y	Delivery of outstanding care. Significant impact on patient and staff experience and reputation of poor performance with commissioners, regulators, and the public.
Risk?	Y	The clinical impact of COVID-19 on planned care and patients that are not clinically urgent is not understood yet, but a clinical risk stratification programme is in development, which follows the nationally published guidelines. Harm cannot be determined until the patient is seen.
Decision to be made?	N	No decision required.
Impacts CQC Standards?	Y	Ensuring robust oversight against the Trust's Recovery Framework links with the CQC well-led domain.
Impacts Social Value ambitions?	N	The recovery approach supports the organisations Social Value ambitions by being a supportive employer and recovering elective services for our local communities, embedding equity in health outcomes into restart processes.
Equality Impact Assessment?	N	The Elective Performance Management Group (EPMG) are focusing on addressing waiting list health inequalities, with a particular focus on ethnicity and deprivation.
Quality Impact Assessment?	N	Quality Committee are providing oversight of patient outcomes.

Title of Meeting	Board of Directors
Date of Meeting	29 September 2021
Report Title	**Recovery Overview**
Author	Natalie Violet, Corporate Business Manager to the CEO
Responsible Executive	Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships

1.0 Introduction

The Board of Directors approved the Trust's Recovery Framework on 28 July 2021. This report provides an overview of progress against the framework.

2.0 Recovery Framework

The organisations recovery priority is twofold – our NHS people and clinical services. The approach is in line with the national 2021/22 Priorities and Operational Planning Guidance, published on 25 March 2021. With objectives for both people and service recovery aligned to this guidance.

Reporting to Board sub-committees is now in place including recovery metrics and performance against trajectories.

3.0 People Recovery

Since the development of the recovery framework the new People Dashboard has been introduced with measures to track recovery aligned to the National NHS People Plan. This is presented monthly to the People and Culture Committee. The dashboard will evolve as it embeds. The next step is to introduce Divisional dashboards into monthly performance reviews.

The first People Recovery Steering Group convened this month, chaired by the Deputy Chief People Officer. Membership includes Head of Organisational Development, Head of Human Resources, Chair of Staff Side, Wellbeing Support Officer, Communications Manager, and Divisional representatives. The group will be meeting bi-monthly with representatives from Optima (Occupational Health), Vivup, and The Wellbeing Practice (on-site counselling provider) are invited to attend twice a year. The focus of the steering group is broader than traditional health and wellbeing steering groups. It attends to the foundations of wellbeing – supply, retention, experience, in addition to directing individual and team wellbeing support.

The organisation has seen an increase in sickness absence with the most frequent reason over the past 12 months remaining mental health issues, specifically anxiety, stress, and depression. The organisation continues to embed the health and wellbeing offers to provide ongoing support to our people. The onsite counselling service remains very busy and is supported by telephone counselling and access to the Vivup Employee Assistance Programme. Wellbeing walkarounds have been reinstated to help staff feel supported, cared for, and ensure their voices are heard – prioritising health and wellbeing. The walkarounds visit departments across the hospital and consist of two to four staff members, led by Mental Health First Aiders. An Executive Director joins the walkarounds once a month.

The Transforming People Practices work, aligned to the Inclusive Leadership Programme, continues with an update provided at this month's People and Culture Committee with a future update expected in December. The work is being undertaken by members of the Diversity Network, supported by members of the People Team. There are three workstreams:

- **Inclusive Recruitment**, work includes developing guides to support candidates and managers in inclusive recruitment practices, trialling values-based recruitment for Health Care Assistants, and introducing trained recruitment champions.

- **Appraisal and Succession Planning**, work includes review of appraisal training and available resources, with an emphasis on wellbeing, for both the appraiser and appraisee, simplification of paperwork, creating a culture of being employed into a career rather than a role, career drop-in sessions, and a review of policies with a view to develop thinking and processes around unlocking potential, managing talent, and succession planning.
- **Just and Learning Culture,** work includes an exploration of lived disciplinary experiences, sharing this with the Inclusive Leadership Programme participants, and a review of the disciplinary policy to move towards a people centre policy and using this as a blueprint for all future people policies.

4.0 Service Recovery

Restarting Elective Services
From April 2021 providers were expected to achieve 85% of pre-COVID income levels, compared to 2019/20 to access money from the Elective Recovery Fund (ERF). ERF was designed to aid reductions in backlogs. It is important to note NHS England and NHS Improvement (NHSE/I) announced the threshold required to qualify for ERF would increase to 95% from 01 July 2021.

The organisation delivered the required income levels for the first three months of the year. July and August achieved just over 84%.

Activity type	Target from July	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Day Case	95%	84.93%	93.84%	94.67%	86.58%	85.64%
In patients	95%	78.49%	70.24%	96.17%	77.44%	64.64%
OP follow up	95%	95.24%	84.40%	100.49%	87.46%	86.34%
OP new	95%	92.85%	87.79%	103.69%	82.90%	95.13%
Total	95%	88.26%	85.05%	98.60%	84.16%	84.15%

Table 1 – percentage of income achieved, by month and activity type, compared to 2019/20

The fall in July and August can be attributed to higher levels of annual leave compared to summer 2019, junior doctor gaps resulting in a significant amount of acting down leading to cancelled outpatient activity, and increasing non-COVID emergency demand resulting in elective cancellations.

ERF Gateways
Acute providers are required to achieve 'gateways' designed to ensure recovery plans are aligned to the ICS ambitions and NHSE/I 2021/22 priorities. Those related to service recovery include clinical validation, health inequalities, and transforming outpatients.

i) Clinical Validation

Organisations are required to incorporate clinically led, patient focused reviews and validation of the waiting list on an ongoing basis, to ensure effective prioritisation and manage clinical risk. All patients clinically validated are allocated a priority code. The number of patients without a priority code is steadily declining and is now at the lowest level since the introduction of the codes.

The highest priority is those patients with a priority code P2, these patients require treatment within one month. The number of P2 patients is increasing; this is due to clinicians reviewing the longest waiting patients and, in many cases, upgrading them. Where a patient had been waiting over 104 weeks, they are automatically upgraded to a P2 and sent for clinical review. This is the largest contribution to the P2 position, however as it is making us an outlier regionally, we have been asked to stop this.

Due to bed pressures, some elective activity has been cancelled, but all P2 patients have gone ahead as planned.

ii) Health Inequalities

Organisations are required to address the longest waiters and ensure health Inequalities are tackled throughout the plan, with a particular focus on analysis of waiting times by ethnicity and deprivation.

Analysis of patients awaiting treatment by ethnicity code is undertaken monthly. July's data indicates a variance of 5.57% in patients who identify as white being treated within 18 weeks, compared to patients of an ethnic minority. There are 198 patients of the total waiting list from ethnic minorities, 1.04%. Further analysis is underway to investigate the difference in wait times and this will also include deprivation.

There are several patients with an unknown ethnicity recorded on our Patient Administration System (PAS). In August, the Senior Leadership Group approved a proposal for our Information Assurance Team to develop plans with each service, with responsibility for collecting patient demographic data, to improve the collection of ethnic group data on PAS.

iii) Transforming Outpatients

This gateway comprises three elements.

1) Maintain and achieve 25% of outpatient activity to be delivered virtually

Since April 2021 the percentage of all outpatient activity delivered virtually achieved the required standard of 25%, except for August which fell below the required standard. Since the end of the summer holidays, this has increased once again to 25%.

2) Introducing Patient-Initiated Follow-up (PIFU), or similar alternative, in at least three major outpatient specialties per provider, including personalised stratified follow up for cancer patients, avoiding unnecessary follow up attendances, and providing faster access to follow up appointments where clinically necessary. All three must be live by the end of quarter 3.

This remains on track and the organisation has been recognised by NHSE for the good work to date, with five specialities likely to be live by the end of quarter 3.

3) Increase the use of Advice and Guidance

DCH is meeting this gateway and has the best turnaround times in the Dorset system. The contractual target for responding to advice requests is 80% within 48 hours. Turnaround of advice and guidance requests has fallen in August to 75.97%, down from 78.36% in July. The volume of advice and guidance responses is 17.96% up year to date compared to 2020/21, and 100% up when compared to 2019/20.

Elective Waiting List Size

In August the total waiting list increased by 584 patients compared to the previous month. This takes the total waiting list size to 1,277 patients above trajectory. The waiting list has grown by 1,895 patients since April 2021. There is a discrepancy in capacity with referral rates sitting 8% above 2019/20 levels and activity at 85% of the same period.

W/L total size	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total W/L trajectory	17274	17171	17516	17711	17812	17599	17688	17456	17813	17772	17608	18342
Total W/L actual	17194	17666	17928	18505	19089							
Variance	-80	495	412	794	1277							

Table 2 – the total waiting list size vs trajectory, by month

The profile of the waiting list has reduced in patients waiting between 52 and 77 weeks. Since the peak in March 2021, the Trust has reduced the number of 52+ week waiters by 1,075. The reduction in 52+ week waiters is significant compared to the trajectory.

52+ week waiters	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
52+ww trajectory	3000	3091	3153	3188	3206	3168	3184	3142	3206	3199	3169	3186
52+ww actual	2947	2589	2386	2256	2227							
Variance	-53	-502	-767	-932	-979							

Table 3 – the total number of 52+ week waiters vs trajectory, by month

The Trust's approach to service recovery recognises the waiting list demand outweighs service capacity and the need to not overburden staff. Therefore, both insourcing and outsourcing activity has been utilised. Most of the surgical specialties have engaged in this with Maxillo-facial commencing this month. This specialty is particularly challenged with patients waiting over 52 weeks.

Community Capacity

Given the capacity constraints on the main site and the requirement to continue to run both COVID and non-COVID pathways, additional estate is required to support service recovery. The organisation has successfully secured capacity within local community hospitals without incurring additional rental costs from Dorset Healthcare. The Family Services and Surgical Division are working with teams to utilise this capacity. It must be noted that many services have been displaced on several occasions throughout the pandemic therefore, negotiating with the teams is being carefully managed.

5.0 Summary

The health and wellbeing of our people is our priority. We are invested in delivering initiatives and practices to support our people through listening and learning from lived experiences. This is key to supporting their recovery following the pandemic. Recruiting, retaining, and developing people is vital to the recovery of services. Performance against ERF for the first three months of the year demonstrates the commitment from our teams and the significant reduction in 52+ week waiters beyond trajectory is particularly pleasing. Recognising the mismatch in capacity and the demand of services we understand the need to look at alternative ways of treating patients. We have therefore invested in both insourcing and outsourcing activity, not to overburden our people. Securing community hospital capacity to assist in recovery is a positive step but requires careful management to support people in this transition.

Meeting Title:	Board Meeting
Date of Meeting:	September 2021
Document Title:	**Workforce Race Equality Standard 2021**
Responsible Director:	Dawn Harvey, Chief People Officer
Author:	Julie Barber, Head of Organisational Development

Confidentiality:	No – publicly published
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**

Purpose of the Paper	This report sets out our 2020/21 data and action plan against the Workforce Race Equality Standard (WRES) metrics							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The WRES is the national framework through which Trusts measure their performance against nine key indicators. These comprise workforce indicators (1-4), Staff Survey indicators (5-8) and an indicator based on Board representation (9). Overall, we have seen improvements in four indicators and negative movement in five indicators and the data is attached at Annex A & B. The rolling WRES action plan has been replaced with our Equalities Plan & Priorities, a comprehensive suite of staff development activities and plans aimed at developing inclusive behaviours and practices across the organisation. This is shown at Annex C.							
Action recommended	The Board Meeting is recommended to: 1. **NOTE** the Workforce Race Equality Standard data and action plan, and next steps. 2. **DISCUSS** the contents and implications 3. **APPROVE** the document to be published on 30/9/21							

Governance and Compliance Obligations

Legal / Regulatory	Y	The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful: discrimination, harassment and victimisation. The public sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.

		Each Trust's WRES data and Action Plan are published on their website annually as a requirement of the standard NHS Contract.
Financial	N	
Impacts Strategic Objectives?	Y	People, Place, Partnership – The new Trust strategy signals our intention to truly value our staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes
Risk?	Y	Non-compliance with the WRES would create risks for the organisation in terms of reputation, but more importantly, in terms of the wellbeing of the overall workforce.
Decision to be made?	Y	Approve publication of WRES 2021
Impacts CQC Standards?	Y	Development of fair and inclusive leadership, practice and culture contributes to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains
Impacts Social Value ambitions?	Y	Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Introduction

This paper provides an overview of our annual performance against the Workforce Race Equality Standard (WRES) metrics for 2020-21. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The NHS Equality and Diversity Council (EDC) introduced WRES as a framework for NHS Trusts to focus specifically on race. This was in response to the 2014 study by Roger Kline titled 'The snowy white peaks of the NHS', which highlighted the link between good patient care and an NHS workforce that is representative of the local population it serves.

It is recognised that Dorset has a lower BME demographic (around 5%) than BME staff population at Dorset County Hospital Foundation Trust (9.38%). It is expected that the staff BME figure will continue to rise over the next few years due to increasing overseas recruitment needed to fill key posts.

