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 **28th September 2022** at **8.30 am to 11.30am** at the **via MS Teams / Vespasian House, Bridport Road, Dorchester, DT1 1TG**.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Presentation	Julia Woodhouse and Sonja Critchley, Patient and Public Engagement Team	Note	8.30-08.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	08.55-9.00
	a) Apologies for Absence: Nicky Lucey	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 27th July 2022	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**COVID Update**	Verbal	Anita Thomas	Note	9.00-9.05
4.	**CEO Update**	Enclosure	Nick Johnson	Note	9.05-9.35
5.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (Aug and Sept 2022) a) Finance and Performance Committee b) People and Culture Committee c) Quality Committee d) Risk and Audit Committee e) Remuneration and Terms of Service Committee f) Charitable Funds Committee (meeting cancelled) g) System Performance Update (Standing Item)	Enclosure	Committee Chairs and Executive Leads	Note	9.35-10.15

	Coffee Break 10.15-10.30				
6.	**Board Assurance Framework and Corporate Risk Register** (September RAC)	Enclosure	Paul Lewis Phil Davis Mandy Ford	Approve	10.30-10.45
7.	**Maternity Update**	Enclosure	Nicky Lucey	Note	10.45-10.55
8.	**Risk Management Strategy Update (deferred)**		Nicky Lucey Mandy Ford		
9.	**GMC Survey Action Plan** (September PCC)	Enclosure	Alastair Hutchison Paul Murray	Approve	10.55-11.10
10.	**Well Led Review – Action Plan Update**	Enclosure	Nick Johnson	Note	11.10-11.20
11.	**Questions from the Public**	Verbal	Mark Addison	Note	11.20-11.30
	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.				
12.	**Annual Reports** • **Charitable Funds annual Report and Accounts** (Charitable Funds Committee)	Enclosure	Simon Pearson James Claypole	Approve	-
13.	**Learning from Deaths Q1 Report** (August QC)	Enclosure	Alastair Hutchison	Note	-
14.	**Guardian of Safe Working Report** (August PCC)	Enclosure	Alastair Hutchison Paul Murray	Note	-
15.	**Communications Team Activity Report (deferred)**	Enclosure	Susie Palmer	Note	-
16.	**ICB Board Minutes Part 1** (Standing Item)	Enclosure	Nick Johnson	Note	-
17.	**Any Other Business** Nil notified	Verbal	Mark Addison		
19.	**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 30th November 2022** via MS Teams. TBC				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 10.00am on 27th July 2022 via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Sue Atkinson	SA	Non-Executive Director
Judy Gillow	JG	Non-Executive Director
Paul Goddard	PG	Chief Financial Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Interim Chief Executive
Eiri Jones	EJ	Non-Executive Director
Nicky Lucey	NL	Chief Nursing Officer / Interim Deputy Chief Executive Officer
Stuart Parsons	SP	Non- Executive Director
Dhammika Perera	DP	Associate Non-Executive Director
Anita Thomas	AT	Chief Operating Officer
David Underwood	DU	Non-Executive Director
In Attendance:		
Julie Barber	JB	Head of Organisational Development *(item BoD22/039)*
Phil Davis	PD	Head of Strategy and Corporate Planning *(item BoD22/035)*
Emma Hallett	EH	Deputy Chief People Officer
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy, Transformation and Partnerships
Laura Symes	LS	Corporate Business Manager
Sarah Williams	SW	Lead Research Nurse *(item BoD22/037)*
Members of the Public:		
Judy Crabb	JD	DCHFT Governor
Roxxanne Dean	RD	DCH Bank Worker (*Staff Story*)
Yvonne Lee	YL	Temporary Staffing Clinical Lead *(Staff Story)*
Apologies:		
Margaret Blankson	MB	Non-Executive Director
Dawn Harvey	DH	Chief People Officer
Stephen Slough	SS	Chief Information Officer
Stephen Tilton	ST	Non-Executive Director

BoD22/027	**Staff Story**	
	EH introduced RD who had worked as a Registered Bank Worker across a variety of departments in the Trust. RD highlighted that she had received a warm welcome in every team where she had worked. RD enjoyed the flexibility working on the Bank provided, enabling her to achieve a good work / life balance and noted good opportunities for ongoing development. RD worked between 30 – 40 hours per week and could flex her working patterns to suit her personal life. RD adopted a positive attitude to supporting each work area despite the challenges arising from staff shortages and patient acuity. RD expressed that she felt part of each team in which she worked and expressed a preference for working on smaller wards. She noted the workload pressures arising and lack of breaks on occasion, particularly on larger wards which tended to be very busy and staff often missed their breaks. This required resilience, particularly for the substantive teams. Working as a Bank Worker enabled choice in	

	working patterns and areas and therefore greater resilience. RD applauded the hard-working teams and standards of care teams were delivering. Bank working allowed RD to look after herself as well as her patients and she had never been pressured to book shifts. There was great flexibility within the booking arrangements enabling booking several weeks or only a few hours in advance which helped when balancing personal commitments. The Board noted the important contribution the Bank provided to support staff and noted the need to relaunch the positive attributes to support flexible working. In order to attract more people to undertake Bank work, RD felt that the opportunities for greater flexible working and development opportunities needed to be more widely promoted. Clear induction processes and an opportunity to 'shadow' when working in a new area would also be beneficial for staff and reduce the anxiety of working in an unknown area. The Board noted the workload pressures and lack of breaks, particularly in respect to larger wards and remitted to the People and Culture Committee to oversee a rebranding and relaunch of the Bank and to gain a better understanding of the workload pressures and steps that could be taken to alleviate these. MA and NL extended their thanks to RD and acknowledged the constant pressures staff were under. The Board had heard this message and noted the important role that Bank staff played in supporting staff and teams.	
	Resolved that: the Staff Story be heard and noted.	
BoD22/028	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed members of public and Governors to the meeting. Apologies were received from Dawn Harvey, Stephen Slough, Margaret Blankson and Stephen Tilton. AH, AT and NL noted that they would need to leave for an urgent meeting at 10.00 am and would re-join later.	
BoD22/029	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD22/030	**Minutes of the Meeting held on the 25th May 2022**	
	Members of the Board considered the minutes of the meeting held on 25th May 2022 and these were approved as an accurate record, noting the following amendments**.** • 'Interim Deputy Chief Executive' to be added to NL's title • A typographical error on page 4 third paragraph '…discussion ensued' not 'ensured'. • Correction to the Interim Chief Executive's title.	

	Resolved: that the minutes of the meeting held on 25th May 2021 were approved.	
BoD22/031	**Matters Arising: Action Log**	
	The action log was considered and updates were noted with approval given for the removal of completed items.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD22/032	**COVID update**	
	AT reported that the increased community prevalence of COVID continued had appeared to plateau although there had not been a reduction in positive patients or staff absences across health and social care sectors. The heatwave had also impacted and there were consistently in excess of 30 positive patients in hospital. Consistent levels staff absences were also affecting elective care and patient flow. AT reported that there would be an autumn COVID booster campaign for the over 50s and mask wearing in clinical areas and meetings was still in place. The majority of meetings were being conducted remotely.	
	Resolved that the COVID Update be noted.	
BoD22/033	**CEO Update**	
	NJ noted the changing national political landscape and the appointment of a new Secretary of State for Health. He also noted the following: • Establishment of the Integrated Care Board from 1st July 2022 and DCH's ongoing involvement. Minutes of the Board meeting had been provided. • The decision on closer collaboration with DHC and the appointments of a joint Chair and joint CEO would be delayed due to operational pressures and clinical priorities. The decision would be revisited in September. • The system was operating at OPEL 4 level due to continued pressures. • UHD had appointed Rob Whiteman as Chair on 1st July 2022. • The number of patients with No Reason to Reside remained a challenge. Internal control actions continued to be implemented • The Operating Plan had been submitted and the Trust was making good progress against measures and offering mutual aid to UHD where possible. • Ambulance handover times remained pressured but had performed well • Financial pressures persisted and would be discussed in further detail later in the meeting • Chris Hearn had been formally appointed as Chief Finance Officer to replace PG	

	• Congratulations were extended to NL on her appointment to the Chief Nursing Officer post on the Hampshire and Isle of Wight Integrated Care Board. MA noted the announcement on pay and the system joint commitment to collaboration at a meeting held the previous evening. Discussion followed regarding the 100 Day Challenge to improve patient flow and noted the Trust's previous involvement in the 10 challenges. Many of the required actions were within the Trust's control and patients were being discharged where no further care package was required. Whilst there had been some improvement in weekend discharges, the whole system was not able to provide seven-day support and the ability of Care Home providers to take patients at weekends was variable. The Patient Tracker had been helpful in providing feedback across the system on delayed discharges which were regarded as harm events. The Patient Tracker and Trusted Assessor model had supported discharges and innovation and DCH had been able to provide mutual aid to UHD and the offer was increasing. Reporting of mutual aid activity would be undertaken via the Finance and Performance Committee. The Board noted that two further wards had achieved accreditation and acknowledged the achievement in the face of ongoing operational pressures. One ward had been particularly disrupted by the pandemic and it was an accolade to the leadership on the ward to bring the team together and achieve a gold award. A letter of congratulations would be sent on behalf of the Board to the wards. Discussion of staff feedback following the publication of the RCN report regarding structural racism noted that quarterly staff surveys provided real time feedback, and the Trust was particularly targeting the International Staff Network on their experiences. The People and Culture Committee maintained oversight of staff responses and actions taken and the next Pulse Survey results would be presented in August.to the committee. Actions to address issues in the prior year's Staff Survey had resulted in ongoing work across the Trust and policy change. The Board heard that a further letter had been received from the Regional Office emphasising waiting time targets following failure to fully achieve the June deadline. Complex clinical cases and patient choice were however, acknowledged as contributory factors. Information was being shared to support mutual aid where capacity to address long waits was an issue. The number of patients waiting in excess of 104 weeks had reduced significantly and the areas of concern had been identified with clear plans in place to address by the end of August. There were also significantly fewer patients waiting 62 days and learning in this area had been shared. An increase in referrals may	**MA / NL**

	have future impact but the Regional Office had been satisfied with the work that DCH had done. Performance was comparative currently and the Region had been assured that organisations had a clear grip of the issues and were managing these. MA concluded; recognising the enormous service pressures and the amazing things staff were doing. He noted that the Finance and Performance Committee would log mutual aid and that a letter of congratulations would be sent to the wards achieving accreditation. The Board would revisit the Pulse Survey results once these had been finalised.	
	Resolved: that the CEO Update be received and noted.	
BoD22/034	**Performance Scorecard and Board Sub-Committee Escalation Reports**	
	The following committee Escalation Reports for June and July 2022 were received, and key points were highlighted: **Finance and Performance Committee** • Earlier discussion by the Board on waiting times was noted. • A focus on the financial position and the Cost Improvement Programme (CIP). • A growing Waiting List due to increases in urgent two-week referrals reflecting national trends • The Trust was closed to Oral Maxillo-Facial referrals and UHD were providing support (note: the workforce is employed by UHD). Two other providers were also being insourced to support. • The Trust was £1.7m off plan in the first quarter due to high levels of Agency spend and a diminishing ability to obtain staff in lower tier agencies. • The Finance Subgroup would meet the following week and focus on the CIP • Inflationary cost pressures were being reflected in financial performance. **People and Culture Committee** • Sickness absence increased to 5.25% in April and was linked to the peak in COVID cases. The figure had subsequently reduced. • Data in the Leavers Report highlighted an issue around fixed term contracts, having wider implications on recruitment • Workload pressures and the cost-of-living impact on staff was noted and linked to increased levels of staff anxiety • The importance of staff appraisal and low compliance percentage was noted. • The Equality, Diversity and Inclusion and Medical Revalidation reports would be presented to the Board	

	Discussion was had regarding high-cost Agency expenditure and noted staff movement to better paid Agencies nationally. Partners in the system had larger Bank pools to maintain safe staffing. A more consistent approach to using Agency staffing and containing costs was being undertaken across the system. The need to ensure that solid staffing foundations were in place in order to avoid greater difficulties over the winter period was noted. AT was the Senior Responsible Officer for the system for this matter. **Quality Committee** • Staff continued to work hard to maintain standards • SHMI was within normal range but the committee noted concerns about Coding workforce shortages and the potential build-up of a further backlog. • There had been a rise in Clostridiun Diffcile cases across the system and the situation was being closely monitored • Maternity Safety report had been reviewed and the committee noted and would monitor ongoing staffing challenges. • The Infection Prevention and Control Annual Report was noted • The Medical Revalidation Report was recommended to the Board JC, AH, NL and AT left the meeting. **Risk and Audit Committee** • Internal Auditors informed of the NHSE nationally mandated audit of the Operational Plan. • Concerns were raised about increases in fraud targeting international nurses – TIAA would discuss with the Overseas Network • Reduced Information Governance mandatory training compliance was noted • SHMI – potential coding back log as a result of workforce pressures • The proposed reduction of the financial risk score of the BAF financial risk, based on breakeven plan submission was not supported by the committee due to concerns regarding the challenging financial position in 2023/24. **Charitable Funds Committee** • Outturn in 2021/22 was £579K against a downgraded income expectation and was reasonable under the pandemic circumstances. • Reserves had been increased to £210K as an upturn in income was expected. **System Performance Update** NJ remarked that key areas had already been discussed but added that access times for children and young people to mental health services was a key issue impacting the hospital.	

	The Dorset Integrated Care Board (ICB) was in place and had met although this was not the same for other ICBs. The initial focus of discussions was centred around the NHS. There was voluntary sector and GP alliance representation at the ICB Board. The Provider Collaborative was due to meet on 6th August and work continued to identify Place Based Leaders and involve the two local authorities, including public health, and the third sector. The meeting would discuss the Integrated Care Strategy and there would need to be a shift in the agenda from away from the NHS towards the local authority and voluntary sector moving forward. No further questions were raised in respect of the Performance Report and Balanced Scorecard which remained in development. The Regional focus would need to be further reflected in the Scorecard in addition to the Constitutional standards and it was expected that these would be in place for the September report.	
	Resolved that: the Performance Scorecard and Sub-Committee Escalation Reports be received and noted.	
BoD22/035	**Board Assurance Framework (BAF) and Corporate Risk Register**	
	PL advised that the summary of the BAF would be enhanced to provide a clearer narrative for the Board and sought feedback on the format of the report. Issues with presentational formatting were noted and would be addressed for future reports. SA noted the inclusion of integration and social value in some places although this required further integration. SA cited that recruitment was an important contributor to the social value ambition for the Trust, as was local procurement in supporting the local economy. These examples needed to be better connected and reflected in the risk mitigations. PD joined the meeting and reported that the proposed risk score reduction of the financial risk had not been supported by the Risk and Audit Committee. There was an inconsistency between the BAF and the Corporate Risk rating and this further supported maintenance of the BAF risk rating. In response to a query regarding the level of confidence that risk mitigations and target dates were appropriately tested, the Board noted evidence of assurances within the document. MA commented on the alignment of the organisation and ICB strategies and the DCH focus on population health and inequalities. It would be challenging for the acute sector to transform service delivery and staff training to address these issues. NJ commented on recent executive discussion regarding embedding population health and the links to Business Intelligence and resourcing. A further discussion would be necessary to consider the Trust's approach and incorporate this into job requirements going forward. **Corporate Risk Register**	

	NL reported that a majority of items had been discussed earlier in the meeting or by committees during the previous week including the SHMI / Coding risk and waiting times risk. Changes to the risk register included: • A slight reduction in the COVID risk • noting of the supply chain delay impact on the COTAG risk • Mitigation plan and actions in place for the Blood Bank MHRA risk The need to reflect limited access to mental health beds for children and young adults was noted. The Board noted that key areas of Board discussion were aligned with the Corporate Risk Register and the BAF. Further discussion would be had regarding the Trust's approach to consistent risk scoring and the diverse considerations in determining a score.	**NL** **NL / DP**
	Resolved: that the Board Assurance Framework and Corporate Risk Register be received and noted.	
BoD22/036	**Medical Revalidation Annual Report**	
	The Board noted prior discussion at the People and Culture Committee the previous week, the committee's recommendation to the Board for approval and request that the Statement of Compliance be signed. Discussion ensued about the extension of appraisal to include Locally Employed Doctors and the number of appraisers required to deliver this. The Board noted that responsibility was with consultant staff and this should be included within Job Descriptions. The matter of GMC training and the inclusion of this in Consultant Job Descriptions would be remitted to the People and Culture Committee.	**EH**
	Resolved: that the Medical Revalidation Annual Report be approved and the Statement of Compliance be signed.	
BoD22/037	**Research Strategy Refresh**	
	Sarah Williams attended for this item to present the refreshed strategy covering the period 2022-25. She noted the aim of the strategy was to develop the DCH research offer and to integrate research into services. Priorities within the document aimed to drive income and identify opportunities for services to contribute. SW noted the need to support service teams such as Cardiothoracic, Diabetes and Ophthalmology to deliver a strong research portfolio. Some disappointment was expressed that the strategy had not been developed jointly with nursing given the opportunities in the fields of care of the elderly and frailty in particular. The strategic objectives could more explicitly state the connection between research and quality improvement and targets would need to be stretching and SMART.	

	The importance of the strategy as a unique selling point and in attracting clinicians to DHC was noted. It was also noted that a number of academic institutions support funded PhD posts. The Board supported the strategy and commented that health services research could also be included citing the positive management of ambulance handovers by way of example. Funding for commercial research would need to come from an ethical source / sponsor. AH, AT and NL re-joined the meeting. AH commented on the restrictive nature of research funding arrangements in the acute sector which determined research priorities and that the funding had significantly diminished. Commercial research aimed to generate income and health service research was an ambition. NL advised about the national drive for nursing research and inclusion into job plans. The Trust hoped to develop capacity in the Research team in order to exploit wider opportunities. The Board recognised the important contribution that research made and requested that the strategy be updated in light of comments received and be returned to the Senior Leadership Group. MA summarised the discussion highlighting • The need to emphasise the contribution of research to quality improvement • The nursing perspective to be reflected • Update the Strategic Objectives • SMART baseline targets • Clear timelines • Links with the new system inequalities focus • Ethical sponsorship and clarity on the approach • Amends to be signed off by the Senior Leadership Group MA extended the Board's thanks to the SW for presenting the item and to the Research team for their excellent work. He also asked that thanks be also extended to Zoe Sheppard, Head of Research, who was noted to be leaving the Trust.	
	Resolved that: the Research Strategy Refresh be approved and amendments be signed off by the Senior Leadership Group.	
BoD22/038	**Blood Sciences MHRA Response Plan**	
	The Board noted prior discussion at Quality Committee and that the report was being presented to the Board to provide an opportunity for Board discussion.	

	AT advised of the meeting with MHRA officials in May. Information requested had been provided and demonstrated that DCH had a grip on the issues and regular meetings to monitor delivery and provide assurances were taking. No further questions had been raised by MHRA subsequently. AT advised that the service aimed to have staff in place and fully trained by Quarter 3 and were ahead of plan. The Board noted the actions taken and underway and thanked the team for their work.	
	Resolved that: the Blood Sciences MHRA Response Plan be noted.	
BoD22/039	**Equality Diversity and Inclusion Annual Report**	
	JB joined for this item The Board noted the report and prior discussion by the People and Culture Committee. JB advised that the report recognised the current operating difficulties and outlined progress made in training, Staff Networks and updating of the Equality, Diversity and Inclusion Road Map. The report provided a balance of positive stories and areas for improvement including equal access to career development and noted increased satisfaction by staff from ethnic communities. Areas of concern included harassment from patients and negative staff experience from working extra hours. Data for 2022 WRES and WDES was being compiled and would be presented to People and Culture Committee and Board in August and September. Respectively The mix of data sources and related availability time periods was noted. The Board noted the work of the Inequalities Steering Group and attendance by Paul Iggulden, Director of Public Health, to shape the Trust's work plan to promote health outcomes for ethnic groups and to reflect the system work. Reciprocal mentoring implementation had been delayed slightly. DCH supported this approach and noted the cultural benefits to be gained from people's lived experiences. Some mentoring pairs had been identified and the scheme would launch in August. Further work to refresh posters and public messaging about the Trust's zero tolerance approach to abuse from patients and the public would be undertaken. The role of Governors in supporting this message was also noted. The Board approved the report.	
	Resolved: that the Equality Diversity and Inclusion Report be received and approved.	

BoD22/040	**Well Led Action Plan Update**	
	The Board noted progress made against a number of recommendation actions outlined in the Well Led Review Report which had been positive overall.	
	Resolved that: the Well Led Action Plan Update be noted.	
BoD22/041	**Questions from the Public**	
	No questions were raised by members of the public.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD22/042	**Maternity Safety Update**	
	Resolved that: the Maternity Safety Update be received and noted.	
BoD22/043	**Annual Reports:** • **Safeguarding** • **Complaints** • **Infection Prevention and Control**	
	Resolved: that the • **Safeguarding** • **Complaints** • **Infection Prevention and Control** **Annual Reports be approved.**	
BoD22/044	**Paediatric Service Action Plan Update**	
	Resolved that: the Paediatric Service Action Plan Update be received and noted.	
BoD22/045	**Nutrition Strategy Assurance Report**	
	Resolved that: the Nutrition Strategy Assurance Report be received and noted.	
BoD22/046	**Subco Annual Performance Report and Financial Statements**	
	The Board noted the financial statements needed to be corrected to the correct financial year. These would be recirculated.	NJ
	Resolved that: the DCH Subco Annual Performance Report and financial Statements be received and noted.	
BoD22/047	**ICB Board Minutes – Part 1**	
	Resolved that: the ICB Board July Minutes Part 1 be noted.	

BoD22/048	**Any Other Business**	
	MA noted that this was the last Board meeting for DH, SS and PG and extended the Boards thanks for them for their service to the Trust over an extraordinary period.	
BoD22/049	**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 28th September 2022.**	

DRAFT

Action Log – Board of Directors Part 1

Presented on: 28th September 2022

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 27th July 2022						
BoD22/033	**CEO Update**	A congratulatory letter to be sent to wards achieving accreditation on behalf of the Board.	**MA / NL**	August 2022		
BoD22/035	**Board Assurance Framework (BAF) and Corporate Risk Register**	Access to mental health beds for children and young adults to be reflected within the risk register	**NL**	August 2022	To be reviewed at Risk and Audit Committee.	
		Further discussion about how risk scoring was consistently applied to be had.	**NL / DP**	August 2022	Complete.	Yes
BoD22/036	**Medical Revalidation Annual Report**	GMC training and the inclusion of this in Consultant Job Descriptions would be remitted to the People and Culture Committee	**EH**	August 2022	Added to People and Culture Committee Action Log	Yes
BoD22/046	**Subco Annual Performance Report and Financial Statements**	The correct version of the Financial Statements to be circulated	**NJ**	August 2022	Complete	Yes
Meeting Dated: 25th May 2022						
BoD22/007	**Review of the Previous Year Committee Priorities, this year's Priorities and Work Plans**	A bi-annual stock take of assurances and effectiveness to be undertaken by Non-Executive and Executive colleagues at committees' regularly scheduled meetings and fed back to the Board	**Committee Chairs**	November 2022	Not Due	No

Actions from Committees…(Include Date)						

Meeting Title:	Board of Directors
Date of Meeting:	28 September 2022
Document Title:	**Chief Executive's Report**
Responsible Director:	Nick Johnson, Interim Chief Executive
Authors:	Laura Symes, Corporate Business Manager to the Chief Executive

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	21/09/2022	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: • On 19 July 2022 the Government accepted the recommendations from the independent NHS pay review bodies in full. • On 21 July 2022 Baroness Heather Hallett officially launched the UK Covid-19 Inquiry and opened its first investigation into how well prepared the UK was for a pandemic, with preliminary hearings starting this year. • On 04 August 2022 the Healthcare Safety Investigation Branch (HSIB) published its review of its 2021/22 Maternity investigation programme. It also announced the name for the new body which will take over responsibility of maternity investigations: the Maternity and Newborn Safety Investigations Special Health Authority. • On 12 August 2022 NHS England set out the next steps in increasing capacity and operation resilience in urgent and emergency care ahead of winter. 8 collective core objectives and actions have been outlined. • On 05 September 2022 Liz Truss became the new Prime Minister for the United Kingdom, succeeding Boris Johnson, who resigned in July 2022.							
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 2022

National Perspective

Department of Health and Social Care – Women's Strategy for England
On 20 July 2022, the Department of Health and Social Care published the Women's Health Strategy for England. The strategy details the government's 10-year ambition and actions to improve the health and wellbeing of women and girls in England.

NHS Pay Award 2022/23
On 19 July 2022 the Government accepted the recommendations from the independent NHS pay review bodies in full. The pay review bodies considered a range of evidence from various organisations including government, the NHS and trade unions. All NHS staff under the remit of this year's pay review will receive a pay rise. Over one million staff under the Agenda for Change contract, including nurses, paramedics, and midwives, will benefit from a pay rise of at least £1,400 this year backdated to April 2022.

COVID-19 Inquiry Launches
On 21 July 2022 Baroness Heather Hallett officially launched the UK Covid-19 Inquiry and opened its first investigation into how well prepared the UK was for a pandemic. Baroness Hallett also set out an ambitious timetable, with preliminary hearings starting this year, and the first witnesses to be called next spring. The Chair has pledged to deliver reports with analysis, findings and recommendations whilst the Inquiry's investigations are ongoing, so that key lessons from the pandemic are learned quickly.