The WRES came into effect on 1st April 2015. The standard is designed to improve the representation and experience of Black and Minority Ethnic (BME) staff at all levels of the organisation and to scrutinise and improve BME representation at senior levels. In the context of WRES, White staff comprises White British, White Irish and White Other (Ethnic codes A, B & C), whereas BME staff comprise all other categories except 'not stated'.

Overall there are nine indicators which make up the NHS WRES. These comprise workforce indicators (1-4), Staff Survey indicators (5-8) and an indicator based on Board representation (9).

The 2020-21 WRES data for Dorset County Hospital is based on staff who have an ethnicity recorded on the Trust's Electronic Staff Records and we currently have data on the ethnic origins of 95.16% of our workforce.

The WRES is now mandated as part of the standard NHS Contract and this supports closer scrutiny of the progress we make and outcomes we achieve. Non-compliance with the WRES would create risks for the organisation in terms of reputation, but more importantly, in terms of the wellbeing of the overall workforce.

Overview of changes since 2019/20 data

Developing an inclusive culture at DCH is a key organisation priority. During the last 12 months the programme of work supporting this has gained momentum. The first stage of shifting culture is to disrupt the existing culture and this has involved raising awareness of inequalities across the organisation and encouraging staff to speak out about experiences. It is helpful to consider interpretation of DCH WRES data in this context.

Overall, the organisation has improved in four indicators and decreased in five indicators. The data is attached at **Annex A**. This annex includes provision of both 2020 and 2021 data for Indicator 4 (likelihood of staff accessing non-mandatory training and CPD) which the Trust has not previously submitted. Year on year changes by indicator for the last 4 years are included.

A detailed breakdown of workforce data is attached at **Annex B.** An Action Plan is shown at **Annex C.**

Indicators where we have seen negative changes

Key Indicator 3: *Relative likelihood of BME staff entering the formal disciplinary process compared to White staff (Note: This Indicator will be based on data from a two year rolling average of the current year and the previous year)*

Last year there were no recorded instances of BME staff entering the formal disciplinary process whereas this year there has been 3, resulting in a likelihood ratio of 1.44. Performance management and disciplinary

policies and procedures are in the process of co design with staff networks as part of the Transforming People Practices Programme.

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

Whilst figures for last year indicated similar experiences for White and BME staff, this year has seen a significant increase for our BME staff. Whilst disappointing to see that there has been an increase against this Indicator, this is welcomed as arising from staff feeling more confident to report incidents in the Staff Survey. Whilst the median figure for White staff indicates we are 4% below the national average, for BME staff the difference is only 0.5% below national average and the disparity between White and BME percentages is 6.1%.

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

This year sees a further significant increase in adverse experiences for our BME staff, which is both disappointing and concerning. As with Indicator 5, we need to understand if this has arisen from staff feeling more confident to report these incidents in the Staff Survey and/or if there has been an increase in such events. Whilst the median figure for White staff indicates we are 3% below the national average, for BME staff the difference is very significant, being 11.3% above the national average. The disparity between White and BME percentages is 14.2%.

Key Indicator 7: *Percentage of staff believing that the Trust provides equal opportunities for career progression and promotion*

Last year's WRES report ranked us as one of the best performing Acute Trust's for this Indicator. This year this has declined from 84.3% to 67.2%. Whilst this is 5.3% below the national average for BME staff, last year the figure was 10.2% above the national average. This year's figures indicate an increasing disparity between White and BME staff, being 23.3% (in comparison with 7.5% last year).

A review of appraisal and succession planning processes and procedures, to include career planning and development discussions and skills training for managers, is underway as part of the Appraisal and Succession Planning work stream of our Transforming People Practices Programme. A review of recruitment and selection processes, procedures and training for recruiting managers is also underway as part of the Inclusive Recruitment work stream of the same Programme.

Key Indicator 8: *In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.*

Following a significant increase in 2019/20 to 18.6%, from 10% in the previous year, our 2020/21 figures show a further increase to 20%, which is 3.2% above the national average for BME staff. Once again, we need to understand if this has arisen from staff being more aware of which behaviours constitute discrimination and/or feeling more confident to report these incidents in the Staff Survey and/or if there has been an increase in such events.

<u>Indicators where we have seen positive changes</u>

Key Indicator 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

Our overall BME headcount has increased very slightly, and whilst BME percentages have remained static across all grades in our non-clinical workforce, we have seen increases in BME clinical workforce in Bands 1-5 and 6-8d. However, there has been a decrease in BME clinical workforce B9+.
A detailed breakdown of workforce data for 2020-21 and 2019-20 is shown at Annex B.

Key Indicator 2: *Relative likelihood of White staff being appointed from shortlisting compared to BME staff*

Our likelihood ratio of 2.24 in 2019/20 has halved to 1.12 in 2020/21 which is to be celebrated, whilst noting that more work needs to be done to further improve the situation. A review of recruitment and selection processes, procedures and training for recruiting managers is underway as part of the Inclusive Recruitment work stream of our Transforming People Practices Programme.

Key Indicator 4: *Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff*

Information relating to participation in non-mandatory training and CPD has not previously been provided by the Trust due to uncertainty of records being kept centrally. However, two years' data has been consistently collected and recorded on the Trust's Electronic Staff Record (ESR) so offers some comparison figures.
The likelihood ratio has increased from 0.62 to 0.90. this means that BME staff are more likely than White colleagues to access non-mandatory training and CPD.

Key Indicator 9: *Percentage difference between the organisation's Board voting membership & its overall workforce*

The positive increase from -1.0% to 4.0% is attributable to the appointment of a Non-Executive Director from the BME community this year. BME voting Board membership is less than half of the total BME staff population (9.38%).

Next steps

Achieving inclusion and equity is central to our mission to deliver outstanding care and reduce health inequalities. The data illustrates that staff from a BME background are increasingly able to speak out about experiences.

The data supports the need to continue building an inclusive culture where everyone is valued and heard and has opportunities for progression. It is important DCH continues with the 18 month programme of work in the Equalities Plan and Priorities agreed by the People and Culture Committee. This is shown at Annex C.

The Equalities Plan and Priorities is regularly reviewed and refined as we measure impact using quantitative and qualitative data as part of the monthly People Dashboard.

All NHS Trusts are required to publish WRES data by 30th September 2021.

Annex A

WRES Indicators	2017/18	2018/19	2019/20	2020/21
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce **See Annex B for detailed breakdown for 19/20 & 20/21**	White: 3130 BME: 245 Unknown: 153 Total staff: 3528 **Overall BME %: 6.94**	White: 2493 BME: 231 Unknown: 102 Total staff: 2826 **Overall BME %: 8.17**	White: 3365 BME: 364 Unknown: 170 Total staff: 3903 **Overall BME%: 9.33**	White: 3474 BME: 380 Unknown: 196 Total staff: 4052 **Overall BME %: 9.38**
Indicator 2 Relative likelihood of being appointed from shortlisting across all posts ***Relative likelihood of White staff being appointed from shortlisting compared to BME staff***	White: 400 (27%) BME: 26 (5%) **Difference: 22%**	White: 370 (27%) BME: 25 (21%) **Difference: 6%**	White: 216 (25.06%) BME: 18 (11.18%) **Difference: 14%** ***Likelihood ratio: 2.24***	White: 382 (53%) BME: 83 (47%) **Difference: 6%** ***Likelihood ratio: 1.12***
Indicator 3 The relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation ***Relative likelihood of BME staff entering the formal disciplinary process compared to White staff***	White: 23 (0.77%) BME: 3 (1.21%) **Difference: 0.44%**	White: 26 (1.09%) BME: 4 (1.71%) **Difference: 0.62%**	White: 26 (0.77%) BME: 0 (0.00%) **Difference: 0%** ***Likelihood ratio: 0.00***	White: 19 (0.55%) BME: 3 (0.79%) **Difference: 0.24%** ***Likelihood ratio: 1.44***
Indicator 4 Relative likelihood of staff accessing non-mandatory training and CPD ***Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff***	Data not available/provided during these years		White: 188 (5.59%) BME: 33 (9.07%) ***Likelihood ratio: 0.62***	White: 379 (10.91%) BME: 46 (12.11%) ***Likelihood ratio: 0.90***
Indicator 5 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White: 25.2% BME: 18.1% **Difference: 7.1%**	White: 23.7% BME: 28.2% **Difference: 4.5%**	White: 24.3% BME: 25.3% **Difference: 1.0%**	White: 21.4% BME: 27.5% **Difference: 6.1%**
Indicator 6 % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White: 24.2% BME: 31.1% **Difference: 6.9%**	White: 23.6% BME: 28.6% **Difference: 5.0%**	White: 23.0% BME: 36.8% **Difference: 13.8%**	White: 26.2% BME: 40.4% **Difference: 14.2%**
Indicator 7 % of staff believing that the	White: 91.9% BME: 92.0%	White: 91.7% BME: 81.6%	White: 91.8% BME: 84.3%	White: 90.5% BME: 67.2%

Trust provides equal opportunities for career progression and promotion	**Difference: 0.1%**	**Difference: 10.1%**	**Difference: 7.5%**	**Difference: 23.3%**
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues	White: 5.9% BME: 19.2% **Difference: 13.3%**	White: 5.5% BME: 10.0% **Difference: 4.5%**	White: 4.7% BME: 18.6% **Difference: 13.9%**	White: 6.6% BME: 20.0% **Difference: 13.4%**
Indicator 9 % **difference** between the organisation's Board voting membership & its **overall workforce**	White:85.7% **Difference: 2.1%** BME: 14.3% **Difference: 5.6%**	White: 85.7% **Difference: 2.8%** BME: 14.3% **Difference: 6.9%**	White: 90.9% **Difference: 5.4%** BME: 9.1% **Difference: -1.0%**	White: 86.7% **Difference: 0.9%** BME: 13.3% **Difference: 4.0%**

Annex B Workforce Metrics – Indicator 1

2021 Workforce data based on total staff figure of **4052**

2020-21	White Clinical	%	BME Clinical	%	Unknown Clinical	%	White Non Clinical	%	BME Non Clinical	%	Unknown Non Clinical	%
Band 1	0	0.0%	0	0.0%	0	0.0%	26	0.6%	2	0.0%	0	0.0%
Band 2	632	15.6%	34	0.8%	15	0.4%	410	10.1%	19	0.5%	13	0.3%
Band 3	183	4.5%	8	0.2%	6	0.1%	263	6.5%	4	0.1%	7	0.2%
Band 4	66	1.6%	14	0.3%	4	0.1%	136	3.4%	2	0.0%	4	0.1%
Band 5	455	11.2%	115	2.8%	44	1.1%	77	1.9%	1	0.0%	0	0.0%
Band 6	443	10.9%	22	0.5%	12	0.3%	45	1.1%	7	0.2%	3	0.1%
Band 7	259	6.4%	12	0.3%	8	0.2%	43	1.1%	0	0.0%	2	0.0%
Band 8A	56	1.4%	2	0.0%	0	0.0%	27	0.7%	1	0.0%	2	0.0%
Band 8B	14	0.3%	0	0.0%	0	0.0%	19	0.5%	0	0.0%	0	0.0%
Band 8C	1	0.0%	0	0.0%	0	0.0%	6	0.1%	1	0.0%	2	0.0%
Band 8D	4	0.1%	0	0.0%	0	0.0%	6	0.1%	0	0.0%	0	0.0%
Band 9	1	0.0%	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%
VSM	1	0.0%	0	0.0%	0	0.0%	7	0.2%	1	0.0%	0	0.0%
Consultants	113	2.8%	36	0.9%	35	0.9%	0	0.0%	0	0.0%	0	0.0%
Non-consultant Career Grade	57	1.4%	27	0.7%	17	0.4%	0	0.0%	0	0.0%	0	0.0%
Trainee Grades	124	3.1%	72	1.8%	22	0.5%	0	0.0%	0	0.0%	0	0.0%
Other	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	2410		342		163		1066		38		33	

2020 Workforce data based on total staff figure of **3903**

2020-21	White Clinical	%	BME Clinical	%	Unknown Clinical	%	White Non Clinical	%	BME Non Clinical	%	Unknown Non Clinical	%
Band 1	0	0.0%	0	0.0%	0	0.0%	30	0.8%	2	0.1%	0	0.0%
Band 2	599	15.3%	28	0.7%	21	0.5%	401	10.3%	19	0.5%	5	0.1%
Band 3	169	4.3%	7	0.2%	4	0.1%	223	5.7%	4	0.1%	5	0.1%
Band 4	47	1.2%	35	0.9%	3	0.1%	130	3.3%	1	0.0%	2	0.1%
Band 5	482	12.3%	78	2.0%	29	0.7%	62	1.6%	2	0.1%	0	0.0%
Band 6	438	11.2%	19	0.5%	9	0.2%	45	1.2%	5	0.1%	1	0.0%
Band 7	248	6.4%	8	0.2%	6	0.2%	38	1.0%	0	0.0%	1	0.0%
Band 8A	59	1.5%	2	0.1%	0	0.0%	29	0.7%	1	0.0%	1	0.0%
Band 8B	14	0.4%	0	0.0%	0	0.0%	15	0.4%	0	0.0%	0	0.0%
Band 8C	2	0.1%	0	0.0%	0	0.0%	5	0.1%	0	0.0%	1	0.0%
Band 8D	2	0.1%	0	0.0%	0	0.0%	3	0.1%	1	0.0%	0	0.0%
Band 9	1	0.0%	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%
VSM	1	0.0%	0	0.0%	0	0.0%	11	0.3%	0	0.0%	0	0.0%
Consultants	119	3.0%	39	1.0%	34	0.9%	0	0.0%	0	0.0%	0	0.0%
Non-consultant Career Grade	60	1.5%	36	0.9%	19	0.5%	0	0.0%	0	0.0%	0	0.0%
Trainee Grades	133	3.4%	77	2.0%	30	0.8%	0	0.0%	0	0.0%	0	0.0%
Other	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	2375		329		155		993		35		16	