HSIB Maternity Investigation Programme
On 04 August 2022 the Healthcare Safety Investigation Branch (HSIB) published its review of its 2021/22 Maternity investigation programme. The report provides a review of the HSIB maternity investigation programme during 2021/22, including an overview of activity during this period, themes arising from investigations and plans for the future. During 2021/22 the programme received 731 referrals for investigations and completed 706 reports. It also announced the name for the new body which will take over responsibility of maternity investigations: the Maternity and Newborn Safety Investigations Special Health Authority.

Urgent and Emergency Care – Preparation ahead of Winter
On 12 August 2022 NHS England set out the next steps in increasing capacity and operation resilience in urgent and emergency care ahead of winter. National planning has begun earlier than usual in recognition the pressure on the NHS is likely to be substantial. The collective core objectives and actions have been outlined as:

1. Prepare for variants of COVID-19 and respiratory challenges
2. Increase capacity outside acute Trusts
3. Increase resilience in NHS 111 and 999 services
4. Target Category 2 response times and ambulance handover delays
5. Reduce crowding in Accident and Emergency departments and target the longest waits in Emergency Departments
6. Reduce hospital occupancy
7. Ensure timely discharge
8. Provide better support for people at home

New Prime Minister
On 05 September 2022 Liz Truss became the new Prime Minister for the United Kingdom, succeeding Boris Johnson, who resigned in July 2022. Responding to the election, Saffron Cordery, Interim Chief Executive of NHS Providers said "Trust leaders – and indeed the public – will expect Liz Truss to deliver on her claims that health is her priority by showing she will not duck the big issues facing the NHS. We need to see a fully-funded long-term workforce plan for the NHS sooner rather than later. With a staggering 130,000 vacancies across trusts in England alone, we know the NHS simply doesn't have enough staff to deliver everything being asked of it".

New Secretary of States
On 06 September 2022 Thérèse Coffey was appointed Secretary of State for Health and Social Care, and Deputy Prime Minister. She was previously Secretary of State at the Department for Work and Pensions. On 07 September 2022 Robert Jenrick was appointed Minister of State in the Department of Health and Social Care.

An announcement on health is expected in Parliament over the next few weeks.

Local Relevance

Autumn Vaccination Campaign
On 15 July 2022 Steve Russell, National Director for Vaccinations and Screening at NHS England, wrote to set out the next steps for the flu and COVID-19 vaccination programmes for autumn and winter following the government's announcement confirming additional cohorts will be offered the flu vaccine and acceptance of Joint Committee on Vaccination and Immunisation (JCVI) advice for the COVID-19 booster dose. DCH are currently training vaccinators and will be circulating communications to staff in September with details of how they can receive their booster flu & COVID-19 vaccinations, to receive either together or separately. There will also be the opportunity for staff who have not had any COVID-19 vaccination yet to receive theirs.

COVID-19 Update
On 17 August 2022 National guidance was updated that masks are no longer mandatory in non-clinical areas, which includes offices, corridors, entrances and restaurants. Masks continue to be required in all clinical areas, including wards and outpatient departments. The Infection Prevention Control leads for all the Dorset NHS trusts are meeting weekly and will continue to review the situation.

On 07 September 2022 there were changes to guidance around pausing the testing of asymptomatic patients and recommended that there is no longer a requirement for asymptomatic staff to continue with lateral flow device (LFD) testing twice a week unless they develop symptoms. For those working with immunocompromised patients the advice remains to continue to LFD test twice a week regardless of symptoms.

DCH Performance
During August 2022 DCH continues to experience patient flow restrictions. Ambulance handover delays improved slightly, but remain at high levels, putting pressure on the ambulance response times. Elective activity performance is not achieving the national 104% target year to date but is performing well in comparison to both the national and regional average. As a result, the number of patients waiting over 78 and 104 weeks continues to decline and while not at the rate set out in the planning guidance, it is at a sustainable rate. Cancer performance is being impacted by high referral volumes, which is now resulting in an increased total waiting list size and an increase backlog.

The Trust continues to support University Hospitals Dorset (UHD) with mutual aid in Orthodontics and Gynaecology. DCH continues to experience significant issues with being able to safely discharge patients who are ready to go home but need some social care support in place before they can leave. The number of no reason to reside patients has increased in August. Work continues with partners to enable discharge of these patients.

Multi-storey Car Park Update
On 01 September 2022, the multi-story car park opened for DCHFT staff to park in to test the flow of vehicles and relieve parking pressures on site. This is for an interim period until the barrier, payment system and staff parking portal are up and running. The surface parking areas next to the North, South and East Wings will become public only spaces for this temporary period to ensure additional parking for public. The West Annex gravel car park has been closed in preparation for the start of the new ED and ITU build.

DCH Board Members Updates
In August 2022 we said goodbye to Dawn Harvey, Chief People Officer, Judy Gillow, one of our Non-Executive Directors, and Stephen Slough, Chief Information Officer. Judy has been with us for six years and, as Vice-Chair and Chair of the Quality Committee, has played a significant role in the success of the Trust. Dawn and Stephen have both joined the Dorset Integrated Care Board. Interim appointments are Emma Hallett, Interim Chief People Officer, and Ruth Gardiner, Interim Chief Information Officer.

Paul Goddard, Chief Finance Officer, retires at the end of September 2022. On 03 October 2022 Chris Hearn will be joining DCH as Chief Finance Officer.

On 06 September 2022 we were successful in our process to find a Chief Nursing Officer to replace Nicky Lucey when she moves on to the Hampshire and Isle of Wight Integrated Care Board. Jo Howarth will be joining us from NHS England where she is currently Deputy Director of Nursing and Quality, and Quality and Workforce lead for the vaccination programme. Jo will be joining DCH in November 2022.

Care Quality Commission Inspection
On 09 August DCH were visited by the Care Quality Commission (CQC) to look at Children and Young People Mental Health Pathways within DCH. They noted how welcoming all DCH staff were. We are providing them with additional information to aid their inspection and await their final report.

Ward Accreditations
During July & August 2022 three more wards completed the Ward Accreditation Programme. Kingfisher Ward, led by Sister Sarah Woodward, CRCU (Critical Care Unit), led by Sister Lynn Standley, and Moreton Ward, led by Sister Lynn Paterson. The programmes offer a framework for clinical teams to provide evidence of quality of care and leadership. After consideration for the evidence and presentation the panel were delighted to award all three Wards the 'SILVER' award. Well done to the leads and their teams for their hard work.

Dorset County Hospital's Greatest Need Appeal
At the end of August 2022 many DCH Staff and their friends and family volunteered to help at the Great Dorset Steam Fair. The Charity Trailer Rides were a huge success, running continuously for the full five days of the Fair with thousands of people enjoying the rides. The hard work and enthusiasm of all the staff and other helpers who came along on their day off or precious weekend was very much appreciated by us and also by the organisers who said the DCH team was amazing. We couldn't have done it without the help of everyone who took part. We will let you know how much was raised for Dorset County Hospital's Greatest Need Appeal as soon as we can.

DCH and DHC Joint Chief Executive & Joint Chair
On 07 September 2022, The Boards of Dorset County Hospital and Dorset HealthCare have agreed to progress the proposal to recruit both a joint Chief Executive and a joint Chair for the two organisations. A partnership strengthened by shared leadership is in line with the aspirations of the newly created Integrated Care System, Our Dorset. We will, of course, continue to work proactively and well with all partners and stakeholders within and beyond our own health and care system. This includes NHS organisations, primary care, local authorities and our voluntary and community sector. The two organisations will now work together on recruitment processes for both the Chief Executive and the Chair. We will update you on progress in due course.

Stroke and Neuro Pathway Funding
DCH has been successful in funding from Health Education England for the stroke and neuro pathway across the system to support peer supervision sessions led by Clinical Neuro Psychology to assist in the MDT in complex formulation and help build clinical reasoning. This is especially important to DCH in West Dorset as we do not have access to Psychology for our patients. In the same process we have been awarded funding to implement a train the trainer model to ready the stroke workforce for a significant change in rehabilitation intensity guidance. This will have a particular focus on our support staff and aims to create a community of practice across the pathway.

Nick Johnson
Interim Chief Executive
September 2022

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**28 September 2022**
Document Title:	**Performance Scorecard and Board Sub-Committee Escalation Reports**
Responsible Director:	**Executive Team**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee (performance metrics)	21 Sept 2022	See committee escalations

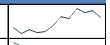
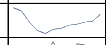
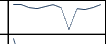
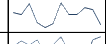
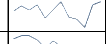
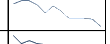
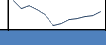
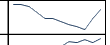
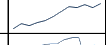
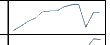
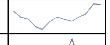
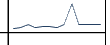
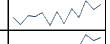
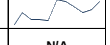
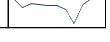
Purpose of the Paper	To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance Scorecard** The reporting month of August 2022 continued to experience patient flow restrictions but improvement against the 4-hour standard. Ambulance handover delays improved slightly, but remain at high levels, putting pressure on the ambulance response times. Delays of over 60 minutes are of concern. Elective activity performance is not achieving the national 104% target year to date but is performing well in comparison to both the national and regional average. As a result, the number of patients waiting over 78 and 104 weeks continues to decline and while not at the rate set out in the planning guidance, it is at a sustainable rate. Cancer performance is being impacted by high referral volumes, which is now resulting in an increased total waiting list size and an increase backlog. The backstop position (over 104 weeks) is also now increasing. Diagnostic waiting list size is an area of concern, with increase demand and staff shortages due to on-going sickness issues relating to COVID. Additional activity has been confirmed for September and October but remains fragile. Imaging modalities are reliant on additional sessions to recover and maintain waiting times. **Escalation Reports** The July Board sub-committees met as follows: Tuesday 20 Sept: Quality Committee and Risk and Audit Committee Weds 21 Sept: Finance and Performance Committee Thurs 22 Sept: People and Culture 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	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	YTD	Movement on Previous Period	12 Month Trend
Safe										
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**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)	**46**	**4 (0.4)**	2 (0.2)	2 (0.2)	**5 (0.6)**	2 (0.2)	**5 (0.5)**	16 (0.3)	↓	
Never Events	**0**	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	1	0	0	1	0	0	1	**N/A**	
Duty of Candour - Cases completed	**N/A**	4	4	9	10	9	5	37	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	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)**	**4**	**2**	0	**2**	**1**	0	5	↑	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.1)	0 (0.0)	2	↑	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.2)	0 (0.0)	0 (0.0)	2	↔	
Emergency caesarean section rate		19.3%	15.1%	31.3%	20.6%	22.8%	27.3%	24.2%	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	92.3%	**88.9%**	100%	**73.3%**	**75.0%**	N/A	**84.5%**	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	91.7%	**88.2%**	100%	100%	100%	N/A	96.2%	↔	
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')**	**1**	**1**	N/A	N/A	N/A	N/A	N/A	**N/A**	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.12 (ratio between observed deaths and expected deaths)**	**1.13**	**1.14**	N/A	N/A	N/A	N/A	N/A	**N/A**	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	**112.4**	**112.2**	**113.9**	N/A	N/A	N/A	N/A	**N/A**	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	**120.2**	**118.2**	**120.9**	N/A	N/A	N/A	N/A	**N/A**	
Stroke - Overall SSNAP score	**C or above**	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%**	94.8%	75.7%	93.7%	95.0%	98.2%	94.4%	91.6%	↓	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	100.0%	100.0%	100.0%	99.4%	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%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Caring										
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	35	28	42	27	47	29	173	↑	
Complaints - Percentage response timescale met	**N/A**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	**92.2%**	**93.1%**	**91.7%**	**92.5%**	**93.1%**	**93.3%**	**92.9%**	↑	
Friends and Family - Emergency Department - Recommend	**84%**	82.9%	**82.8%**	**80.5%**	**82.3%**	**82.0%**	**82.0%**	**81.9%**	↑	
Friends and Family - Outpatients - Recommend	**94%**	94.1%	**93.4%**	**93.1%**	**93.5%**	**93.7%**	94.6%	**93.8%**	↑	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	