WRES Report by Band clusters

1/4/20 – 31/3/21

2021	White Clinical	%	BME Clinical	%	Unknown Clinical	%	White Non Clinical	%	BME Non Clinical	%	Unknown Non Clinical	%
Band 1-5	1336	33.0%	171	4.2%	69	1.7%	912	22.5%	28	0.7%	24	0.6%
Band 6-8D	777	19.2%	36	0.9%	20	0.5%	146	3.6%	9	0.2%	9	0.2%
Band 9 +	297	7.3%	135	3.3%	74	1.8%	8	0.2%	1	0.0%	0	0.0%
Total	2410		342		163		1066		38		33	

1/4/19 – 31/3/20

2020	White Clinical	%	BME Clinical	%	Unknown Clinical	%	White Non Clinical	%	BME Non Clinical	%	Unknown Non Clinical	%
Band 1-5	1297	33.2%	148	3.8%	57	1.5%	846	21.7%	28	0.7%	12	0.3%
Band 6-8D	763	19.5%	29	0.7%	15	0.4%	135	3.5%	7	0.2%	4	0.1%
Band 9 +	315	8.1%	152	3.9%	83	2.1%	12	0.3%	0	0.0%	0	0.0%
Total	2375		329		155		993		35		16	

Annex C – WRES Action Plan (Equalities Plan and Priorities)

Our starting point for getting inclusion right will be to initially focus on staff as this will support getting it right for patients. Throughout 2021-22 we are embarking on a range of staff development activities and programmes aimed at developing inclusive behaviours and practices. Our key work programmes are presented here with high level detail to show the range of interventions and indicative timeframes.

	Programme	Summary	Timescale
1	**Dignity & Respect at Work** *This will be a mandatory session for all existing staff & will initially be aimed at Bands 2-6*	A development session to support **all staff** understand their personal & role responsibilities for role modelling respectful behaviour and calling out inappropriate behaviour.	Programme commences October 2021
2	**Mental Health First Aid** *This will be a mandatory session for all line managers (and be available for other staff as required).*	A one day course will qualify **line managers** as an MHFA Champion, giving them an understanding of common mental health issues, knowledge and confidence to advocate for mental health awareness, provide ability to spot signs of mental ill health and develop skills to support mental health wellbeing.	Programme commences January 2022
3	**Bystander to Upstander** *Linked to Dignity & Respect Programme*	A poster/communications campaign backed by skill sessions suitable for **all staff** to help challenge inappropriate behaviour through speaking up and reporting routes.	Programme commences October 2021
4	**Inclusive Leadership Programme for Middle Managers** *This will be a mandatory session for all line managers at B7+ initially, with a tailored rollout to staff Bands 1-6 in due course.*	A programme of workshops, self-directed learning and group activities **for leaders with line management responsibility** to develop confidence and understanding of the importance of creating inclusive, compassionate teams to address inequalities, improve team performance and organisational effectiveness.	Programme commences June 2021
5	**Staff Development Programmes for staff from minority communities.** .	Participation in the programmes is intended to accelerate career progression and support applicants to contribute to removing inequity by becoming knowledgeable and skilled agents of change. The programmes will support ethnically diverse staff to release their	Programme* commences September 2021 **Beyond Difference**, *Dorset ICS Programme*

		leadership capabilities.	
6	**Reciprocal Mentoring for Inclusion**	A Change Programme that uses Reciprocal Mentoring as a tool for supporting greater systemic change that actively reduces inequity.	Programme start date to be reviewed in September 2021.
7	**Transforming People Practices – 3 workstreams:** 1. Just & Learning Culture 2. Appraisal & Succession Planning **3.** Inclusive Recruitment	Workshops aimed at developing new policies and frameworks to ensure all staff processes and procedures are inclusive, fair and equitable. We will review and update how we recruit, develop, appraise, performance manageand promote staff to build a fair and inclusive culture.	Programme commences March 2021
8	**Staff Networks**	The Trust currently has 3 staff nertworks: **Diversity Network** (for staff from minority ethnic communities) **Pride Network**(for our LGBTQ+ community) **Without Limits Network** (for Staff with Disabilities/Long Term Health conditions and Carers) Staff Networks for other under-represented groups are being planned and encouraged, including an **Overseas Staff Network**	Ongoing – latest two staff networks launched in April and May 2021
9	**Management Toolkit**	A range of resources and development sessions to support line managers with effective and inclusive management practices.	Programme commences May 2021

Measures of Success

We will evaluate our progress on EDI, ensuring it is measured against realistic and achievable targets which in turn will help us to learn, develop and improve over time. Cross-referencing our strategy to data and documents will ensure all areas are progressed and measurable. A dashboard of inclusion metrics will be created for on going monitoring of progress.

Evidence of success will look, sound and feel like *(& our measurement tools)*:

- Board members and leaders at all levels will routinely demonstrate their commitment to equality, diversity and inclusion

- Board and Committee papers will identify equality-related impacts and how they are mitigated and managed
- When at work staff are free from abuse, harassment, bullying and physical violence from any source *(SOS, Quarterly staff survey, ER data, WRES & WDES)*
- Staff believe the Trust provides equal opportunities for career progression and promotion *(shortlist to hire data)*
- Staff recommend the Trust as a place to work and receive treatment *(SOS, Quarterly staff survey)*
- Greater diversity in our senior management and leadership structures *(workforce demographic by band, improvements at 8a and above via a goal-oriented trajectory of progress)*
- People report positive experiences of Trust services *(FFT)*

Meeting Title:	DCHFT Board
Date of Meeting:	29.9.21
Document Title:	**DCH Charitable Fund Risk Management Policy**
Responsible Director:	Nicholas Johnson, Deputy Chief Executive
Author:	James Claypole, Deputy Financial Controller

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Charitable Funds Committee	29.6.21	Charity Committee recommended DCH Charitable Fund Risk Management Policy for noting by Risk and Audit Committee and approval by Trust Board (Corporate Trustee).
Risk & Audit Committee	21.9.21	Risk and Audit Committee has noted the policy and proposed for approval to Board (subject to amendments in Risk Appetite section).

Purpose of the Paper								
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	This policy outlines the principles and strategies that DCH Charity applies to manage its risks through ensuring significant risks are identified, managed, monitored and reported accordingly.							
Action recommended	DCHFT Board is recommended to: 1. **Approve** DCH Charitable Fund Risk Management Policy							

Governance and Compliance Obligations

Legal / Regulatory	Y	DCH Charitable Fund registered with Charity Commission DCH Charity registered with Fundraising Regulator
Financial	Y	Standing Financial Instructions – DCH Charitable Fund
Impacts Strategic Objectives?	Y/N	N
Risk?	Y	This policy links to the DCHFT Risk Management Framework and Board Assurance Framework
Decision to be made?	Y	To approve DCH Charitable Fund Risk Management Policy
Impacts CQC Standards?	N	N
Impacts Social Value ambitions?	Y	DCH Charity contributes to aims of DCH Social Value programme and commitments.
Equality Impact	Y/N	N

Assessment?		
Quality Impact Assessment?	Y/N	N

Dorset County Hospital
NHS Foundation Trust

CHARITABLE FUND (Registered Charity 1056479)
RISK MANAGEMENT POLICY

Policy Title	**CHARITABLE RISK MANAGEMENT POLICY**		
Procedure Number	***To be advised***	**Version number**	**1**
Applicable to	**Corporate Trustee, Charitable Funds Committee and DCH Charity Team**		
Date issued	**XXX 2021**		
Review date	**XXX 2024**		
Author's name and title	**James Claypole, Deputy Financial Controller**		
Development group/committee	**Charitable Funds Committee - Charity Governance Group**		
Stakeholders	**Charitable Funds Committee, DCHFT Finance, DCH Charity Team, DCH Cashiers.**		
Approved by	**Risk & Audit Committee**		
Date approved	**XXX**		
Ratified by	**DCHFT Board**		
Ratified on	**XXX**		
Keywords	**Risk Management, Risk Register**		

Document Management Section (if applicable)			
Previous policy number	N/A	**Previous version number**	N/A
Changes requested or dictated by	N/A		
Description of changes since last version	N/A		

1. BACKGROUND

The Charity acknowledges that efficient and effective management of risk is important in achieving its business objectives.

1.1 Responsibility for risk management of the Dorset County Hospital NHS Foundation Trust Charitable Fund (the Charity) is the responsibility of the Charitable Funds Committee, comprised of members of the Board, acting as representative of Dorset County Hospital NHS Foundation Trust, which is the corporate trustee of the Charity.

1.2 These responsibilities include: Manage risk in accordance with best practice.

1.3 In order to fulfil these responsibilities, trustees should have in place a Risk Management Policy.

1.4 This policy links to the DCHFT Risk Management Framework and Board Assurance Framework: http://sharepointapps/clinguide/CG%20docs1/1101-risk-management-strategy-and-policy.pdf and Risk Event Reporting Policy: http://sharepointapps/clinguide/CG%20docs1/1104-risk-event-reporting-policy-and-procedure.pdf

1.5 This policy is aligned to the Standing Financial Instructions (Charitable Fund): http://sharepointapps/clinguide/CG%20docs1/1895-Standing-financial-instructions-charitable%20Fund.pdf and all DCH Charity policies accordingly.

2. PURPOSE

This policy reflects its commitment to sound risk management principles and practices.

2.1 The Charity's risk management objectives are to:

- Integrate risk management into the culture of the organisation
- Manage risk in accordance with best practice
- Consider legal compliance as an absolute minimum
- Anticipate and respond quickly to social, environmental and legislative change
- Prevent injury, damage or loss and reduce the cost of risk events
- Raise awareness of the need for risk management

2.2 This policy outlines the basic principles and strategies that the Charity applies to help manage its risks through ensuring significant risks are identified, known, managed and monitored, enabling the Corporate Trustee and those working on its behalf to:

- make informed decisions about how to respond to these risks and take timely action
- make the most of opportunities and develop them with the confidence that any risks will be managed
- improve forward and strategic planning
- achieve the Charity's aims more successfully

3. DEFINITIONS

3.1 Risk is defined as uncertainty surrounding events and their outcomes that may have a significant impact on any area of the Charity's operations. Risk is an everyday part of charitable activity, either from potential threats or from failing to realise opportunities, and managing it effectively is essential if the Corporate Trustee is to achieve its key objectives and safeguard the Charity's assets.

3.2 Risk assessment is a qualitative and quantitative evaluation of the nature and magnitude of risk to the Charity's objectives. The evaluation is based upon known or theoretical vulnerabilities and threats, as well as the likelihood of the threats being realised and the potential impact on the Charity.

3.3 Risk management is the process of evaluating and responding to risks to the Charity's business for the purpose of reducing those risks to acceptable levels. Risk management is inclusive of the risk assessment process, and uses the results of risk assessments to make decisions on the acceptance of risks or on taking action to reduce those risks.

3.4 Major risks are those risks that have a major impact and a probable or highly probable likelihood of occurring. If they occurred they would have a major impact on some or all of the following:

- governance
- operations
- finances
- environmental or external factors such as public opinion or relationship with funders
- a charity's compliance with law or regulation

4. RISK MANAGEMENT STATEMENT

4.1 Where the Charity's Annual Report and Accounts are required to be audited, in accordance with the Charities Act, the Corporate Trustee must make a risk management statement in the Annual Report confirming that they have given consideration to the major risks to which the Charity is exposed and satisfied themselves that systems or procedures are established in order to manage those risks.

4.2 The Charity acknowledges the value of a risk management statement and an open and frank statement of major risks and how they are managed in demonstrating its commitment to good governance. This Policy is designed to enable the Charity to make a risk management statement whether required by law or not.

4.3 The statement shall include:

- an acknowledgement of the Corporate Trustee's responsibility
- an overview of the risk identification process
- an indication that major risks identified have been reviewed or assessed
- confirmation that control systems have been established to manage those risks
- a description of the current key strategic risks faced

- how each risk is managed or mitigated
- that these risks and other identified risks relating to the Charity are analysed in a formal risk register which includes controls and actions to mitigate the risks.