Metric	Threshold/ Standard	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	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%**	**58.4%**	**58.1%**	**60.0%**	**59.2%**	**59.5%**	**58.3%**	**58.3%**	↓	
RTT Incomplete Pathway Waiting List size	**17,399**	17195	17535	17602	**17751**	**17889**	**18512**	**18512**	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	**53.6%**	**51.5%**	**68.3%**	**66.4%**	**48.0%**	**44.4%**	**55.5%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	94.1%	**81.5%**	93.1%	**92.3%**	96.2%	**80.0%**	**88.8%**	↓	
Cancer (ALL) - 28 day faster diagnosis standard	**75%**	**73.0%**	**71.1%**	**74.2%**	**73.0%**	**65.5%**	**70.9%**	**71.0%**	↑	**N/A**
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	97.6%	97.4%	97.9%	99.1%	97.6%	100.0%	98.4%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	**88.9%**	**88.9%**	100.0%	100.0%	**88.9%**	100.0%	94.1%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	**97.2%**	**77.4%**	**96.2%**	**95.0%**	**96.6%**	100.0%	**89.4%**	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	-	-	-	-	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	**81.9%**	**70.7%**	**70.8%**	**76.4%**	**75.0%**	**61.4%**	**71.2%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	**81.3%**	**62.5%**	**60.7%**	**50.0%**	**78.6%**	**82.4%**	**66.7%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	**84.3%**	**77.3%**	**77.1%**	**76.7%**	**76.4%**	**68.3%**	**73.2%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	**54.2%**	**54.4%**	**53.1%**	**52.5%**	**53.8%**	**56.1%**	**54.1%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**65.6%**	**67.4%**	**67.8%**	**68.8%**	**69.4%**	**70.9%**	**69.0%**	↑	
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
Sickness rate (one month in arrears)	**3.3%**	**6.10%**	**5.28%**	**4.2%**	4.51%	5.70%	N/A	4.93%	↓	
Appraisal rate	**90%**	**66%**	**65%**	**64%**	**63%**	**67%**	**70%**	**66%**	↑	
Staff Turnover Rate	**8 -12%**	10.5%	11.4%	11.28%	11.7%	11.3%	12.0%	11.5%	↓	
Total Substantive Workforce Capacity		2,922.3	2,916.8	2,787.9	2,878.7	2,868.0	2,857.1	2,967.3	**N/A**	
Vacancy Rate (substantive)	**<5%**	**6.3%**	**6.8%**	**7.2%**	**8.5%**	**8.4%**	**9.3%**	**8.0%**	↓	
Total Substantive Workforce Pay Cost		**18,886.6**	**12,382.5**	**12,186.7**	**12,228.5**	**12,169.6**	**12,204.8**	**12,665.3**	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	0	0	0	0	0	0	0	**N/A**	
Essential Skill Rate	**90%**	90%	91%	91%	89%	89%	90%	90%	↑	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**	**2,409**	**2,149**	**2,632**	**2,371**	**2,522**	**2,330**	**12,004**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**	**£2,414,961**	**£2,410,614**	**£2,869,208**	**£2,654,886**	**£2,736,806**	**£2,389,099**	**£13,060,613**	↓	
Surplus/(deficit) (year to date)	**2022/23 = £(0) YTD M5 = £(1,012)**	**(402)**	**(1,678)**	**(4,309)**	**(1,737)**	**(3,669)**	**(4,407)**	**(4,407)**	**N/A**	**N/A**
Cash Balance	**2022/23 - M4 = 16,095**	25,951	23,665	20,522	22,052	25,818	22,081	22,052	↑	
CIP - year to date (aggressive cost reduction plans)	**2022/23 target - £(5,744) M5 target £(2,012)k**	Yet to be decided	**(49)**	**(77)**	**(433)**	**(810)**	**(1,225)**	**(1,225)**	**N/A**	**N/A**
Agency spend YTD	**2022/23 = £11,000 YTD M5 = £4,585**	**12,086**	853	**2,168**	**3,454**	**4,555**	**5,756**	**5,756**	**N/A**	**N/A**
Agency % of pay expenditure		**7.3%**	**6.2%**	**7.7%**	**8.2%**	**8.1%**	**8.2%**	**8.2%**	↓	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Jul-22	Aug-22
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)	**43**	0 (0.0)	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**46**	2 (0.2)	**5 (0.5)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)		0	0
	SHMI - Rolling 12 months (May-21 to Apr-22)	**<1.13**	**1.14**	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Jun-21 to May-22)	**100**	**113.9**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**59.5%**	**58.3%**
	RTT Incomplete Pathway Waiting List size	**17,399**	**17,889**	**18,512**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**75.0%**	**61.4%**
	Maximum 6 week wait for diagnostic tests	**99%**	**76.4%**	**68.3%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**69.4%**	**70.9%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,736,806**	**2,389,099**
	Surplus/(deficit) (year to date)	**2022/23 = £(0) YTD M5 = £(1,012)**	**(3,669)**	**(4,407)**
	CIP - year to date (aggressive cost reduction plans)	**2022/23 target - £(5,744) M5 target £(2,012)k**	**(810)**	**(1,225)**
	Agency spend YTD	**2022/23 = £11,000 YTD M5 = £4,585**	**4,555**	**5,756**

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 22nd August 2022

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• Finance and Cost Improvement Plans behind plan. • Increase in cancer referral rates – also impacting Diagnostic Services • Closure to Oral Maxillo-Facial referrals – diverted to UHD • Programme work to improve patient flow demonstrated improvements in Pathway 0 length of stay.
Key issues / matters discussed at the Committee	• Finance Report noting that the Trusts was £2.8m behind plan year to date and that the Cost Improvement Programme was also behind plan. The forecast on an extrapolation basis would indicate circa £8m deficit by year end but the finance team were in the middle of a formal forecast to confirm the position. A system solution to the capital expenditure risk arising from the Car Park was being sought by the region but this was proving to be very challenging. • Finance Sub Group Report noted the deep dive into the Cost Improvement Programme and the plan to focus on agency expenditure at future meetings. • Performance report noting a 31% increase in the number of cancer referrals following changes to guidance to promote earlier detection and treatment and end to COVID restrictions. The committee also noted significant pressures within the Gastroenterology service and the closure of the Oral Maxillo-Facial service to cancer referrals currently. • No Reason to Reside Deep Dive and discussion of the extensive work and review of patient flow - including improvement in both process design and length of stay for Pathway 0 patients • Divisional Exception Reporting noting implementation of Patient Initiated Follow Up appointments and the new theatre schedule due to be implemented to improve usage and efficiency. • The Southern Counties Pathology Programme Outline Business Case was deferred to September. • DCH Subco performance was meeting all indicators with no incidents of complaints. The space constraints on capacity were reiterated
Decisions made by the Committee	• The Patient Pathway Improvement Programme update report was approved including the decision to continue to go at risk on the planning and associated fees in advance of the bid decision so as to prevent a delay in the milestones and patient benefits. • Community Diagnostics Centres Programmes Business Case was supported.
Implications for the Corporate Risk Register or the	• Medical Devices Group Escalation report noted that replacement was confined by finances and the committee noted the need to reassess the risks within the Capital Programme in order to identify a solution.

Board Assurance Framework (BAF)	
Items / issues for referral to other Committees	• Finance Sub Group to review 'Best, Worst and Realistic' forecast scenarios. • People and Culture Committee to review the correlation between substantive, bank and Agency Expenditure and fills rates to ensure that spend reductions were not subsequent to an inability to fill requested shifts.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Wednesday 21st September 2022

Presented by: Stuart parson (Vice Chair)

Significant risks / issues for escalation to Committee / Board for action	• The Season Surge / Winter Pressure Plan is recommended to the Board. • The Southern Counties Pathology Programme Outline Business Case is recommended to the Board. • The Request and Reporting System (ICE) Contract is recommended to the Board.

Key issues / matters discussed at the Committee	The meeting had been re-arranged to accommodate Her Majesty The Queen's funeral and the Agenda was refocussed on business to be transacted. The following were taken as consent items:
	• Finance and Performance Report noted
	  ○ an amber alert regarding coding
	  ○ Challenges on the two week cancer referrals target
	  ○ An increase in the Diagnostic Services backlog
	• Divisional Escalation Reports
	• Board Assurance Framework Bi-Monthly Update
	• Subgroup Escalation Reports – none received.
	• Strategic Estates Master Plan Quarterly update noting the outline business case for the Hew Hospitals Programme had been submitted to the Joint Investment Committee
	• ED15 Bi-Monthly Update.

Decisions made by the Committee	• The Season Surge / Winter Pressure Plan was approved subject to alignment with system plans once these were known. • The Southern Counties Pathology Programme Outline Business Case – approval was given to progress to Full Business Case – noting the need to include benefits for patients and staff. The committ3ee reserved judgement on the final proposal. • The Request and Reporting System (ICE) Contract was approved. The following items were deferred: • Minutes of the meeting held on 22nd August 2022 and the Action Log. • Premises Assurance Model. • EPRR Annual Assurance Report
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• As per the Board Assurance Framework and Corporate Risk Register – items noted on the Board Agenda
Items / issues for referral to other Committees	• None

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 22nd August 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• The Guardian of Safe Working Hours is recommended to the Board • The WRES Data Report is recommended to the Board for approval and publication

Key issues / other matters discussed by the Committee	The committee received, discussed, and noted the following reports:
	• People Performance Report and Dashboard noting
	  ○ A 4% increase in appraisal compliance
	  ○ A reduction in agency expenditure but also fill rates.
	  ○ The potential impact of national pension abatement from November 2022
	  ○ Safeguarding training compliance below 80% and actions to make training more accessible.
	  ○ A review of wellbeing service provision for staff
	  ○ A longer term increasing vacancy and turnover trend.
	• Family and Surgical Services Division Escalation Report noting
	  ○ Increased number of employees retiring
	  ○ Increased nursing agency expenditure
	• Estates and Facilities Escalation Report noting
	  ○ Establishment and structure review underway
	  ○ The Sustainability Manager had resigned
	  ○ Successful recruitment to key catering posts
	  ○ The commencement of a recruitment campaign for Porters.
	• WRES Data noting areas of good performance and areas for improvement.
	• Workforce Health and Wellbeing Bi-annual Report noting a review of the wellbeing offer for staff
	• Education, Training and Development Report noting a request by the Duke of Edinburgh Scheme to run further Introduction to Medicine Schemes following the success of the first.
	• Guardian of Safe Working Quarterly Report.
	• DCH response to the Messenger Review.
	• Escalation Reports from the following subgroups:
	  ○ Medical and Dental Local Negotiating Committee
	  ○ ED&I Steering Group

Decisions made by the Committee	• WRES Report was approved and is recommended to the Board for approval and publication. • The Guardian of Safe Working Hours Report is recommended to the Board
Implications for the Corporate Risk Register or the	•

Board Assurance Framework (BAF)	
Items / issues for referral to other Committees	•

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Thursday 22nd September 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• The Annual WRES Report is recommended to the Board for approval and publication. • The GMC Survey Action Plan is recommended to the Board.
Key issues / other matters discussed by the Committee	The meeting had been re-arranged to accommodate Her Majesty The Queen's funeral and the Agenda was refocussed on business to be transacted. The following were taken as consent items: • People and Performance Report and Dashboard • Board Assurance Framework Bi-Monthly Update • Inclusive Recruitment Update • Talent Management and Appraisal Report • Escalations from Subgroups – Partnership Forum
Decisions made by the Committee	• The Annual WRES Report was approved. • The GMC Survey Action Plan was approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Two red rated risks were noted within the Board Assurance Framework relating to recruitment and retention and talent management. More detailed review to be had at the October meeting.
Items / issues for referral to other Committees	•

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 23rd August 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Update following the recent CQC inspection • Entonox concerns – urgent management in place and escalation if unresolved • The Mortality Report is recommended to the Board. • End of Life Report, positive direction of improvement noting the challenges relating to communication • Clinic letter backlog with concerns regarding potential quality outcome impact – ongoing oversight • New national guidance on patient safety incident management • Ongoing work on transition from child to adult services. • Risk of the ongoing operational flow and care standards risks with increased no criteria to reside patients

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Ongoing service operational pressures and maintenance of Quality metrics. Increased focus on preventing Pressure Ulcers and falls
	  ○ An update on the recent CQC inspections
	  ○ Prior discussions in Finance and Performance Committee of the particular pressures in Gastroenterology and Oral Maxillo-facial services and the ongoing work to review and improve patient flow.
	• Maternity Safety Report noting:
	  ○ Ongoing staffing challenges
	  ○ Works to improve ventilation when Entonox was used had been delayed.
	  ○ 100% compliance with Foetal Monitoring training
	• Learning from Deaths Q1 Report noting the SHMI was within expected range, although coding and staffing issues may impact this position and quality outcomes going forward.
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division
	  ○ Family and Surgical Services Division
	highlighted the need for further Board discussion on recruitment given that significant staffing pressures was a national as well as a local issue across a number of disciplines.
	• Transformation work programme update
	• Patient Safety Strategy Update outlining a new national approach to patient safety incident management to be implemented.
	• End of Life Survey Results positive but noting the need for earlier referral and communication and engagement with patients and families.
	• Transition from Children's to Adult's Services noting and approving the statements of intent.
	• Escalation Reports from

	○ Safeguarding Group ○ Medicines Committee ○ Patient Experience Group
Decisions made by the Committee	• The Learning from Deaths Q1 Report was approved and recommended to Board
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Ongoing significant staffing pressures and operational pressures relating to patient flow
Items / issues for referral to other Committees	• Triangulation with Finance and Performance Committee on Patient Flow and addressing the numbers of patients with No Reason to Reside. • Triangulation with People and Culture Committee on the staffing pressures and recruitment.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 20th September 2022

Presented by: Eiri Jones / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Winter plan to be discussed in October, with a formal paper to follow • Quality Report highlighting positive metrics, particularly regarding patient feedback despite the current pressures • The Trust remains at OPEL 4 and Critical Incident level • Risk of staffing, as highlighted in the Board Assurance Framework. People and Culture Committee asked to undertake a deep dive in this regard.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Overall positive feedback from Friends and Family. Areas of concern are regarding discharge management, communication, and delays in treatment.
	  ○ Mixed sex accommodation remains a challenge
	  ○ Review of C.Difficile cases indicate no lapses in care and that the high rate is a regional and national issue, not specific to the Trust
	• Maternity Safety Report noting:
	  ○ Datix triggers to be reviewed to provide a more accurate picture of risks. Concerns that staff are becoming used to low staffing levels and so are not reporting this as frequently
	  ○ Progress on reducing levels of Entonox on the ward
	  ○ Action being taken to improve training levels amongst Maternity Support Workers
	• Board Assurance Framework Bi-Monthly Update. Comprehensive discussion regarding staffing and how this impacts on all facets of the organisation.
	• Divisional Exception Reports from the two divisions taken as read without Divisional Heads of Nursing and Quality present due to operational pressures, with a focus on the mental health pathways in the system.
	• Pressure Ulcer Deep Dive
	• Escalation Reports – Nil to note

Decisions made by the Committee	• The Nutritional Strategy Implementation Update was deferred to October.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• Further to discussion about the risk of staffing highlighted in the Board Assurance Framework, People and Culture Committee requested to undertake a deep-dive in to recruitment and retention.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 20th September 2022

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The Internal Audit Sub-Contractor Governance Report provided limited assurance in respect to the Trust's process design and effectiveness • The HFMA Financial Sustainability Audit will comprise a review of all elements of the recently published guidance. • Additional requirements of the External Audit (ISA 315) may attract an additional fee. • The Board Assurance Framework is recommended to the Board.

Key issues / other matters discussed by the Committee	The committee received and noted the following reports:
	• Internal Audit
	  ○ Progress Report the HFMA Financial Sustainability audit requirements for self-assessment and action planning and evidencing.
	  ○ Subcontracting Governance Audit Report noting limited assurance in respect to process design and effectiveness
	  ○ 2021/22 Annual Benchmarking Report
	  ○ BDO Global Risk Landscape Report
	• External Audit Update noting further assessment of the ISA 315 requirements within this year's work programme and implications for the Audit Fee and Benchmarking Reports
	• Subgroup Escalation Reports
	  ○ **Information Governance Group** noted further work to understand concerns regarding reduced capacity and increasing demands
	  ○ **Emergency Resilience Planning Group** noting the development of refresher training for on call managers and new members of the Executive Team.

Decisions made by the Committee	• Refresh of the Standing Financial Instructions was deferred to November.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework noting improved presentation of changes and risk history tracking. • Corporate Risk Register noting reductions in the COVID and Paediatric Diabetes staffing risks.
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Remuneration and Terms of Service Committee

Date of Meeting: 14th September 2022

Presented by: Mark Addison, Trust Chair

Significant risks / issues for escalation to Committee / Board for action	• The appointment of Joanne Howarth to the role of Interim Chief Nursing Officer was approved.
Key issues / matters discussed at the Committee	• Appointment of the Interim Chief Nursing Officer
Decisions made by the Committee	• The interview panels recommendation to appoint Joanne Howarth was approved.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• None
Items / issues for referral to other Committees	• None

Meeting Title:	Board of Directors
Date of Meeting:	28 September 2022
Document Title:	**Dorset Integrated Care System Overview**
Responsible Director:	Nick Johnson, Interim Chief Executive
Author:	Laura Symes, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	15/09/2022	Approved

Purpose of the Paper	The purpose of this report is to provide the Board of Directors with an overview of the Dorset Integrated Care System from a performance, quality, and finance perspective.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	**Highlights include:** **Performance:** • The most significant issue affecting a wide range of metrics is system flow. "No Criteria to Reside" remains high including in community hospitals. • ED attendances are now in line with previous 3 years for August 2022. 999 activity has now fallen and is in line with 2019/20 levels. • Ambulance handover delays continue to be a challenge. In July 2022 response times for category 1 calls for Dorset saw a slight increase, with a mean response time of 10.6 minutes, and for category 2 calls saw a slight improvement, with a mean time of 54 minutes. • Significant workforce pressures remain across local Child and Adolescent Mental Health Services (CAMHS) services affecting waiting times. • Inpatient demand for acute adult mental health beds continues to be a pressure. Out of area bed days remain above the zero target and are unlikely to recover in the short-term. • The diagnostics waiting list for July increased slightly from the June position by 473 patients with +197 more patients waiting over 6 weeks. **Quality:** • The number of COVID-19 outbreaks have significantly decreased in care homes and in acute trust providers. • The pattern of safeguarding is changing, reflecting the national picture, in the Bournemouth Christchurch & Poole (BCP) Local Authority area there is a focus on violent crime with close working between the Community Safety Partnerships and both Safeguarding Boards. • There are concerns with delays in access to maternity beds that are co-located with neonatal cots, when in-utero transfer to tertiary centre is necessary. • The final documents and preparation guides to support implementation of the new NHSE Patient Safety Incident Response Framework for responding to patient safety incidents was published on 16 August 2022. This signifies a step change in the approach that will be taken to responding to incidents, ensuring investigations focus on safety in systems and supporting patients and families' involvement in the process.							

	Finance: • As at July 2022, the ICS has reported a variance to the breakeven plan of £10.1m year to date. • Agency expenditure in July 2022 is on the same level as it was in February 2022 at a system level, however both Dorset County Hospital and Dorset Healthcare have seen increases from February. • The system is reporting Cost Improvement Programme (CIP) achievement of £27.1m to date against a target of £34.2m; an underachievement of £7.1m. Of this, £14.8m has been achieved recurrently.
Action recommended	The Trust Board is recommended to: 1. **Note** the information provided.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Title of Meeting	Board of Directors
Date of Meeting	28 September 2022
Report Title	**Dorset Integrated Care System Overview**
Author	Laura Symes, Corporate Business Manager to the Chief Executive
Responsible Executive	Nick Johnson, Interim Chief Executive

1.0 Introduction

The purpose of this report is to provide the Board of Directors with an overview of the Dorset Integrated Care System from a performance, quality, and finance perspective.

The information is taken from meeting papers from the Dorset System Senior Leadership Team meeting held on 22 September 2022.

2.0 Performance

The most significant issue affecting a wide range of metrics is system flow. "No Criteria to Reside" remains high including in community hospitals. This affects hospital occupancy with consequent restrictions on elective recovery. In the most extreme cases this impacts on the ability of services to treat patients in a timely way in Emergency Departments with further consequences in ambulance handover delays.

As at July 2022 ED attendances are now in line with previous 3 years for August 2022. 999 activity has now fallen and is in line with 2019/20 levels. South West Ambulance Service Foundation Trust (SWASFT) have been at their highest alert level (REAP Black) since June 2021, and enacted EOC58 (a standard operating procedure for the clinical safety management of patients) on 18 August 2022 due to pressures in Cornwall and Devon but deescalated the protocol that same day.

Ambulance handover delays continue to be a challenge at University Hospitals Dorset (UHD) and Dorset County Hospital (DCH). In July 2022 response times for category 1 calls for Dorset saw a slight increase in the month end position compared to June 2022, with a mean response time for Dorset of 10.6 minutes against a target of 7 minutes and a 90th Percentile response time of 19.3 minutes against a target of 15 minutes.

Response times for category 2 calls for Dorset in July 2022 saw a slight improvement in the month end position compared to June, with a mean time for Dorset of 54 minutes against a target of 18 minutes and the 90th Percentile response time ending at 121.1 minutes against a target of 40 minutes.

Significant workforce pressures remain across local Child and Adolescent Mental Health Services (CAMHS) services affecting waiting times. Service leads are currently working on a recovery plan to achieve a 4-week access timeframe.

Inpatient demand for acute adult mental health beds continues to be a pressure. Out of area bed days remain above the zero target and are unlikely to recover in the short-term. Key factors related to this include decreased flow associated with an average of 10-15 delayed transfers of care at any one time and lower than required bed capacity. Interim step-down beds options are currently being considered as a means of easing current pressures. Further additional beds form part of the local mental health estates plan due for completion in 2026.

Progress on reducing long waiters continues and now increased focus on the next cohort (> 78 weeks) in September. Service managers are collaborating across the system to develop 78ww delivery plans in key specialties; Maxillofacial (OMF), Ear Noes & Throat (ENT), Gynae, Colorectal and Gastroenterology. A single mutual aid arrangement (in Gynae) has been agreed between the Trusts and will hopefully reduce the Gynae waiting list by 400 patients at risk of waiting longer than 78 weeks.

The diagnostics waiting list for July increased slightly from the June position by 473 patients with +197 more patients waiting over 6 weeks. Dorset is the best performing system in the Southwest with the lowest proportion of patients waiting over 6 weeks. However, areas which remain under significant pressure are Echocardiograms (where additional local and independent sector capacity is being sourced) and Endoscopy.

3.0 Quality

The number of COVID-19 outbreaks have significantly decreased in care homes and in acute trust providers. Workforce absence continues to pose an impact on services across our providers. A system decision took place to remove the requirement to wear masks in non-clinical areas following the risk-based approach.

In Infection Control, a serious incident has been reported in August 2022 by an acute trust provider associated with Clostridiodes difficile infection (CDI). An investigation and root cause analysis is being undertaken both within the acute setting and primary care to identify any underlying problems and/or learning that will allow necessary improvements in patient safety and reduce incidences happening in the future.

In safeguarding, there is no change in the ongoing delays in completing the Initial Health Assessments for Dorset resident children, coming into care which has been escalated to contract leads to performance manage. The pattern of safeguarding is changing, reflecting the national picture, in the Bournemouth Christchurch & Poole (BCP) Local Authority area there is a focus on violent crime with close working between the Community Safety Partnerships and both Safeguarding Boards.

Concerns with delays in access to maternity beds that are co-located with neonatal cots, when in-utero transfer to tertiary centre is necessary, has been discussed at the Local Maternity and Neonatal System (LMNS) meetings. The LMNS is working with the Operational Delivery Network (ODN) to share the guidance to improve access and all cases of births in the wrong place are reviewed with the ODN and learning shared through LMNS Safety group.

The final documents and preparation guides to support implementation of the new NHSE Patient Safety Incident Response Framework for responding to patient safety incidents was published on 16 August 2022. This signifies a step change in the approach that will be taken to responding to incidents, ensuring investigations focus on safety in systems and supporting patients and families' involvement in the process. This is a programme of work that will take place over the next 12 months with transition to the new framework anticipated to be in September 2023. The Wessex Patient Safety Collaborative will be working with NHS Dorset on the project and have agreed monthly task and finish groups with patient safety & risk leads and key stakeholders.

4.0 Finance

As at July 2022, the ICS has reported a variance to the breakeven plan of £10.1m year to date. Agency expenditure in July 2022 is on the same level as it was in February 2022 at a system level, however both Dorset County Hospital and Dorset Healthcare have seen increases from February. More recently, all of the providers with the exception of UHD have seen a decrease in agency expenditure this month compared to last, but at a system level this results in an overall increase in July when compared to June.

The system is reporting Cost Improvement Programme (CIP) achievement of £27.1m to date against a target of £34.2m; an underachievement of £7.1m. Of this, £14.8m has been achieved recurrently. As confirmed in previous reports, there are varying degrees of profiling within the system, with most choosing to profile efficiencies equally across the year therefore it is expected that this position may improve as efficiency schemes begin to deliver.

Meeting Title:	Board of Directors
Date of Meeting:	28 September 2022
Document Title:	**BAF Review**
Responsible Director:	Nick Johnson – Interim Chief Executive Officer
Author:	Philip Davis – Head of Strategy

Confidentiality:	*Yes: Whilst Trust Strategy is a public document – the delivery details underneath would not be considered public domain.*
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EMT	02 Sep 2022	BAF discussed, recommendations: - Risk PL2.1 (Resources to NHP) risk reduced to 10. SEED funding now agreed. - Refinements to Mitigations and Gaps in control to PL1.1 and PL1.2 (CNO) - Refinements to Mitigations and Gaps in Controls for PL1.5 (COO)
Risk and Audit Committee	20 Sep 2022	Noted and Approved.