5. RISK APPETITE

5.1 The level of risk associated with the attainment of Charity objectives is reviewed by, and referenced to, the risk appetite accepted by the Corporate Trustee. This provides oversight and consistency in the level of risk taken. The DCHFT Board as Corporate Trustee has determined its risk appetite in the following key areas:

5.1.1 **Organisational risk** - The Charity recognises that it works in an ever-changing environment where its governance arrangements and organisational structure will need to evolve over time. As per the Charity's Risk Register, risks are assessed to ensure it is positioned to optimum advantage providing any change does not impact on its core sustainability.

In line with the DCH Risk Management Framework, the Charity has a low risk appetite in its decisions that have consequential effects upon patient safety, quality of care or clinical outcomes. The Charity has no appetite and are strongly adverse to decisions that result in poor quality of care; unacceptable clinical risk; and non-compliance of CQC or financial standards.

The Charity has a low risk appetite for financial commitments that do not relate to delivering quality and safe patient care or delivering a more efficient, effective service. It is prepared to have a high appetite to investments and its flexibility in resources when the decision relates to ensuring quality and safe services are provided to patients or service efficiencies can be delivered.

The Charity has no appetite to proceed with any financial decision that does or could negatively impact on quality and safe care, unless a robust quality impact assessment has been completed and provides assurance on the perceived risk and mitigations of the risk.

5.1.2 **Developmental risk** – In line with the Charity's Risk Register, risks relating to the charity's development are assessed in order to support innovation, facilitate change and to evolve its support for the benefit of NHS patients, staff and the wider public. These risks will be monitored as grants are awarded and projects are completed.

In line with the DCH Risk Management Framework, has a significant appetite for innovation, depending upon the nature of the innovation being proposed.

For transformation or innovation that supports quality, safety and operational effectiveness the Charity has a high appetite.

For innovation and transformation that has been tested elsewhere and proven to be transferable and will enable the Charity to meet its quality, safety, financial, operational and reputational objectives the Charity has a significant appetite.

The Charity has a moderate appetite for untested innovation or transformation that affects quality, safety and operational effectiveness and efficiencies objectives.

5.1.3 **Reputational risk** - The Charity has a very low risk appetite for actions and decisions which may damage our reputation. It therefore puts a strong emphasis on rigorous processes to be followed in its financial dealings, and when engaging third parties.

6. RESPONSIBILITIES

6.1 The Corporate Trustee will determine the risk appetite and set the culture of risk management within the Charity. The Corporate Trustee Board will have ultimate responsibility for risk management including major decisions affecting the risk profile or exposure. The Trustee Board will receive minutes from the Charitable Funds Committee in order to monitor the management of important risks facing the Charity.

6.2 The Charitable Funds Committee will act under delegated authority of the Corporate Trustee Board to provide an independent and objective view of the arrangements for the management of risk.

- It will report to the Trustee Board on internal controls and alert them to any emerging issues.
- It will oversee internal and external audit and review their recommendations and advise the Trustee Board on the effectiveness of the internal control system including the system for the management of risk.
- It will satisfy itself that risks are appropriately owned and that risk owners are actively managing their risks with the appropriate controls in place and working effectively.
- It will monitor and critically review the management of important risks and the maintenance of the risk register to ensure they are fit for purpose. It will be responsible for preparing the Risk Management Statement for the Annual Report and Accounts.

6.3 The Committee will have responsibility for the identification and management of risks that threaten the achievement of business objectives within their areas of competence. This approach will align to the DCHFT Risk Management Framework and Board Assurance Framework. They will consider the quality and timeliness of information provided on key risks and escalate any risks to the Corporate Trustee Board which have a high residual score, which do not appear to be being managed, or where assurances are either not available or not received.

6.4 The Charity management will work with the Committee to identify and assess major risks. They will ensure that controls are implemented and provide regular reports to the Trustee Board and Committee on the status of risks and their controls. They are responsible for encouraging good risk management practices and a positive attitude towards the control of risk amongst all levels of staff.

6.5 Staff of the Charity are responsible for controlling risk when carrying out their duties, for following policies and procedures set by the Trustee Board designed to mitigate risk, and for providing such information as the Trustee Board or its Committees may require in fulfilling their responsibilities under this Policy.

7. RISK IDENTIFICATION, EVALUATION AND THE RISK REGISTER

7.1 Identifying risks is the first step in building the Charity's risk profile, which is followed by the risk analysis and risk evaluation. The process of identifying and defining risks establishes a common understanding and therefore better capability to respond as appropriate. The Charity's Risk Register details the main risks considered by the Charitable Funds Committee to require managing and mitigating accordingly.

7.2 When identifying and defining risks the following guidelines will be taken into account:

- risks will be related to Charity's business plan objectives
- risks will be identified at a level where a specific impact can be identified and a specific action or actions to address the risk can be identified
- care will be taken to avoid stating impacts which may arise as being risks themselves, and to avoid stating risks which do not impact on business plan objectives
- equally, care will be taken to avoid defining risks with statements which are simply the converse of objectives.

7.3 There are a number of mechanisms that should be considered when identifying risks, such as: strategy working groups, business planning and audit reports.

7.4 For each risk identified in each area an analysis is undertaken of:

- the factors that may cause the risk to occur
- the controls that are in place to mitigate the likelihood or impact of the risk
- an action plan for further management of the risk

7.5 A consensus evaluation for each risk is made of the likelihood of the risk occurring on a scale 1-5 (rare to almost certain) and the severity of the impact if the risk were to occur, also on a scale 1-5 (insignificant to catastrophic). The product of these two scores is the risk rating (ranging from 1 to 25), where scores of 1-6 are low, 7-14 are moderate, and those scoring 15 or above are the major risks.

7.6 The list of risks, risk ratings, control measures and action plans is the Risk Register for the Charity. Risks are also assigned ownership so that operational and oversight responsibility is easily identifiable in every case.

7.7 The Charity's Risk Register shall be reviewed quarterly by senior management to enable the Corporate Trustee Board and Charitable Funds Committee to formally review and reconsider risks as follows:

- risk rating - 1 to 3 – annually
- risk rating – 4 to 6 - annually
- risk rating – 8 to 12 – 6 monthly
- risk rating – 15 to 25 – quarterly
- the possibility of new risks to be considered at every review point

Policy Review

The Charitable Fund Committee will formally review the Risk Management Policy every three years and will determine if any modifications are required.

Paul Goddard
Chief Financial Officer

XXX 2021

Meeting Title:	Board of Directors
Date of Meeting:	29 September 2021
Document Title:	**Infection Prevention & Control Annual Report 2020-2021**
Responsible Director:	Nicky Lucey, Director infection Prevention & Control/Chief Nursing Officer
Author:	Nicky Lucey, Director infection Prevention & Control/Chief Nursing Officer Emma Hoyle, Associate Director Infection Prevention & Control/Acting Deputy Chief Nursing Officer

Confidentiality:	*No*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Infection Prevention and Control Group	Circulated 08/09/2021	Agreed circulated prior to formal sign-off

Purpose of the Paper								
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	As part of the assurance required for Trust Board an annual Infection Prevention and Control report is required. This meets the national requirements set via NICE, NHSE/I The Board of Directors is asked to accept the report, and to use the report to highlight concerns and areas for quality improvement to the Trust Board. For noting: • The Trust met the trajectories set for MRSA bacteraemia and *Clostridium difficile* infections for 2020-2021 • The Trust has successfully reduced healthcare acquired infections year on year • The Trust developed and adjusted in the global pandemic of COVID-19 • Hand hygiene compliance has remained high and sustained at 97% • No outbreaks of Norovirus • 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).							
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **RECEIVE** assurance on actions to address any performance issues 3. **AGREE** the key points, risks & concerns to be reported to the Board							

Governance and Compliance Obligations

Legal / Regulatory	Y	Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.
Financial	Y	Undetermined, but could incur penalty if unable to achieve agreed standards/targets.
Impacts Strategic Objectives?	Y	The quality of our services in providing safe, effective, compassionate and responsive care links directly with strategic objective one and our ambition to provide outstanding care
Risk?	Y	*Links to Board Assurance Framework*
Decision to be made?	N	*For assurance*
Impacts CQC Standards?	Y	As this report incorporates standards outlined by NICE/NHSE/I it is important to note progress or exceptions to these standards.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Infection Prevention and Control Annual Report 2020-21

Nicola Lucey – Chief Nursing Officer/Director of Infection Prevention and Control

Emma Hoyle - Acting Deputy Chief Nursing Officer**/**Associate Director Infection Prevention and Control

INDEX

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 Chief Nursing Officer 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 work plan, 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 2020- 2021 was a challenging but 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 2020-2021
- The Trust has successfully reduced healthcare acquired infections year on year
- The Trust developed and adjusted in the global pandemic of COVID-19
- Hand hygiene compliance has remained high and sustained at 97%
- No outbreaks of Norovirus
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to control pseudomonas and legionella in tap water in high risk areas
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNet).

1. INTRODUCTION

This is my fifth year as Chief Nursing Officer, 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 2020– 31st March 2021. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

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

The Trust met the target for zero cases of preventable MRSA bacteraemia and reported 12 trajectory cases of *Clostridium difficile* against a target of 16 cases. In addition, the Trust has been very proactive in reviewing trends and improvements in Gram-negative blood stream infections (BSIs) with sharing across system partners as part of the Dorset Integrated Care System (ICS). The Infection Prevention and Control Team has seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

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

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

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

Nicola Lucey
Chief Nursing Officer
Director of Infection Prevention and Control

2 INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 5 times during 2020- 2021. 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. Chief Nursing Officer, 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 2020-2021:

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

2.3 INFECTION PREVENTION and CONTROL TEAM

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

- Nicola Lucey, Chief Nursing Officer / Director of Infection Prevention and Control
- Dr Paul Flanagan, Consultant Microbiologist and Infection Control Doctor – left July 2020 – temporary replacement role by Dr Lucy Cottle and Dr Amy Bond
- Emma Hoyle, Associate Director Infection Prevention and Control – left for secondment March 2021
- Abigail Warne, Specialist Nurse- secondment to Matron IPC role from March 2021
- Julie Park, IPC Nurse
- Christopher Gover, IPC Nurse
- Helen Belmont, IPC Nurse
- Cheryl Heard, Administrator
- Rhian Pearce, Antimicrobial Pharmacist
- Emma Diaz, Lymphedema Specialist Nurse (supported the team and worked with us during COVID-19 peak period until June 2020)

3. HEALTHCARE ASSOCIATED INFECTIONS

3.1 METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2020-2021 assigned to the Trust. The last case of preventable 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 2020-2021 there were a total of 57 cases of MSSA bacteraemia, of these 40 cases were identified <48 hours of admission and 17 identified >48 hours after admission (Chart 1).

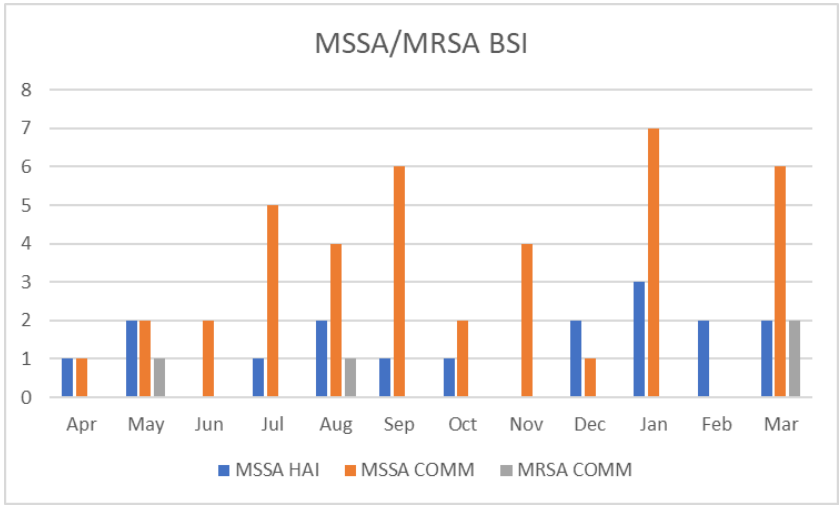


Chart 1

To manage MSSA blood stream infections 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.

3.3 GRAM NEGATIVE BLOOD STREAM INFECTIONS

3.3.1 Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving this reduction has been changed to 2023. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.)*

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

3.3.3 In 2020-2021 there were a total of 172 positive BSI samples for E.coli. 17 of these cases were attributed to the Trust (Chart 2). 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.

3.3.4 In 2020-2021 there were a total of 40 positive BSI samples for Klebsiella sps, 10 of these cases were attributed to the Trust (Chart 2). This was a decrease by 8 cases from 2019-2020.

3.3.5 In 2020-2021 there were a total of 17 positive BSI samples for Pseudomonas *aeruginosa*, 6 of these cases were attributed to the Trust (Chart 2).