Purpose of the Paper	*Monitor risks to delivery of the Trust Strategy (and achieving the benefits therein) - Approved by Board Dec-21. The BAF is in its 5th round of 2 monthly review.*							
	Note	✓	*Discuss*	✓	*Recommend*		*Approve*	
Summary of Key Issues	*There are 5 risks scored >20 (Almost certain and Major consequence): Mitigations in place have yet to drive reduction in risk score for any of these.* *PE1.2 Failing to attract & retain staff, increased pressure on existing teams CPO. People & Culture Committee.* *PL1.1 Failing to attract & retain staff, will not meet required Care Standards CNO. Quality Committee.* *PL1.3 Failing to meet Performance Standards, not providing High Quality Care COO, Finance & Performance Committee.* *PL1.5 Emerg Pathways not meeting demand, not providing High Quality Care COO, Finance & Performance Committee (Perf), Quality Committee (Harm)* *PA 2.1 Failing to deliver financial breakeven, risk to fiscal sustainability CFO, Finance & Performance Committee.* *Risk PL2.1 score reduced to 10 from 15, Seed funding has now been received so NHP significantly de-risking the program.*							

Action recommended	The Board is recommended to: 1. **NOTE** the changes this month, made in Red within the BAF, which update on mitigations and progress towards delivering lower risk towards targets. 2. **APPROVE** the final BAF

Governance and Compliance Obligations

Legal / Regulatory	Y/N	*N*
Financial	Y/N	*N*
Impacts Strategic Objectives?	Y/N	*Y*
Risk?	Y/N	*Y*
Decision to be made?	Y/N	*Y - Delivery of Trust Strategy is critical to securing a sustainable future for the Trust*
Impacts CQC Standards?	Y/N	*Y - Clinical Plan is closely focused on improving Patient Outcomes & Patient Experience, and People Plan strongly focused on staff wellbeing*
Impacts Social Value ambitions?	Y/N	*Y - Social Value Action plan sits within Sustainability & Efficiency Workstream, underlying the Trust Strategy.*
Equality Impact Assessment?	Y/N	*N*
Quality Impact Assessment?	Y/N	*N*

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE **Sep-22**

Summary Narrative

In total, the Board Assurance Framework includes 35 risks, a number of which have remained in the high risk category with scores of over 20. These have been summarised below.

People
Whilst work continues at a system and Trust level to plan and consider new ways of working, a national workforce shortage still exists, therefore the risk of more pressure on teams as a result of failing to attract and recruit the right people with the right skills continues to score 20 (Risk PE 1.2)

Place
As above, the workforce pressures mean that if there is a continuous inability to recruit or retain sufficiently skilled clinical staff to meet the demand of patients then will not be able to meet care standards required so will not meet the strategic ambitions on quality, personalised care and financial objectives. This risk continues to score 20 (PL 1.1)

A risk regarding our national performance standards for long waiting times was raised to a score of 20 in December 2021 (risk ref PL 1.3). The recently published national Elective Recovery Plan sets out a three year plan towards achievement of the NHS Constitutional Standards, when full details are available a structured plan can be developed.

There is a further risk that if our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly, the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population. This risk, PL 1.5, has been scored at 20.

Partnership
Whilst current financial performance is delivering according to the plan, the future outlook is predicting a significant deficit for the Trust. Risk PA2.1 is therefore scored at a risk of 20.

Risk Heatmap

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10 PL2.1	15 PL2.1	20 PE1.2	25
4	Major	4	8 PA1.1, PA3.1, PA3.2	12 PE2.1, PE3.3, PA2.2	16 PE1.1, PL1.2, PL1.10, PL1.11, PL 2.2	20 PL1.1, PL1.5, PL1.3 PA2.1
3	Moderate	3 PL3.1	6 PE3.4, PL1.4, PA1.3, PA2.3	9 PA1.2, PA4.1, PL2.3	12 PA3.3, PL1.6, PL3.2, PL 3.3, PL4.1, PL4.2, PA1.4	15 PE3.2
2	Minor	2 PL1.9	4	6	8	10
1	Negligible	1	2	3 PL3.1	4	5

Key

Letters:	
PE	PEOPLE
PL	PLACE
PA	PARTNERSHIP
Numbers (example):	
1.1	Objective 1 , Risk 1
1.2	Objective 1, Risk 2
2.1	Objective 2, Risk 1

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# People Risks: 7
People Objective 1														
We will look after and invest in staff, developing our workforce, creating collaborative and multidisciplinary teams to support outstanding care and equity of outcomes														
PE 1.1	PCC QC FPC	CPO	Deputy CPO	**Risk description:** If we fail to create environments that support staff wellbeing then our ability to resource service recovery and ongoing delivery safe care are at risk	4	4	16	• People strategy • People performance dashboard • People Committee reports • People recovery steering group • Targeted wellbeing support • Wellbeing offer • System & national wellbeing offers	• People strategy (development) • People Dashboard - PCC • PCC reports • FPC reports • Divisional performance reviews • Quarterly people pulse survey • National staff survey • FTSUG reports • Staff listening exercises • Exit interviews	Good	Good	12	Jun -22 All mitigations in place.	
								Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working Impact of pent up demand on the front door and pressures within system impacting workforce stress & anxiety - working across ICS						
PE 1.2	PCC	CPO	CPO	**Risk description:** If we fail to attract and retain the right people with the right skills then more pressure on existing teams	5	4	20	• People strategy development • Implementation of workforce business partner model • System attraction strategy • Resourcing function business case • Career pathways • CESR academy proposition • Locally employed doctor appraisal and development • Pilot site for national stay and thrive initiative & international nurse experience deep dive • OD team • Development of flexible & temporary staffing function • Inclusive leadership programme • Transforming people practices programme • Values based recruitment -HCA workforce	• People strategy (development) • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitment control panel • System workforce plan	Good	Good	15	Jun -22 All mitigations in place.	
								Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working						
People Objective 2														
We will create an environment where everyone feels they belong, they matter and their voice is heard														
PE 2.1	PCC	CPO	Head of OD	**Risk description:** If we fail to create a culture and environment where ALL stay feel valued, heard and that they belong then attraction, availability and retention will be compromised	4	3	12	• People strategy • EDI roadmap – culture transformation programme (inclusive leadership development, transforming people practices work streams) • Staff networks x 5 • FTSUG and champions • People performance dashboard as cultural barometer • Exit interviews	• People performance Dashboard - PCC • PCC workplan • PCC deep dives • Divisional performance reviews • EDI steering group • Exec sponsors for staff networks • Quarterly pulse survey • National staff survey • Junior dr survey	Good	Good	8	Jun -22 All mitigations in place.	
								Gaps in Control and Actions:						
People Objective 3														
We will improve safety and quality of care by creating a culture of openness, innovation and learning														
PE 3.1	People & Culture Committee and Quality Committee	CPO/CNO/CMO	CPO/CNO	**Risk description:** If People not feel safe to speak out about safety and care quality then the safety culture is effected and there can be increase in safety risks and harm, with a reduction in teamwork and quality improvement. In addition issues will not be addressed and patients and staff are at risk of harm.	4	2	8	• Trust strategy • Trust values • People strategy • Implementation of just & learning culture principles • Raising concerns policy • Whistleblowing policy • Trust induction • Leadership & management development • FTSUG and champions • Safety walkabouts - Target date: in place (Complete) and ongoing feeding into respective sub-board or group • Ward accreditation framework - Target score: implemented process/ complete first round by April 2023 • Incident reporting -Target score: in pace and reports to Quality Committee and in turn to Board	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whistleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix	Good	Good	4	Jun -22 All mitigations in place.	
								Gaps in Control and Actions:						
PE 3.2	QC	CEO	Deputy Director of Strategy	**Risk description:** If operational pressures continue then there will be less time for teams and staff to innovate and so the will and capacity for innovation will be stifled.	3	5	15	• Quality Improvement and Innovation Programme overall supports importance and value of innovation and learning and provides resource support • QSIR Training protected and supported by division • Transformation and Improvement team providing support • Research and Innovation strategy and plan • Engagement in Academic Health Science Network • Divisional Performance Meetings with focus on innovation	• S&T SLG reporting on QI programme and progress • Research and Innovation Governance • Divisional Performance Meetings	Good	Good	6		
								Gaps in Control and Actions:						

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# People Risks: 7
PE 3.3	PCC	CPO	Head of Education	**Risk description:** If operational pressures reduces capacity for learning then there could be a detrimental impact on placement experience, our ability to attract students, patient safety may be compromised and staff engagement may suffer	4	3	12	• People strategy • Appraisal policy • Medical appraisal • Study leave policy • Mandatory training KPI's • Practice education team • PCC reporting • Quality committee reporting • PCC and QC risk sharing & triangulation	• Mandatory training KPI's • Appraisal KPI's • Monthly performance review • PCC reports • QC reports • Medical and nursing revalidation • System education workstreams	Good	Good	8	Jun -22 All mitigations in place.	
								Gaps in Control and Actions: Demand and capacity challenges - close monitoring and escalation						
PE 3.4	QC	CMO	CMO	**Risk description:** If DCH is not actively encouraging and pursuing research aims in line with the strategy then it will be a less attractive place for staff to work and research income will reduce. So DCH needs to actively encourage and facilitate staff to take part in existing projects and develop new ones.	3	2	6	• Strong clinical research and innovation programme. • Research Strategy in place for 2019-22 with plans to review in 2022. • Research team established within Urgent & Integrated Care Division	• Reports to Quality Committee through the Urgent and Integrated Care division - with annual reporting to Board.	Good	Good	6	Oct-22	
								Gaps in Control and Actions:						

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
Place Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual														
PL 1.1	QC (triangulation with PCC)	CNO	CPO - Recruitment and retention and People Strategy	Risk description: If there is a continuing inability to reliably recruit or retain sufficiently skilled clinical staff to meet patient demand, then we will not be able to meet required care standards, so will not meet the strategic ambitions on quality, personalised care and financial objectives.	4	5	20	See People objective • Recruitment and retention policies and work streams • International recruitment • Wellbeing support • Maximise use of opportunities through Health Education England and NHSE/I funding streams • Maximise where able apprenticeships • Workforce planning and innovation with redesign of roles to enable clinicians to practice at the top of their licence • Increased opportunities for supported training places • Stay and thrive programme to aid retention Controls non-HR/OD: • Protocols and policies for clinical care • Quality improvement work to streamline care or improve effective patient care • Compliance with national standards to support patient care • Engagement with service users to assist in re-design effective and efficient care to maximise workforce efficiencies • Sub-board oversight of standards delivery and interventions as part of strategic objectives	• Sub board reports: PCC; QC & RAC • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT/Networks • Corporate risk register actions and tolerated/managed risk	Good	Good	12	2024	
								Gaps in Control and Actions: - International shortage of certain clinical professions. Action: part of the stay and thrive programme to improve experience and support of international recruits; workforce planning to grow talent and career pathways into health - Uncertainty over Health Education England funding that impacts upon training, education and funding support for pipeline roles. Action: Close liaison with HEE South West and regional workforce/ people supply work streams - Increase in covid pandemic wave impacting on staffing resource, epidemiology shows a wave with a slight plateau at present. Ongoing waves likely for foreseeable year - Financial pressures hinder options to cover backfill costs of NHSE/HEE opportunities to support workforce bids - Accommodation locally due to the property markets and large numbers of second homes hinder affordable housing options, which impacts upon staff attraction and retention - Cost of living impact on professional roles impacting upon attraction and retention in nursing, AHPs and midwifery - National increase in attribution of students undertaking nursing degree, with a higher issue in the South West of England					
PL 1.2	QC	CNO	CNO - quality and safety CMO - Clinical Strategy and GIRFT CFO - Estates Strategy	**Risk description:** If the population demand is over the ability to create and deliver capacity that meets the constitutional standards and quality standards outline under the CQC regulatory framework then the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.	4	4	16	• Capacity planning • Commissioning of capacity • Clinical pathways design and system working for sustained capacity • Estates strategy • Workforce planning including job planning • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives • ICS governance framework • Clinical networks to support pathway design and resources based on population need	• Sub-board committee FPC, QC & PC • Estates master plan and associated business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSE/I) • Benchmarking data: clinical networks; GIRFT	Good	Strong	8	2025	
								Gaps in Control and Actions: - Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and collaboration workstreams - Mental health capacity to meet growing demand is impacting on potential delivery of longer term care in the right place and therefore clinical outcomes. Escalated to partners and working with partners.						
PL1.3	FPC	COO	Associate Director of Performance	**Risk description:** If we continue to not achieve the national performance standards due to long waiting times then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.	4	5	20	• April 22 - Planning Guidance submissions agreed. Guidance acknowledges this is a multi-year improvement plan. Key steps are outlined in the plan for this coming year. DCH has agreed trajectories for achievement which will be tracked through EPMG and reported up through both Divisional governance and EPMG to FPC/Quality cttees. Target date: completed and reporting through to FPC/Board as planned • Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement. Target date: 6 specialties enrolled in CWT System work (complete), 6 specialties enrolled for System 78wk focus (completed), Theatre program established • Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - triggers for intervention/support. Target date: completed and reporting through SLG/FPC • Provider assurance framework/Finance and Performance Committee -	• Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee • Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board)	Good	Good	12	All monitoring in place. monthly targets to be reviewed at FPC	
								Gaps in Control and Actions: National Elective Recovery Plan sets out a 3 year plan towards achievement of NHS Constitutional Standards. Trajectories agreed for achievement of in year milestones and will be reported via FPC both in the Performance/EPMG report and the						
PL 1.4	FPC	COO	Head of EPRR	**Risk Description:** If we don't have Emergency Preparedness and Resilience Plans then we will not have a defined programme to manage safe services and the triggers for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met.	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE	• Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	Good	6	is at target	
								Gaps in Control and Actions:						

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
PL 1.5	FPC - performance QC - Harm related concerns	COO	COO	**Risk description:** If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	4	5	20	• UEC Assurance Framework • Performance Framework reporting - triggers for intervention/support. Target date: framework in place and enacted • Redesign through ED15 to increase estate and flow within current dept including commitment to increased workforce. Target date November 2022 dept alterations completion date • Increase to 7 day SDEC offer across medicine and surgical specialties. Target date - 7 day service completed. Surgical element November 2022. • Clinical and People Strategies addressing emergency flow. Target date: strategies established withindividual delivery timeframes - most significant is Em Zone - delivery phased from 23//24. Home First Board work streams. Target date: winter 23/24 for first iteration of delivery • Internal Home First work streams - 7 day discharge services, strengthened front door multi-agency response, PAT. Target date: Key frameworks in place and completed - Patient Flow Program supporting wards to utilise available resources - Target date: Winter Plan- December 22 - March 23	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting Home First Board and workstream documentation Home First (DCH) documentation Divisional reporting via Performance Meetings, FPC, Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	Good	12	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
								Gaps in Control and Actions: Home First Board launching new governance and approach in Autumn 2022. Program behind plan as full integrated service anticipated prior to winter 22/23. Internal flow cell in place and a refresh of the Patient Flow Program underway - mapped to the interim arrangements. Focus on Pathway 0 patients and font door (ED/Ilchester) multi-agency response to prevent admission - August 2022 reduction in Pathway 0 LoS noted						
PL 1.6	FPC - performance QC - Harm related concerns	COO	COO	**Risk description:** If we fail to work with our partners on effective criteria to admit, criteria to reside, and discharge pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	3	4	12	• Home First Board membership • Urgent and Emergency Care Board - COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity. Target date: SDEC and Discharge 7 day services completed. Increased Hospital at Home - November 2022 • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. Completion date: via Patient Flow Program Winter 2022 • VSCE support front door and discharge response. Pilot in place (completed) Clinical and People Strategies for front door response. Target date:	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	Requires Improvement	9	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
								Gaps in Control and Actions: System actions currently in development, low level of confidence actions will meet needs**. Please see action detailed above.**						
PL 1.9	FPC	COO	COO	**Risk description:** If we do not provide as a minimum 35% of our outpatient activity away from the DCH site then we will not be delivering and designing care in a way which matters to patients or building on sustainable infrastructure and digital solutions to better meet the needs of our population.	2	1	2	• Outpatient Improvements (within Elective Care Board Programme). Target date: Improvement Program established. PAS patch implemented in June 22. Full roll out of virtual offer by March 23	• Reports to SLG and through to Board via Strategy updates	Good	Good	2	Internal transformation plan full delivery by March 23	
								Gaps in Control and Actions:						
PL 1.10	QC?	CMO	CMO	**Risk description:** If the Trust's SHMI is out of range then it will suggest excess deaths are occurring regardless of the actual cause. So this will cause reputational damage and invite inspections by regulators, which are not necessary if coding is the underlying correctable cause.	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to FPC • The CMO receives a monthly update of number of uncoded SPELLS	• Regular reports to Hospital Mortality group, Quality Committee and Board.	Requires Improvement	Good	8	Ongoing	
								Gaps in Control and Actions:						
PL 1.11	RAC	CIO	CIO	**Risk description:** If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through KPI's such as the Summary Hospital-level Mortality Index.	4	4	16	The coding department is attempting to recruit a new full-time manager (2 yr FTC now under consideration) and to fill all existing vacancies. The current coding backlog is expected to be recovered before the annual data submission deadline of 19/5/22.	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	6	?	
								Gaps in Control and Actions:						
Place Objective 2: We will build sustainable infrastructure to meet the changing needs of the population														
PL 2.1	FPC	CFO	Strategic Estates Project Director	**Risk description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver	5	2	10	• Full Programme Structure in place with dedicated team • NHP Project Board, Clinical Assurance Group, • Finance and Performance Committee into Trust Board - Lobbying of NHSEI/NHP team re. seed-funding at all levels - SEED funding for 2022/23 now agreed	• NHSEI SOC Approval; - NHSEI NHP Deep Dive re. OBC, OBC submitted June 2022	Good	Good	10	Completion of FBC - circa 31/12/2022	
								Gaps in Control and Actions: - Regular reporting to FPC						
PL 2.2	FPC	CFO	Deputy Director of Finance	**Risk description:** If we do not embed appropriate business case approval processes then plans will not be sustainable so we will not be able to meet the needs of patients and populations	4	4	16	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets	• Working Group papers • External approval of business cases e.g. NHP	Requires Improvement	Requires Improvement	10	31/03/2023	
								Gaps in Control and Actions: - Lack of adherence to and application of agreed processes - Lack of knowledge of agreed processes - No review/check of business cases against required templates						
PL 2.3	FPC	CFO	CFO	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	Ongoing	
								Gaps in Control and Actions:						

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk	Mitigations - Target Date	# Place Risks: 17
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients														
PL 3.1	FPC	CIO	CIO	**Risk description:** If we do not achieve a Dorset wide integrated electronic shared care record then we run the risk of not making the right information available to care professionals, so we will not be able to make sure the right information is available to the right person in the right place at the right time about the right patient increasing the likelihood of patient harm	1	3	3	Dorset Care Record project lead is the Director of Informatics at UHD. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director **Gaps in Control and Actions:**	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	Good	3	Achieved - currently at Target Risk	
PL 3.2	FPC/QC/RAC	CIO	CIO	**Risk description:** If we do not have adequate cyber security defences to protect the Trust's digital assets then we increase the likelihood of impact from a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits **Gaps in Control and Actions:**	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT • SIRO, Deputy SIRO, Information Security Manager, Data Protection Officer - all posts filled	Good	Good	9	Ongoing task, no fixed delivery date	
PL 3.3	QC/RAC	CIO	CIO	**Risk description:** If Trust staff are not trained sufficiently to minimise targeted and social engineering threat attempts then we increase the likelihood of the impact of a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Part of DSPT annual assurance, digital training team providing training for all new starters and annual refresh training . Regular phishing campaigns. **Gaps in Control and Actions:**	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT	Good	Good	9	Ongoing task, no fixed date	
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services														
PL 4.1	Quality Committee	CNO	Alison Male Patient Engagement Jo Hartley: Maternity voices partners	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use then.	3	4	12	• Your Voice group of service users- Target date: complete process in place and ongoing (reports to PEG and then QC) • Maternity Voices Partners as part of the Local Maternity & Neonatal System - Target date: in place and ongoing (Reports to QC and ICS SQG) • Communication and Engagement lead for estate development to support further engagement with local population: target date: in place and ongoing (reports via project Board) • Learning Disability Advisor linked activity with independent groups of service users- Target date: in place and ongoing (reports to QC) • Engagement roadmap with leadership from Head of patient Experience and Engagement: Target date: in place and ongoing reports to PEFG and QC • Networked links with external engagement partnerships such as Healthwatch Dorset, CCG/ICS team, Dorset Council: Target date in place and ongoing, feeds into QC • Council of Governors links into community coordinated by Trust Secretary • Quality Improvement methodology includes service user engagement: Target date: In place • Public Health networks into key work streams for population health and wellbeing (such as smoking cessation) • Health Inequalities group and networked activity across ICS to support engagement with diverse population • Communication teamwork across the ICS - ICS strategy work to commence +engagement of population May-Jun **Gaps in Control and Actions:** - Capacity of internal team to expand co-design and engagement is limited, even with working collaboratively with others in the system through networks. Action: Continue to maximise other resources and support where able and focus upon priorities to mitigate.	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Diis Data and Public Health reports • Health Inequalities data	Good	Good	4	Apr-24	
PL 4.2	QC	CNO & CMO	CIO - digital and BI Alison Male Patient feedback CMO - AHSN CEO/Director of Strategy - ICS	**Risk description:** If we fail to utilise population health data in a meaningful way to inform service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing	3	4	12	• DiiS dataset • Partnership in ICS with Public health and Local authority at PLACE level • Primary care Networks • Digital data sources with shared records • Business intelligence resources across the system • ICS Health inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance **Gaps in Control and Actions:** - Gap in analytics of data capacity to support clinical leads: ACTION: part of the One Dorset approach to digital and business intelligence resources aligned to the ICS digital strategy development	• HI group reports and actions • Benchmarking data • Patient feedback • Partners feedback • Data • National published reports or network reports • ICS Clinical reference group notes • National audits on outcomes	Good	Good	4	Apr-24	

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# Partnership risks: 12
Partnership Objective 1: We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population														
PA 1.1	Board	CEO	CEO/Director of Strategy	**Risk description:** If the Trust decision-making processes do not take due account of system elements then the Trust will not be able to engage proactively within the system so the impact of the Trust on the system will be diminished	4	2	8	• SLG and Corporate Governance includes system updates and information • Membership of Provider Collaboratives and system other forums • Board feedback and monitoring of system engagement	• SLG Meetings • Board and Committees • System Oversight Framework	Good	Good	8		
								Gaps in Control and Actions:						
PA 1.2		CIO	CIO	**Risk description:** If the Trust does not embed population health data within decision-making which highlights health inequalities then the Trust will not know if it is delivering services which meet the needs of its populations	3	3	9	• Dorset Insight and Intelligence Service (DIIS) accessible and available to Trust • DIIS/BI dashboards on key trust metrics provided	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	Requires Improvement	6	Mar-23	
								Gaps in Control and Actions: Funding being sourced for a Data Scientist to join the DiiS Team Funding being sourced to continue to provide the System PHM team which will benefit efforts at DCH Trust BI team to make more use of inequality data and wider determinants data available in the DiiS in DCH toolsets The resolution requires more staff/more experience , this is pending outcome of planning round, and subsequent recruitment &/or training following						
PA 1.3		CMO	CMO	**Risk description:** If robust departmental, care group and divisional triumvirate leadership does not facilitate genuine MDT working, then services will be less effective, so that poor patient outcomes are more likely	3	2	6	• Divisions supported by the Strategy and Partnerships Team (Estates/place based portfolio). • Development of the clinical strategy	• Reporting through SLG	Good	Good	6	Jul-22	
								Gaps in Control and Actions: Many Clinical Leads have never had leadership/management training. ACTION: Appropriate training to commence September 2022 - Julie Doherty.						
PA 1.4		CMO	CMO	**Risk description:** Recovery of waiting lists plus increasing workload within the hospital may impair our ability to contribute effectively to the objectives of the ICS	3	4	12	• Development of the Clinical and People Strategies, recognising the need for integrated working • Trust Board oversight and assurance of ICS Involvement in Elective Recovery Oversight Group with clinical leads present in key workstreams - MSK, Eyes, Endoscopy, ENT - opportunities noted and acted upon to share resource, space, ideas to maximise recovery as a system	• Monitoring and oversight of Trust Strategy and enabling strategies, reporting to Trust Board evidenced through papers and minutes - ECOG and associated workstream documentation	Requires Improvement/ Good	Good	6	Sep-22	
								Gaps in Control and Actions GAP: Waiting list recovery is hampered by NCTR patients. ACTION: Joint working with DHC and Dorset Council to improve patient flow.						
Partnership Objective 2: We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways														
PA 2.1	FPC	CFO	CFO	**Risk description**: If the Trust fails to deliver sustained financial breakeven and to be self sufficient in cash terms then it could be placed into special measures by the regulator and need to borrow externally to ensure it does not run out of cash	4	5	20	• ICS Financial framework and Financial Strategy. • Current operating plan delivers a breakeven and does not require external financing, but are heavily reliant on non recurrent funding and 2.5% CIP.	• ICS Financial framework and Financial Strategy • Reporting to Board, FPC and BVBCB.	Good	Requires Improvement	12	31/03/2023	
								Gaps in Control and Actions: System summit progressing some transformational recovery actions and financial recovery support has been commissioned working across the system to develop a plan to get back into balance.						
PA 2.2	FPC	CFO	CFO	**Risk description**: If the Trust fails to deliver sufficient Cost improvements and continues to be efficient in national financial benchmarking then there will be increased focus from the regulator and a detrimental impact on reputation as well as highlighting financial sustainability concerns.	4	3	12	• Track record, PMO facilitating ideas for savings etc and increasing dedicated workforce resource. • BVBCB, FPC and Board monitoring CIP plans and delivery	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	Good	9	31/03/2023	
								Gaps in Control and Actions: CIP programme for 22/23 not fully identified						
PA 2.3	QC	CEO	CEO	**Risk description:** If the Trust does not engage with commercial and VCSE sector partners then cost effective solutions to complex challenges will be restricted and so the Trust will be limited in the impact it is able to have	3	2	6	• Commercial and Partnerships Strategy and Plan • VCSE engagement via patient and public engagement and charity teams. • SLG reporting	• Commercial strategy delivery reporting • Your Voice Engagement Group • Social Value strategy oversight	Good	Requires Improvement	6		
								Gaps in Control and Actions:						
Partnership Objective 3: We will increase the capacity and resilience of our services by working with our provider collaboratives and networks and developing centres of excellence We will work together to reduce unwarranted clinical variation across Dorset														
PA 3.1	FPC	COO	COO	**Risk description:** If the Trust does not optimally collaborate with provider partners through the ICS Provider Collaboratives and other existing clinical networks then sustainable solutions via collaboration will not be explored or adopted and so v/m, sustainability and variation of services for patients will not decrease sufficiently	4	2	8	• Engagement in current 'provider collaboratives' e.g. Elective Care Oversight, Home First etc, UECB, DCP. Target date: completed • Commitment to be engaged fully in ICS 'Provider Collaborative' - Target date: December 22 for effective delivery South Walks initiative with system partners including Local Authority and community provider. Target date: initial phase completed. Second phase dependent on funding stream - 23/24 completion date if funded	• Reporting to Trust Board and FPC • System documentation for Home First, Urgent and Emergency Care Board, Elective Care Oversight Group including Deep Dives and SRO roles, work-stream specific documentation	Good	Good	8	Provider collaborative effectively working Dec 22 South walks - phased throughout 23/24	
								Gaps in Control and Actions: ICS The Provider Collaborative has now formed but is in the process of determining its agenda for 22/23.						