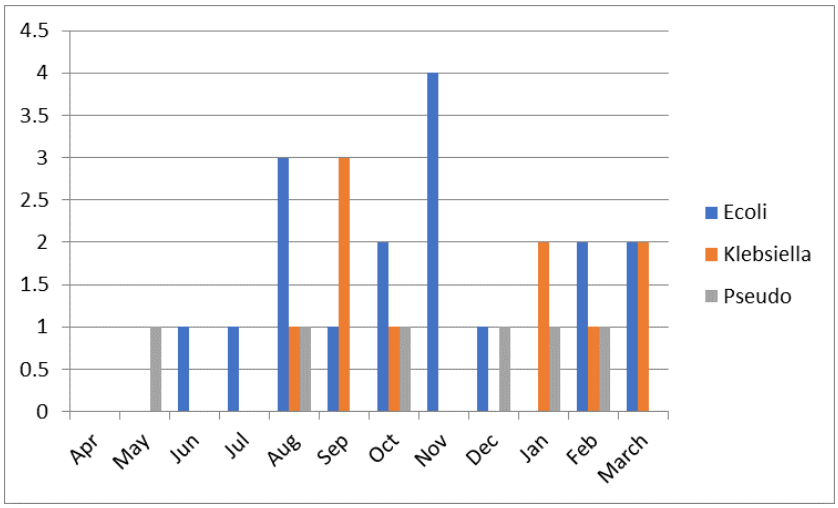


Chart 2

3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

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

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients has been an inpatient in the Trust reporting the case in the previous 4 weeks
- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks

- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust ion the previous 12 weeks

Due to the COVID-19 pandemic trajectories were not nationally set. The Trust agreed to work towards the previous years trajectory which was 16 cases. In total the Trust reported 22 cases detected HOHA; of these cases 10 were appealed as non-preventable with no lapses in care; this resulted in 12 cases reported as hospital acquired. The Trust identified 57 cases in total.

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

4. OUTBREAKS OF INFECTION

4.1 NOROVIRUS

There have been no outbreaks or cases of Norovirus in the reporting year 2020-2021. This could be attributed to the national and local lockdowns implemented as a result of the COVID pandemic and measures put in place to manage social contact.

4.2 INFLUENZA

There has been a dramatic national reduction in cases of Influenza A & B during the Winter 2020-2021 in comparison to the previous year. The impact of social distancing, mask wearing in the community and local lockdowns reduced the infectivity to zero at DCHFT and we had no inpatients with influenza.

In preparation for ‘Flu Season’ all Trust staff were offered the annual flu vaccine. 91% of front line staff were immunised and 91% of all staff, an increase from 84% the previous year.

5 CLINICAL AUDIT

5.1 SURGICAL SITE SURVEILLANCE

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

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

SSI for all surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay

Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure
Stage 3- review of patients readmitted within 365 with SSI

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

5.2 SURGICAL SITE SURVEILLANCE OF FRACTURE NECK OF FEMUR

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for July – September 2020 (Table 1) and last 4 periods for which data was available. Data for Quarter 4 has not yet been received from PHE and is therefore not included in this report.

The percentage of post discharge questionnaires returned by patients is lower than the national data for all hospitals. The reported infection rate of 1.4% for the previous 4 periods is slightly higher than national picture of 1.1% over the past 5 years.

Table 1 July – September 2020 Repair of Fractured neck of femur

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Jul-Sept 2020	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	53 47 66%	138 115 58.3%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0%	1 0.7%
	No of post discharge confirmed % infected	1 1.9%	1 1.0%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	1 1.9%	2 1.4%

Results for the second quarter 2020-21 show a slight improvement on those for the fourth quarter 2019-20 with an infection rate of 1.9% against 2.4 Continued surveillance during the next audit cycle (2021-22) will assist in maintaining improvements as will the continued feedback to surgical teams on performance

5.3 GETTING IT RIGHT FIRST TIME (GIRFT)

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

5.4 PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVC's are commonly used devices in acute hospitals, used for the administration of intravenous fluids and drugs. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular auditing to check that all PVCs are having visual infusion phlebitis (VIP) score checks completed has continued this year and remains ongoing. The annual average compliance for this year's audits has been 79% down from 92% last year Information from the audits is shared with Matrons and Divisions to discuss with ward leaders. Audits will then be retaken to see if there is increased compliance. 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. Results from any re-audits are fed back to Matrons and ongoing audits are completed to ensure any actions identified are effective.

5.5 ISOLATION AUDIT

This year's side room isolation audit took place in March and looked at all inpatient areas (excluding Kingfisher Ward and ITU) with results as follows; Out of 34 rooms in use for infection control purposes 74% had correct signage, 26% incorrect signage and a total of 85% overall side rooms in use across the trust. At the time of audit being carried out staff were educated on the importance of using correct signage to protect not only the patient but also themselves and visitors and thus reducing the transmission of infection.

5.6 COMPLIANCE WITH URINARY CATHETER POLICY

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

- Indwelling Urinary Catheter Recording on Vital Pac

Compliance with the requirement to accurately document indwelling urinary catheter insertion on VitalPac has been good with an overall trust compliance of 97 % of all catheters being recorded. When split between the Divisions, Family and Surgery returned 96% compliance and Urgent and Integrated Care 98% compliance. These percentages are and average. Urinary tract infections are the second largest single group of healthcare associated infections in the UK. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is taken into account and considered prior to insertion of urinary catheter and there is a continuous process for review. Please note due to increased pressures trust wide a catheter recording audit was not carried out for the month of April 2020.

5.7 Carbapenemase producing enterobacteriaceae audit (CPE)

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 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 recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. Although PHE advice on this changed in December 2019 we have now produced a dedicated policy for CPE and it remains that all patients admitted to the Trust must have a screening risk assessment carried out on admission.

This audit, which was carried out in May and December 2020, 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.

Results show that for May the compliance with undertaking the admission screening risk assessment was 73% and in December 77.1%. This gives an overall compliance of 75% which is down 1% on the previous year's result. This audit will be repeated next year and, following launch of the new CPE policy, it is anticipated that compliance will improve. In order to demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated for 2021-22. In conjunction with the role out of a new CPE policy ward and unit leads have also had the opportunity to discuss changes in guidance with the IPC Team and it is hope that this will have a positive impact upon future audit results

6 EDUCATION

Despite the COVID pandemic the Infection Prevention & Control Team continued to provide formal face to face education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and all of the nursing team were involved in delivering the sessions:

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

Mandatory Training for clinical and non-clinical staff has been also offered via an online workbook.

Overall compliance with mandatory IPC training over the year was 82% for clinical staff and 82% for non-clinical staff. The Divisions are responsible to release staff to access their training. During the pandemic some release of staff for mandatory training was reduced due to the safety pressures, as pressure reduced staff were able to move forward with the mandatory training.

IPCT recognised that additional support and training was required and now provides face to face mandatory training in addition to the online package.

Throughout the pandemic the infection control team also promoted the use of PPE, revisited hand hygiene and supported good IPC clinical practice trust wide, this included educating and demonstrating to staff how to effectively apply the fundamentals of donning and doffing to further protect themselves in their working environment.

During the second wave of the Covid-19 pandemic Dorset County Hospital were fortunate to have members of the military work alongside our workforce offering additional support with increased pressures across the trust and as such the military staff were also offered Infection Control Training.

7 POLICY DEVELOPMENT/REVIEW

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

Standard Precautions
Covid-19 outbreak
Ebola guidance
Surveillance guidelines
SOP for COVID testing unit
IPC Advice for suspected Avian Flu
Management of patients with multidrug resist inc ESBL
Urinary Catheter
Major Outbreak
SOP TVC endoscopy water tests
Pandemic flu
Ice making machine
CJD
CPE
Major Outbreak

8. COVID-19

The global pandemic of Covid-19 remains ongoing and at the forefront of providing healthcare services that are safe for both patients and staff. The trust response continues to be led by the Incident Management Team.

The hospital environment has been adapted to suit the needs for this new virus and the complexities that it creates. Over the past 18 months the IPCT have continued to

support the trust throughout the pandemic with updates to guidance in line with Public Health England and expert response to emerging situations. The IPCT have also worked closely with the Dorset wide ICS to share best practice and learn from other trusts.

At DCHFT the IPCT have managed the routine swabbing of inpatients to ensure patients are swabbed for Covid-19 on admission, day 3 and day 5-7 as per national guidance. This has helped to ensure any potential cases or outbreaks are identified in a timely manner and have ultimately helped to achieve a low rate of nosocomial transmission.

However, due to the extremely transmissible nature of Covid-19 and increased prevalence in the community we did have 4 wards with identified outbreaks between December 2020 and January 2021. Comparatively this was a low number of outbreaks for an inpatient setting in the South West region.
There was also an outbreak in the Poole Dialysis unit (external provider) January 2021.

One staff outbreak within a non-clinical team based at Vespasian House.
The total number of patients affected from outbreaks was 63 compared with 33 positive staff members.

The outbreaks were complex in nature to manage as prevalence of Covid-19 was high and the pandemic in the UK was reaching its second wave peak. The decision was made during the outbreaks to cohort positive patients due to the volumes being admitted.

These were our first outbreaks of covid-19 and increased cases of nosocomial transmission since the start of the pandemic was declared and the UK experienced its first wave of the virus in March 2020. The trust followed national IPC guidance throughout the pandemic and this is supported by the board assurance framework. On investigation due to the nature of the virus and its transmissibility it was hard to identify the root cause of outbreaks. However, the first outbreak was during a period of time when visiting was not restricted and Dorset was in tier 2 national restrictions and the outbreaks following this could have been attributed to the relaxation of lockdown rules over the Christmas period.

The response from the ward teams, matrons, CSM, microbiologists and IPCT was prompt enabling actions required following positive results to be taken quickly. Personal Protective Equipment (PPE) supplies have remained good and there have been no shortages. Staff support remains ongoing remobilisation of patient services was in place from September 2020.

9 Infection Prevention and Control Surveillance System (ICNet)

Last year we highlighted the joint procurement and implementation of a County Wide instance of ICNet, an infection prevention and control surveillance solution supplied by Baxter Healthcare Ltd.

a. The status of the Dorset partners varied at the inception of this Programme:

- Dorset County Hospital (DCH
- Poole Hospital (UHD)
- Dorset Health Care (DHC)
- Royal Bournemouth and Christchurch Foundation Trusts (UHD)

b. The IPC Programme is divided into three phases:

Phase 1 – DCH migration to hosting by DHC – completed July 2020

Phase 2 – UHD implementation – completed 2021

Phase 3 – DHC implementation – scheduled September 2021

There have been several delays due to the pandemic which consisted of staff availability in testing, pathology lab issues and new pathology systems due to be installed. It is hoped that by the end of this current year the system will be running smoothly across the trusts.

10 FACILITIES REPORT - CLEANING SERVICES Sarah Jenkins

INFECTION PREVENTION CONTROL & CLEANLINESS ANNUAL REPORT 2020/21

Throughout the past year, the Housekeeping team have worked hard to maintain the cleanliness of the hospital, coping with the fast changing nature of the service due to the unprecedented challenges of the covid 19 pandemic, and thus contributing to the safety of patients and staff.

We have worked in collaboration with the wider teams throughout the hospital, particularly with our colleagues in Infection Prevention Control, to ensure our continued focus on providing and maintaining a hygienically clean and appropriate environment for our patients, visitors and colleagues.

Cleanliness

Cleaning services throughout the hospital site and now, following office moves required by the new social distancing rules brought about because of the covid-19 pandemic, several office buildings outside are provided by our in house team of 140 housekeeping staff. The numbers of staff were increased by a number of volunteers who came to work in the Spring/ Summer of 2020 and by a number of military personnel in the early months of 2021. This team is augmented by external contractors who undertake the external window cleaning and pest control across the site, both contracts being managed by the housekeeping team.

As far as is practicable staff are allocated to a particular ward or area, giving them a sense of ownership and continuity in the cleaning regime. The amount of time allocated to the cleaning on a daily basis is determined initially by use of a software system, DomTime, and further by input from the cleaning and clinical teams. Throughout the past year the time allocated to areas have been reviewed and amended on a more frequent basis due to the changes in use of many areas and the changes in IPC and other guidance. Our team have adapted well to this constantly changing environment.

We are currently reviewing the needs of the whole hospital with the changes brought about by the return to business as usual, the increase in the amount of weekend working and the expansion of areas such as the Emergency Department (ED). This is also further necessitated by the introduction of the new national cleaning standards which we will incorporate into our working patterns to ensure our compliance with these and the maintenance of the high standards we strive to achieve. The review of all the cleaning schedules will form part of this to ensure they remain fit for purpose and further to ensure they can be converted to electronic form with the introduction of a new cleaning software solution.

Standards of cleaning are monitored through the audit process, which is carried out weekly or monthly depending of the category of risk, information submitted in several ways to the PALs team, the PLACE assessment and CQC surveys.

We receive the majority our patient feedback on a report from the PALS team on a monthly basis. Most of the comments we receive are favourable and we endeavour to share these with the staff who are responsible for the areas concerned. If there are a number of negative comments the area is audited to check standards are being maintained.

In spite of the additional pressures placed on the hospital and the housekeeping team due to the covid-19 pandemic, the high standard of cleaning across the site has been maintained. This contributes to the positive patient experience, patient safety and low infection rates.

Cleanliness- Deep Cleaning

In what has been a busy year it is pleasing to report that we have taken every opportunity to complete our deep cleaning schedule. Our deep cleans are supported with the use of fogging using our HPV machines, which use hydrogen peroxide vapour to ensure the area is sterile.

To enhance the efficacy of the cleaning of the ward areas of the hospital, a deep clean programme is planned for all areas throughout the year. The cubicles are deep cleaned frequently following the discharge of patients with infections.

The air conditioning work which took place on level 3 south wing facilitated the clean of all of the wards in that area, along with two of the level 2 wards. Other wards have been deep cleaned following covid outbreaks. We have worked hard with the clinical teams to schedule and complete these cleans whilst continuing to allow flow through the hospital and will continue to do so throughout the coming year.

We have started to work on the program to replace our current HPV machines and will be working with the IPC team and procurement to identify the best machines for our use. The new generation machines use much shorter cycles as the scrub the air after the HPV has had time to work and so will help with patient flow. They further use modern technology so that the user does not have to be present in the room to start the cycle thus contributing the health and safety of staff and visitors.

Cleanliness- internal Monitoring

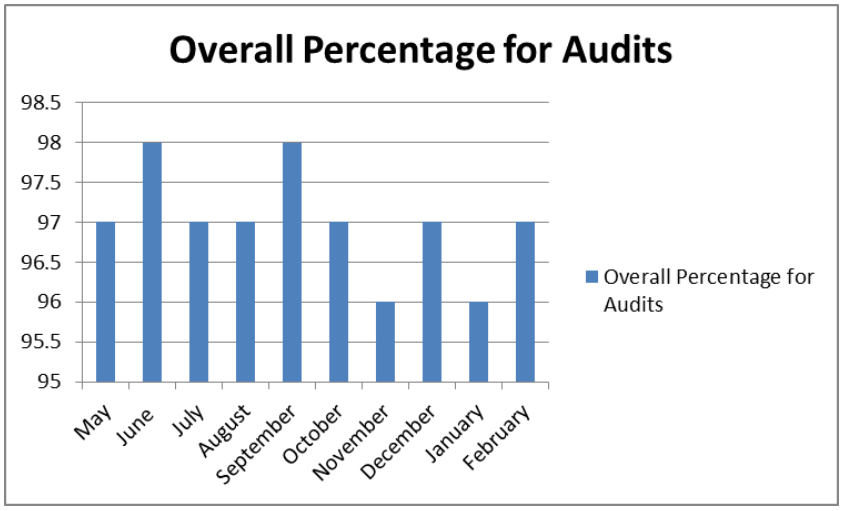
The restrictions put in place due to the covid 19 pandemic have affected the ways in which the standard of cleanliness is measured.

Audits, measuring our standard against the national standards of cleanliness, have continued to be carried out throughout the past year, although the areas that could be visited at times meant that some rooms could not be assessed due to infection control measures. The supervisors carry out these audits on a weekly or monthly basis, the timescale depending on the deemed level of risk in an area, and issues

are highlighted and addressed by the housekeeping team. Should the score be concerning a schedule of remedial work is put into place.

We are hoping to have a new IT system in place in the coming months which will make the amount of rectification needed and the timescale of completion more transparent to the clinical teams. This system will also support the audit of the new items required for audit under the new cleaning standards, such a mid-height surfaces which were not previously included.

A casualty of the covid 19 pandemic has been the weekly environmental audit where the housekeeping management team along with an IPC and estates representative are joined by two patient assessors to assess the cleanliness and condition of a ward or outpatient area. This has been used as a validation of the supervisor's audit. These were recommenced for a short period in the latter part of the year without the presence of the patient assessors and it is hoped that in the coming year the full program can be reinstated.



PLACE- Patient Led Assessment of the Care Environment

Due to the workload placed on the NHS and the infection control measures that remained in place throughout the year, the PLACE assessment for 2020 was cancelled. We are still waiting to be advised of the dates during which we will have to hold our assessment this year but this is likely to be in the autumn of 2021.

11 ESTATES REPORT (DON TAYLOR – Head of Estates and Facilities)

11.1 WATER QUALITY

Throughout 2020, the Estates Team have maintained the Trust's water services and reported to the Water Quality Management Group (WQMG). Both have been made more difficult to achieve due to the restrictions of COVID with the WQMG sitting only three times.

Activities to maintain water quality continue to be supported and audited by independent experts in water hygiene management from the Water Hygiene Centre.

The Responsible Person role has been transferred to the Deputy Head of Estates and Facilities, Terry May, whilst the role of Authorising Engineer (Water) continues to be fulfilled by Paul Limbrick. Nicola Lucey, Chief Nursing Officer/ DIPC is the Executive Director on Trust Board for Water Safety.

In March 2020 the 'Water Safety Policy' and accompanying 'Operational and Maintenance Procedures' were amended, in agreement with the WQMG, to take account of anticipated difficulties in routine surveillance monitoring due to COVID-19. These remain in force and under review.

Although COVID has presented the Estates team with unique and complex challenges there has been continued progress in the remediation and closure of items identified in the L8 Risk Assessment throughout the period including;

- Installation of subordinate loop temperature monitoring system (ongoing)
- Servicing and testing of Thermostatic Mixing Valves
- Replacement of booster sets and systemic balancing of systems temperatures,
- Removal of dead legs and Little Used Outlets across the system.

Additional resource should continue to improve system integrity alongside the continuing review and update of system schematics, asset registers and information on system use.

Pipework corrosion issues continue to occur resulting in leaks although these are fewer than in previous years. These primarily present risks to continuity of supply rather than direct infection issues and are handled promptly, making improvement as opportunities present themselves.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has been improved in its scope and management, however, COVID has presented some difficulties with whole departments becoming less used and risking stagnation.

Over the period covered by this report, MAR20 – MAR21, there were a little over one hundred missed routine samples, the vast majority being sampled the next week but with the longest delay being six weeks in ICU due to it being a Red Zone for Covid and inaccessible. ICU carried out enhanced flushing as a prophylactic and the outlets showed clear when eventually tested.

There were eighty five instances of raised Pseudo. A. counts during regular surveillance testing involving eight outlets. The vast majority of the raised counts are from a single issue on Prince of Wales ward (POW) that was extremely difficult to fault find due to the multiple causative factors and considerable delay in correcting it as the system had to remain available for patients. Of the others, all of which short lived, there were two more in POW, one on SCBU and the remainder on Fortuneswell.

There were seventeen instances of raised Legionella counts during regular surveillance testing involving five outlets. Most of these are due to the design issues previously reported in the Robert White Centre which are yet to be satisfactorily addressed. There were wone other issue in each of ICU and Renal Dialysis.

11.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME

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

11.3 REPLACEMENT FLOOR COVERINGS

Ordinarily we would have a list of areas re-floored with new vinyl, often replacing carpet. However this was not carried out in this period due to the pandemic.

11.4 DECORATION AND ENVIRONMENT

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

11.5 VENTILATION

During 2020/21 Estates and Housekeeping have continued to carry out high level deep cleaning in critical areas, particularly areas that have been affected by Covid. Any deficiencies are reported through the Decontamination Group.

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

11.6 WARD AUDITS

The Estates Dept. continue to support weekly environmental audits in association with Infection Control, Pharmacy Housekeeping and Patient Representatives, although these have been limited due to the pandemic.

11.7 CAPITAL WORKS

11.7.1 BED Triage unit – modular unit quickly procured and installed to a high standard outside ED. This was in response to the pandemic and allowed ED to triage patients with or without Covid-19 symptoms outside of the

department. The unit is largely HBN and HTM complaint with appropriate water services and wash hand basin provision.

11.7.2 Assisted in-house estates team with the acquisition and installation of additional hand washing facilities and separation lines as the hospital configuration changed in response to the pandemic

11.7.3 **Supply and install of new signs** to compliment changes brought on by the pandemic, For instance, wash hand reminders, directional signage to relocated departments, social distancing signs, directional signs to Covid-19 testing unit and vaccination centre

11.7.4 **Dermatology** – improved spacing in PUVA treatment area to better separate patients and staff. Creation of additional clinic rooms in lieu of offices to improve clinical facilities in the department

11.7.5 **Female Changing Rooms (South 0)** – refurbishment removed some IPC risks including split flooring, porous surface finishes and overall fabric condition

11.7.6 **New CT Scanner** – environment designed and built to HTM and HBN. Improved ventilation, lobby protection, water services and wash hand basin provision

11.7.7 **Ridgeway Bay and Anaesthetist Office** – More suitable non-clinical location for anaesthetists combined with release of space to create 5 additional beds to HBN standard. New bay included suitable distancing between beds, wash hand basin provision and surface finishes to compliment cleaning

11.7.8 **Pharmacy Robot** – Replacement and upgrade of Pharmacy Robot including new flooring and associated mechanical and electrical works.

11.7.9 **Medical Day Unit (MDU) into Audiology** – Reconfiguration of Audiology area in South 0 into a suitable space for MDU to enable works to ED to commence.

11.7.10 **Flat Roof above Rehab** – Flat roof improvement / replacement

11.7.11 **Physio West Annex** - Alterations to Hall area to create suitable space for Physio / Pulmonary rehab - restart works to include 2no. Side rooms.

11.7.12 **Therapy Changing Room Facility** - Changing room facilities for therapy staff. Staff needed facility following departmental move from rehab corridor to Damers House.

11.7.13 **Children's centre audiology booth** - Construct an Audiology Booth within the Children's Centre

11.7.14 **LED Lighting** - Replacement of traditional lighting with energy efficient LED lighting

11.7.15 **Maternity Entonox** - Upgrade of ventilation system across delivery suites

11.7.16 **Ridgeway Ward Storeroom** - Create a storeroom in new clinical bay. Demand caused by patient type changing and need for more patient aids

11.7.17 **ICU curtain rails** - Reposition curtain rails to offer privacy to patients where layouts in bays have changed

11.7.18 **New Modular Unit for Renal** - Provision of modular unit to increase renal dialysis space. Location outside South 0

11.7.19 **UPS Upgrades** - Replacement / upgrade of UPS in North Wing Main Server Room & Main Theatres 1 & 2

11.7.20 **Same day Emergency Care (SDEC)** - Multiple small jobs to enable currently SDEC area (formerly SAL) to work as SDEC in the longer-term

11.7.21 **3 Nr Distribution Board Replacement** – As part of the Pathology upgrade replacement of 3Nr distribution boards on North wing Level 3

11.7.22 **South Wing Cooling** – Installation of comfort cooling within the South Wing 3rd floor

11.7.23 **Therapies equipment Storage** – Provision of containers to provide storage for therapies equipment

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

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive is transferring to the Medical Device Regulation and as our Notified Body is based in Sweden an EU Representative has been appointed to ensure compliance with transitioning UK standards.

The Notified Body will be undertaking a two day surveillance audit in April 2021 and this will be undertaken remotely via video link due to ongoing travel restrictions.

The Accreditation held by the service continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service.

Environmental Monitoring

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

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

The laboratory also tests:

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

Latest testing of all areas occurred in February 2021 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

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

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

Tracking and Traceability

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

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

Shelf Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis or when a new wrap is introduced. Previous testing still showed 100% sterility which gives assurance that the decontamination process is effective.

A new double-bonded wrap was introduced in 2020 and sets wrapped in this will be sent for testing once they have expired their 365 day shelf life.

Staff Training

All Managers and Supervisors have achieved qualifications relevant to their role. This gives assurance that they have a full understanding of the Decontamination process 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.

ENDOSCOPY DECONTAMINATION UNIT

Quality Management System - Accreditation

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

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

Environmental Monitoring

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

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

The laboratory also tests:

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

Latest testing of all areas occurred in February 2021.

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.

Rinse water samples are taken from each washer chamber on a weekly basis to be tested for TVC and pseudomonas aeruginosa. There have been very occasional raised results but these have returned to an acceptable limit on the next round of testing. Pseudomonas aeruginosa has not been found in any sample taken.

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.

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and more recently in the outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4936 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

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

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

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

The 2020 audit showed that compliance with the use of the appropriate system is overall very good and has been sustained in those areas familiar with its use.

The only non-conformance related to appropriate record keeping in the patient's health care records in one area. That particular area was already under increased surveillance since the 2018 audit and whilst a significant improvement has been seen they are still unable to evidence full compliance with appropriate record keeping. There are no concerns relating to the decontamination of the item. Increased surveillance in this area will continue.

Audit #5010 Decontamination and Single Use Instruments

This annual audit is used to measure compliance with requirements for the management of sterile instruments and single use instruments as per HTM 01-01:2016 and the sample involves each department that is supplied by Decontamination Services and also 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 2020/21 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 and having evidence of local protocols relating to the use of single use instruments and hood masks. These were rectified promptly and noted as complete on the non-conformance log. The log is reviewed during the Decontamination Group meetings.

13 ANTIMICROBIAL REPORT - RHIAN PEARCE (Antimicrobial pharmacist) Antimicrobials: Summary report for financial year 2020/21

1. Overview

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

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

2. Summary 2020/21

- The Antimicrobial Stewardship Committee (ASC) is now meeting regularly. In recent years the ASC has suffered from dwindling clinician engagement. Since medical clinical leadership is critical to the success of any antibiotic stewardship programme, we are pleased to welcome Alastair Hutchison (Chief Medical Officer) as the new chair.
- Effective antimicrobial surveillance is the foundation of any stewardship program, but sustained progress in this area can only be delivered through continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship Team;
    - ❖ 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 has greatly improved our ability to monitor antibiotic prescribing trends across the Trust. It also allows us to compare our prescribing trends against other hospitals.
- We have continued work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. Our antibiotic guideline webpage has been reconfigured, making our guidelines easier to navigate.
- We performed several audits, including;
    - ❖ An audit of the adherence to Teicoplanin prescribing guidelines
    - ❖ Audit of antibiotic course length in Community Acquired Pneumonia

- Participated in *Clostridium difficile* RCA meetings, providing a formal review of antibiotic prescribing and feeding back to clinical teams directly, allowing us to capture any emergent themes related to antimicrobial prescribing.
- We lead and investigate RCAs involving antimicrobials; as an example, we have implemented a range of improvements relating to gentamicin prescribing and monitoring as a result.
- We published the following Safe Medication Practice Bulletins;
    - Gentamicin and Ototoxicity
    - Gentamicin 5mg/kg extended interval dosing regimen
- Developed a series of posters to promote the early discharge of patients receiving antibiotics.
- Procalcitonin has been introduced to steward early discontinuation of antimicrobials in COVID patients. We also participated in a national research project investigating the utility of procalcitonin during the COVID pandemic**.** Improving the range of laboratory-based diagnostic testing for infection is recognised as an essential tool for tackling resistance and optimising patient outcomes.
- Teaching sessions to ANPs and FY1s;
    - Principles of antimicrobial prescribing
    - Gentamicin/Teicoplanin/Vancomycin prescribing
    - Introduction to the Antibiotic review toolkit with case studies.
- Dalbavancin and Ceftazidime/avibactam were welcome additions to the local formulary, improving the range of antibiotics available locally to treat increasingly complex cases involving resistant bacteria.

2.1. National targets/regional benchmarking.

CQUINs: Suspended due to COVID

NHS Benchmarking Network, Pharmacy & Medicines Optimisation – Antimicrobial Stewardship 2019-20;

DCHFT were noted to be outliers in terms of joint microbiologist/pharmacist AMS rounds, performing significantly fewer than the national mean (national mean = 1.3 AMS rounds per 100 beds per week, DCHFT = 0.4 AMS rounds per 100 beds per week).

Limited resource, coupled with competing demands from mandatory targets, has hampered a formal programme of sustained ‘stewardship ward rounds’ over the last 2-3 years. Timely reporting with feedback to clinicians is recognised as a significant

driver for changing behaviour and improving prescribing. This is something we are prioritising over the coming years, with an initial target of 1 extra extended ward-round per month visiting inpatient wards that are not currently covered. This will increase in frequency as microbiologist cover improves. We have also developed a range of EPMA reports to target specific areas for antimicrobial improvement, allowing us to perform AMS rounds remotely in a more resource-efficient way.

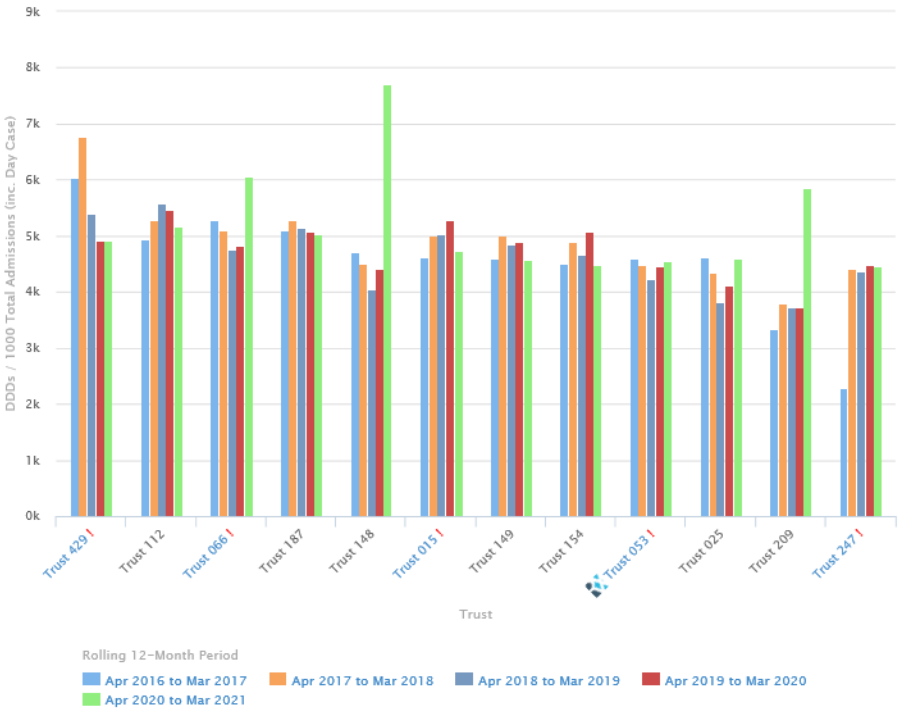
2.2. Antibiotic consumption trends

Typically, total antibiotic consumption targets form part of the standard NHS contract. However, the COVID pandemic has had a significant impact on antimicrobial consumption both regionally and nationally; for this reason, no specific targets have been agreed.

2.2.1 Total antibiotics.

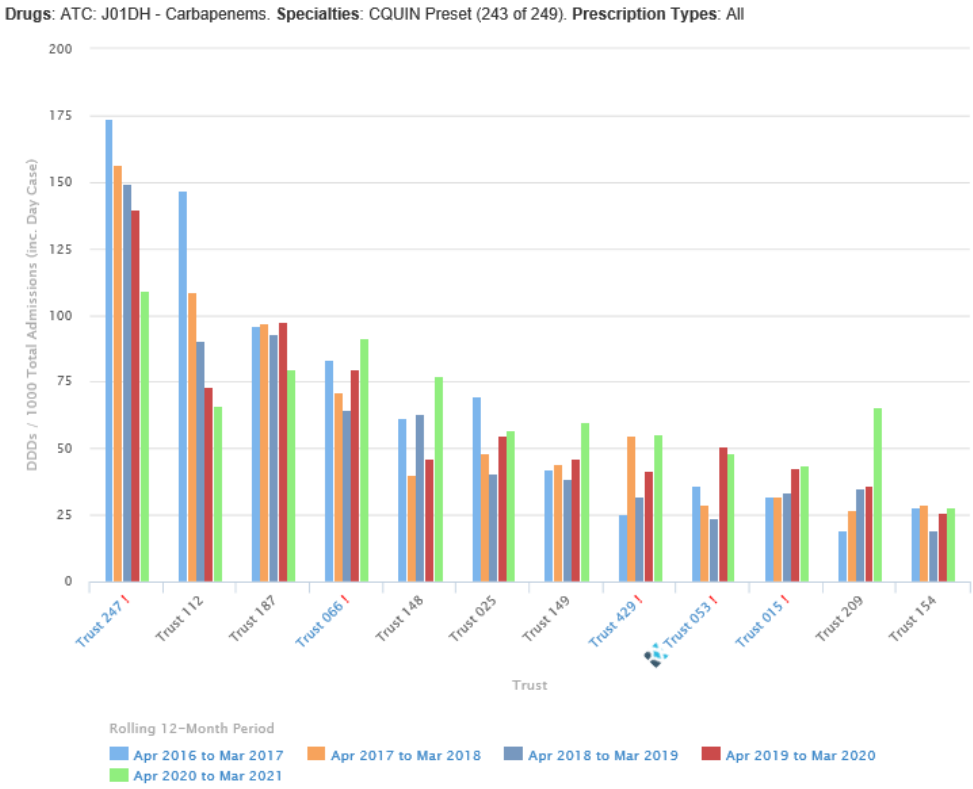
Total antibiotic consumption is up 1.9% on the previous financial year (see fig 1. DCHFT =Trust 0.53). Like other trusts, we observed an upswing in antimicrobial use during the first and second wave of the pandemic. As the pandemic eases and hospital activity returns to normal, a more accurate picture of any lasting change in consumption trends should emerge.

Fig. 1



2.2.2. Carbapenems

Carbapenem prescribing is down 4% on the previous financial year (Fig. 2). However, this still represents a significant increase compared with the 2018 financial year, equating to a doubling in consumption (Fig. 2). We perform regular audits of inpatient carbapenem use, which indicate that carbapenem use is generally appropriate, with the vast majority being recommended by the microbiology team. We are also implementing a regular review of local resistance data, specifically looking at ESBLs, which may be driving carbapenem use locally; CPEs will also be monitored more formally.



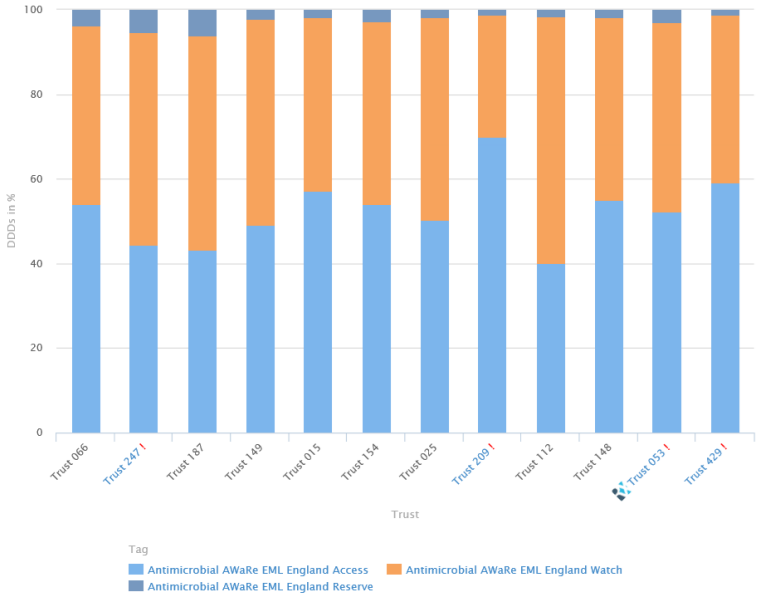
2.2.3. Proportion of total antibiotics by AWaRe category

53% of DCHFT's total antibiotic consumption for 2020/21 were narrow-spectrum agents (AWaRe access category), comparable to the previous year (56%). See Fig. 3.

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

(DCHFT =trust 053)



2.3. Limitations

Data are unadjusted for the confounding effects of case mix, age and sex. As such, direct comparison between DCHFT and the national or regional average is limited. In addition, patient outcome data is not routinely collected or published alongside CQUIN and consumption data, raising concerns over the potential unintended consequences following their implementation.

3. Summary of future work

- To ensure that AMS CQUINs are allocated to a suitable clinical lead to encourage clinical engagement.
- Updating and streamlining the existing audit programme to incorporate CQUIN specific indicators for 2021/22, if they are re-introduced.

  Historically, AMS CQUINs have had a demanding data collection element. NHS England discourages stewardship teams from collecting data; instead, their time is better spent steering intervention and focussing on quality improvement. We would echo this recommendation and urge the Trust to recognise that the stewardship team cannot absorb CQUIN data collection demands without displacing core stewardship activities.

- To develop a systematic approach for reviewing local susceptibility patterns as part of the antibiotic guideline development process.
- To delineate channels within the organisation to disseminate audit results and garner support for AMS.
- Continued work on integrating the laboratory and stewardship programme to ensure rapid provision of test results and that clinicians understand their implications.
- Continued work on developing Microguide (platform for hosting antimicrobial guidelines) to ensure guidelines are readily accessible at the point of care, thus promoting antibiotic guideline adherence.
- We plan to introduce a comprehensive antimicrobial prescribing and stewardship training package for doctors, nurse prescribers, and pharmacists. This will be delivered via e-learning.
- Continued work on developing a set of metrics for monitoring stewardship activity, focusing on process and outcome measures to better illustrate the value and sustainability of our programme. This should also provide us with evidence for future investment and better resource allocation.
- As pharmacist recruitment and retention improves, we are keen to implement a framework for pharmacy-led interventions to optimise antimicrobial therapy, including dose optimisation, systematic conversion from intravenous to oral antimicrobial therapy, and challenging excessive antibiotic course lengths.

We must 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 CQUIN targets when they are re-introduced.

CONCLUSION

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

2020-2021 has been a very successful year with significant reductions in healthcare acquired infections reported i.e. gram negative 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 2020-2021 reflects a continuation of support and promotion of infection prevention & control. Looking forward to the year ahead the staff at DCHFT will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

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

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

Emma Hoyle

Associate Director Infection Prevention & Control

Appendix 1

Infection Prevention & Control Work Plan 2020-2021 V1

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Acting matron Infection Prevention & Control	Bi-Monthly	Bi-monthly IPCG meetings in place.
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet. Support of the Dorset wide project to be clinically lead by DCHFT.	Contract renewal	Acting Matron Infection Prevention & Control	September 2021	Dorset wide ICNet roll-out in progress- May 2021.
		The Trust will maintain a high standard of Infection Prevention &	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance	Evidence that IPC performance dashboard is discussed	Heads of Nursing / Quality	March 2022	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		Control	meetings IPC performance standard dashboard to be met Learning from performance data to be disseminated	and actioned at Divisional Governance meetings			
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 and PLACE-lite	The environment is safe and clean	Infection Prevention & Control Team	Sept 2021	First PLACE lite scheduled May 2021
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	March 2022	March 2021 – Deep clean plan halted by COVID 19 pandemic – however, deep cleans carried out when opportunities arose – Facilities to summarise via Annual Report.
			Participation in	Review of	IPC Team	March	Environmental audits

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			weekly environmental technical audits	weekly audits identifies deficits and monitors remedial actions have been taken	Facilities Manager Estates Manager Patient representatives Pharmacy	2022	restarted in April 2021 and on-going weekly. Currently no patient representative but this will be reviewed.
		All clinical equipment is clean and ready for use at point of care	Use of Clean/Dirty indication stickers implemented Trust wide 2018/19	All clinical equipment will be identified as clean or requiring cleaning	IPCT to implement review process via ward rounds Divisional Heads of Nursing / Matrons to monitor	August 2021	Process reinforced agreed as ongoing requirement to monitor
		DCHFT will maintain a clean and safe water system	Policy to be updated and communicated and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy. Water Safety is a standing item at IPCG.	Head of Estates	March 2022	March 2021 – Water Safety remains a standing item on IPCG meeting. Weekly updates provided by Estates team on water quality
3	Provide suitable	Patients will be fully informed	IPCT to visit newly identified infectious	Positive patient	IPCT	March	May 2021 – IPCT continue to visit patients with newly

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	accurate information on infections to service users and their visitors	about their presenting infections. All new cases of *CDifficile,* MRSA and ESBL will be counselled by an IPCN	patients and their carers. Provide verbal and written information and contact details	feedback		2022	acquired infections and established infections to provide information and reassurance.
		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 2022	May 2021 – All information leaflets in date, new leaflets developed in response to COVID-19
4	Provide suitable accurate information on infections to any person concerned with providing further	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department,	Minimum cross infection, reduced prolonged outbreaks of infection, reduced	IPCT	March 2022	Daily IPCT ward rounds in place.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	information support nursing/ medical care in a timely information	staff	providing clinical support 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) TBC cases (does not include cases whereby no lapses of care were identified	Undertake Root Cause analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset-Healthcare Acquired and Community Onset Healthcare Acquired	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Divisional Head of Nursing / Matrons	March 2022	May 2021 – All cases of CDI that are hospital acquired are subjected to RCA. Yearend for 2020/21 not yet complete so final figure not yet available – to be reported via Annual Report. 1 case to go through PIR.
		Reduce rates of Gram-negative blood stream infections (BSI)	Undertake IPC led Root Cause analysis of all hospital acquired	All cases of Gram negative BSI will have	Acting Matron Infection Prevention &	March 2022	March 2021 - Yearend not yet complete so final figure not yet available – to be

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		by 50 % by 2023	cases of gram negative BSI – escalate to full RCA if lapses in care	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)	Control		report via Annual Report May 2021 awaiting final figures to report.
		Ensure the Trust is robustly prepared for Winter	Support staff vaccination programme for seasonal influenza Reinforce Seasonal Influenza Policy and Pandemic Influenza Policy Ensure staff are familiarised with the Outbreak/Noro	The Trust will be able to function effectively during the Winter months and Infection Control standards are maintained	Acting Matron Infection Prevention & Control	October 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			policy				
		Ensure Trust remains aligned to Public Health England COVID-19 Infection Control Guidance.	Maintain COVID-19 Board Assurance Framework and report bi-monthly to IPCG , Quality Committee and Trust Board	The Trust will be able to support the demands of the COVID-19 pandemic	Acting Matron of Infection Prevention and Control Associate Director of Infection Prevention and Control Director of infection Prevention and Control	Ongoing	May 2021- All current guidance and action cards in place align with PHE guidance. IPCT continue to keep up to date with any guidance changes. May 2021- Board assurance framework updated.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
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	March 2021 – As per dashboard May 2021- as per dashboard
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT	Bi-Monthly	March 2021 – As per dashboard May 2021 – As per dashboard
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2021	May 2021- International hand hygiene day promoted by IPCT October 2021- IPC week,

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
							IPCT to organise events.
		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 2022	Ongoing – Mandatory training provided face to face and via remote learning throughout the year
7	Provide or secure adequate isolation facilities	Ensure the risk of cross infection is reduced Trust wide	Undertake annual audit of isolation precautions to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation.	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2022	March 2021 – Audit completed.
8	Secure adequate access to	IPCT to support and be involved in the county	IPCT to be involved in county wide meetings	Safe transition of service	Acting Matron & Associate Director	September 2021	March 2021 – Ongoing support offered by IPCT to project – anticipated

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	laboratory support as appropriate	wide pathology project ensuring delivery of safe patient care is not affected	where appropriate and provide expert support for the project		Infection Prevention & Control		completion of project Summer 2021
			IPCT at DCHFT to take nursing lead on development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project to be implemented once funding released	One ICNet system across Dorset	Acting Matron & Associate Director Infection Prevention & Control	September 2021	March 2021 – Project in final stages DCH, UHD complete and DHC last Trust to have single instance added
9	Have and adhere to policies, designed for the individual's care and provider	Audit programme- to audit compliance with Key IPC policies	PVC audits undertaken to ensure compliance with observation standard	PVC observations will be observed every shift and recorded on Vital Pac	IPCT	Quarterly	March 2021 – As per dashboard May 2021 – as per dashboard
			Urinary catheter	Urinary	IPCT	Monthly	March 2021 – As per

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	organisations that will help to prevent and control infections		documentation audits undertaken to ensure compliance with observation standard	catheters will be reviewed on a daily basis and care documented on Vitalpac			dashboard May 2021 – As per dashboard
			Audit compliance with CPE screening recommendations. Divisional Matrons to review results with wards and develop action plans dependant on results of audits	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust	IPCT Divisional Matrons	Biannually	March 2021 – As per dashboard May 2021 – As per dashboard, roll out of new policy with changes to CPE screening in place.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan to be developed and implemented Results to be presented at Divisional Governance Meetings and IPCG	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads Divisional Matrons	March 2022	March 2021 – SSI Surgical Surveillance of Repair of Neck of Femur Surgery – Completed Surgical Surveillance of Breast Surgery – In progress Plan in place for 2021-2022 SSI surveillance.
1	Ensure, so far as is	Reduce the number of sharps	Undertake annual Sharps Audit to	Audit identifies	IPCT	Sept 2021	March 2021 – as per dashboard and

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
0	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	injuries caused by sharps disposal	ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	compliance with safe management of storage and disposal of sharps		(IPCT) Oct 2021 (Provider)	Occupational health report presented at IPCG. May 2021 - As per dashboard
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask testers in place to support evolving needs created continuous change of suppliers of masks influenced by COVID-19 pandemic	All clinical staff will have access to FFP3 training and able to care for patients using airborne precautions	Health & Safety Lead	Ongoing	Sept 2020 – Divisional fit mask testers in place and supporting requirement – portacount machine also available for use via IPCT
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious	Ensure all 'IPC Emergency Boxes' are maintained and in date Ensure all relevant policies are up to	All clinical staff are aware and able to support the emergency preparedness	IPCT Acting Matron Infection Prevention & Control / Lead Emergency	October 2021	May 2021 – Policies updated as required. Action cards updated to reflect IPC guidance as current

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		patients	date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	of the trust for IPC issues	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.

Abigail Warne, Acting Matron, Infection Prevention and Control. Version 1 May 2021.

Meeting Title:	Board of Directors
Date of Meeting:	29th September 2021
Document Title:	**Board Assurance Framework Review by Committees**
Responsible Director:	Nick Johnson, Deputy Chief Executive
Author:	Trevor Hughes, Head of Corporate Governance

Confidentiality:	*If Confidential please state rationale:*
Publishable under FOI?	No

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Various Board and committee meetings throughout 2021	2021	Paper consolidating discussion, process and committee relationships to be presented to the Board.

Purpose of the Paper	This paper aims to consolidate prior discussion by the Board, its subcommittees and the Executive and Non-Executive teams regarding the review and management of the Board Assurance Framework by Board committees and to summarise the interdependencies with other key strategic documents and processes.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	Section 2.5 of the Trust's Standing Orders provides that the Board is responsible for formulating the strategic direction of the Trust through the development of a strategy and for holding the organisation to account for the delivery of the strategy. This includes having a clear implementation plan and managing the risks to the achievement of the Strategy Objectives (People, Place and Partnerships). Section 8 of the Trust's Risk Management Framework defines the Board Assurance Framework (BAF) as risks to delivery of the Strategic Objectives and mitigating actions. The Corporate Risk Register articulates high scoring operational risks that may individually or collectively impact on delivery of the Trust strategy or associated action plan. Following approval by the Board in the summer 2021 of a refreshed Trust Strategy, a plan, set out over the period of the strategy and articulating actions aligned to the Strategic Objectives, is currently in development. Risks to the delivery of the Strategic Objectives are currently being reviewed with the aim of presenting a refreshed BAF to the Risk and Audit Committee in November following a working group review by the Senior Leadership Group in October. Corporate risks are also under review to reflect the revised Strategic Objectives within the refreshed Trust Strategy. Board sub-committees have a clearly defined portfolio of responsibility delegated to them by the Board and defined within their respective Terms of Reference. Whilst the Board subcommittees have shared interests across common areas, people and workforce for example, the subcommittee portfolio defined within the Terms of Reference, makes clear the aspect of focus for each committee: • Quality Committee – impact on service quality and safety / patient experience arising from workforce issues;							

	• Finance and Performance Committee – impact on Agency and bank expenditure / budgets arising from workforce issues; • People and Culture – focus on safe staffing levels and skill mix / staff experience and wellbeing. There is a shared interest in achievement of the Strategic Objectives and overall strategy by Board subcommittees, although again, their portfolio responsibilities are clearly defined within their respective Terms of Reference. Board sub-committee membership comprises Executive and Non-Executive experts providing scrutiny to the strategy implementation plan and challenge to risk mitigation and controls. It is therefore appropriate that Board sub-committees review the Strategy Implementation Plan and risks to delivery of the Strategic Objectives, via review of the Board Assurance Framework and Corporate Risk Register. Following the annual review of committee effectiveness at the end of 2020/21, Non-Executive and Executive discussion took place regarding the strengthening oversight of strategic risk by the Board sub-committee with delegated portfolio responsibility and expertise. It was agreed that as part of the further review of the Board Assurance Framework and the Corporate Risk Register, respective Board Assurance Framework risks would be reviewed alongside the relevant aspects of the Strategy Implementation (Annual) Plan and Corporate Risk Register by the most appropriate Board Sub-committee. This will ensure that scrutiny and challenge is applied by the relevant expert members of Board sub-committees to the: • Actions to implement and deliver the Trust Strategy (Annual Plan) • Strategic risks and controls (Board Assurance Framework), within the Trust's agreed appetite for risk • High scoring operational and emergent risks (Corporate Risk Register) are evaluated for their impact on delivery of the strategy and achievement of the Strategic Objectives. The Risk and Audit Committee will retain oversight of the BAF overall and seek assurance from Board sub-committee Chairs on the adequacy of risk mitigations and controls on behalf of the Board.
Action recommended	The Board of Directors is recommended to **NOTE** the prior discussion and agreed arrangements for the future scrutiny of respective elements of the Board Assurance Framework, Annual Plan and Corporate Risk Register by expert Board sub-committees and maintenance of the oversight arrangements for systems of internal control and the overall BAF by the Risk and Audit Committee.

Governance and Compliance Obligations

Legal / Regulatory	Y/N	Good governance practice requires that risks to the achievement of the Trust's Strategic Objectives and overall strategy, a founding responsibility of the Board of Directors, are robustly managed.
Financial	N	
Impacts Strategic Objectives?	Y	Scrutiny of the relevant risks within the BAF (i.e. within the delegated responsibility portfolio of the committee) by expert members of respective Board sub-committees will provide greater challenge and scrutiny and strengthen Board oversight of strategy implementation.
Risk?	Y	See above
Decision to be made?	N	
Impacts CQC Standards?	Y	Strengthening Board oversight of the management of strategic risks and delivery of the strategy will support good governance practice and the Well

		Led domain.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	Y	Strengthening Board oversight of the management of strategic risks and delivery of the strategy will support good governance practice