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	Mitigations - Target Date	# Partnership risks: 12
PA 3.2	FPC	CEO	CMO	**Risk description:** If the Trust does not initially support the appropriate delegation of authority to the Provider Collaborative and then does not adequately acknowledge and accept the delegation then effective functioning of the Provider Collaborative will not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented	4	2	8	• Engagement of Trust Board in ICS discussions and planning • Trust Board review and approval of any delegation. The Trust has a legal obligation to collaborate outlined in the amended provider licence	• Trust Board papers	Good	Good	8		
								Gaps in Control and Actions:						
PA 3.3	QC	CMO	CMO	**Risk description:** If the Trust does not invest and support key services identified as 'centres of excellence' by the clinical strategy then investment into key services integral to the future sustainability of the Trust will not be forthcoming	3	4	12	• The Clinical Strategy will set out the areas for investment and prioritisation. • Investment through business planning will be aligned to clinical strategy to ensure investment in key areas which are integral to the future sustainability if the Trust • Review of investment and impact via divisional performance framework and sub-committee structure.	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	Good	8	?	
								Gaps in Control and Actions GAP: Centres of Excellence need to be identified across all Dorset Trusts and developed jointly. ACTION: Joint working within the ICS will support development.						
Partnership Objective 4 Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities														
PA 4.1	FPC	CEO	Head of Social Value	**Risk description:** If the Trust does not recognise the impact of it's decisions on the wider economic social and environmental well-being of our local communities then our impact will not be as positive as it could be and so the health our populations will be affected	3	3	9	• Social Value Programme. • Social Value Impact Assessments against decision • Reporting of social value programme progress and impact against social value plan to SLG and Trust Board.	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	Good	6		
								Gaps in Control and Actions:						

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

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

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

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

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

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

Identifying Risks

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

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

Scoring & Grading

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

Consequence score (C)

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

DOMAIN C1: SAFETY, QUALITY & WELFARE

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

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

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

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

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

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required inadequateperformance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING					
	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

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

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

Risks	RAC Dates: Nov-21	11-Jan-22	15-Mar-22	10-May-22	12-Jul-22	20-Sep-22	Trend
PE 1.1	16	16	16	16	16	16	Unchanged
PE 1.2	20	20	20	20	20	20	Unchanged
PE2.1	12	12	12	12	12	12	Unchanged
PE 3.1	8	8	8	8	8	8	Unchanged
PE 3.2	12	12	15	15	15	15	Worsening
PE 3.3	12	12	12	12	12	12	Unchanged
PE 3.4	6	6	6	6	6	6	Unchanged
PL 1.1	20	20	20	20	20	20	Unchanged
PL 1.2	16	16	16	16	16	16	Unchanged
PL1.3	16	20	20	20	20	20	Unchanged
PL 1.4	6	6	6	6	6	6	Unchanged
PL 1.5	20	20	20	20	20	20	Unchanged
PL 1.6	12	12	12	12	12	12	Unchanged
PL1.7	12						Unchanged
PL1.8	16						Unchanged
PL 1.9	2	2	2	2	2	2	Unchanged
PL 1.10	16	16	16	16	16	16	Unchanged
PL 1.11			16	16	16	16	Worsening
PL 2.1	15	20	15	15	15	10	Improving
PL 2.2	16	16	20	16	16	16	Unchanged
PL 2.3	9	9	9	9	9	9	Unchanged
PL 3.1	6	9	3	3	3	3	Improving
PL 3.2		12	12	12	12	12	Unchanged
PL 3.3		12	12	12	12	12	Unchanged
PL 4.1	12	12	12	12	12	12	Unchanged
PL 4.2	12	12	12	12	12	12	Unchanged
PA 1.1	8	8	8	8	8	8	Unchanged
PA 1.2	9	9	9	9	9	9	Unchanged
PA 1.3	6	6	6	6	6	6	Unchanged
PA 1.4	12	12	12	12	12	12	Unchanged
PA 2.1	20	20	20	16	16	20	Unchanged
PA 2.2	12	12	12	12	12	12	Unchanged
PA 2.3	6	6	6	6	6	6	Unchanged
PA 3.1	8	8	8	8	8	8	Unchanged
PA 3.2	8	8	8	8	8	8	Unchanged
PA 3.3	16	16	16	12	12	12	Improving
PA 4.1	9	9	9	9	9	9	Unchanged

1. Report Details			
Meeting Title:	Audit and Risk Committee		
Date of Meeting:	20 September 2022		
Document Title:	Corporate Risk Register		
Responsible Director:	Nicky Lucey Chief Nursing Officer	Date of Executive Approval	*15 9 22*
Author:	Mandy Ford, Head of Risk Management and Quality Assurance		
Confidentiality:	*n/a*		
Publishable under FOI?	*No*		
Predetermined Report Format?	*No*		

2. 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,

3. Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level operational risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that corporate risks are effectively being managed and that controls are in place to monitor these. 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 (✓)*	✓
4. 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. All risks have been aligned with the revised Board Assurance Framework.							
5. 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							

6. Governance and Compliance Obligations				
Legal / Regulatory Link		**Yes**		*Duty to ensure identified risks are managed*
Impact on CQC Standards		**Yes**		*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.*
Risk Link		**Yes**		*Links and mitigations to the Board Assurance Framework are detailed in the individual risk entries.*
Impact on Social Value		**Yes**		*This will impact on the Trust's ability to provide high quality safe services and the recruitment and retention of staff.*
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?**		
Strategic Objectives	People Place Partnership	All corporate risk register items are individually linked to the BAF. This is detailed in the appendices		

Dorset Integrated Care System (ICS) Objectives	**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		
Improving population health and healthcare	**Yes**		Effective management and mitigation of the Trusts' operational and strategic risks will support delivery of the ICS objectives.
Tackling unequal outcomes and access	**Yes**		
Enhancing productivity and value for money	**Yes**		
Helping the NHS to support broader social and economic development	**Yes**		
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)	**Yes**	**No**	n/a
Quality Impact Assessment (QIA)	**Yes**	**No**	n/a

Audit and Risk Committee
Corporate Risk Register as at 20.09.2022

Executive Summary
The Committee will note that the highest risks are associated with the impact of delayed patient treatment 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 July 2022 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 09.09.2022 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 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)

2. Top Themes:

2.1 **Covid 19**

- 919 – Covid 19 (Moderate 12 (down from 20))

4.1.1 As discussed at the previous Committee in July, the Trust was looking to reduce the risk score for this risk as the National alert level had been lowered. This has now been actioned.

4.1.2 Clearly the number of positive cases remain variable throughout the hospital as does staff absence. However, the number of patient requiring ITU intervention are low, and the IPC review guidance has changed

4.1.3 In order to mitigate the risk to the staff, the Trust continues to provide all staff with the recommended PPE types with a rational for use:

- Filtering face piece class 3 (FFP3) respirators
- Fluid resistant surgical masks
- Eye and face protection
- Disposable aprons and gowns
- Disposable gloves

- Outpatients and visitors required to wear masks in cliniocal areas, unless they are exempt. (Masks continue to be provided by the Trust at all entrances, and visitors to wards are provided with the necessary PPE and visits are pre-booked.)
- FFP3 lead appointed and will be supported by the Health, Safety and Security manager and staff from the Divisions.
- Action cards revised

4.2 1221 - Tackling the backlog of elective care (Extreme (20))

4.2.1 The guidance within the delivery plan for tackling the Covid-19 Delivery plan for tackling backlog of elective care with focus on four areas of delivery published 08.02.2022:

- Increasing health service capacity
- Prioritising diagnosis and treatment
- Transforming the way we provide elective care
- Providing better information and support to patient.

4.2.2 The access team are continuing to keep contact with patients on the waiting list. Patients are being called in clinical priority with consultants having oversight of the lists. The Board will receive performance reports in terms of progress against trajectories.

4.2.3 DCH will achieve zero 104-week waiters at the end of September and maintain this position.

4.2.4 However, there has been a 29% increase in Cancer referrals which is putting pressure on waits to first seen appointments and is leading to growth in the waiting list. DCH is closed to cancer referrals in the two most at risk areas – Maxillo-Facial and Gastroenterology. We are working with colleagues at UHD on reducing waiting times.

4.2.5 This risk has been scored 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 there is an increase in litigation if patient harm has been caused due to delays caused by Covid 19.

4.2.6 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.

4.3 Mortality

- 641 – Clinical coding (High 15) (update as at 13.09.2022)
- 464 – Mortality Indicator (Moderate 12) (update as at 13.09.2022)

4.3.1 Both of these items are discussed and reviewed regularly at the Hospital Mortality Group (HMG) chaired by the Chief Medical Officer.

4.3.4 Discussion at the HMG noted :-

- The latest SHIMI is inside the expected range following the reduction in backlog of the coding of patient notes.
- Chief Medical Officer is hopeful a further substantial drop in the SHIMI will occur when the latest codding is updated on the rolling 12-month period and should improve substantially from autumn onwards.

- Following review and discussion, it was determined that the risk score for Clinical Coding should remain as high and mortality as moderate.

4.4 Staffing

Staffing remains challenging due to the impact of Covid although it is now improving. This is being mitigated by the use of agency and bank staff as well as redeploying staff from wards to other services areas to support safe patient care and safer staffing.

5 UPDATES:

5.1 461- High volume of patients with no reason to reside (Extreme (20))

5.1.2 We still have a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed which is impacting on the patient's well-being and the flow of patients. As at 13 September 2022, the figure stands at 103 patients.

5.1.3 Predominantly, this cohort of patients are waiting for some form of care package, or placement within a residential or nursing home setting, or a mental health facility. 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.

5.1.4 Clinical teams continue to report 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.

5.2 1252 – Financial Sustainability 2022/23

5.2.1 The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective. However, since then NHSI requested all deficit systems to resubmit operational plans for the 20.06.2022 demonstrating how they would achieve a break even position.

5.2.2 The current year to date position is £3.4m worse than plan for the Trust and delivering the planned year end position will be challenging to recover.

5.2.3 There are a number of workstreams in progress across the Dorset system which should improve the position. Ongoing working across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan. Robust CEO and CFO support is in place via regular meetings to discuss the financial rigor governance and delivery of cost improvements. The CIP identified level continues to increase and now stands at 72%.

5.3 1251 – Critical Failings in hospital blood bank (Extreme 20)

The Trust underwent an MHRA visit in January 2022, where a number of issues were identified that required some corrective action. Failure to take corrective action could result in the service receiving a 'Cease Service' order. This would have severe consequences for services across the Trust.

5.3.2 The main areas for concerns are:

- Demand for service outstripping capacity and staffing shortfalls leading to the Quality Management System not being maintained. This would result in tests not being reported in a timely manner.
- Delays in blood test results reporting leading to delays in resulting in delays in ED.

- Staff competencies in using the equipment not maintained.
- Risk of losing the UCAS accreditation
- Vacancy for Blood bank Lead

5.3.3 Mitigations currently in place: (as at 08.09.2022)

- Action plan regularly reviewed
- Rolling recruitment plan in place
- Training plan in place.
- Monthly updates supplied to MHRA
- Electronic blood tracking system purchased.

5.3.4 Update as at 08.09.2022

- The MHRA asked for monthly updates, to include current staffing levels, training performance and progress against areas of concern within the Quality Management System (QMS). After dealing with their queries and concerns to the first two updates (May and June), there have been no further concerns/inquiries (July, August and September).
- Divisional meetings occurred daily following a team huddle within HTL. Now these meetings occur weekly, or by exception, due to a belief that the risk is now less given the lower level of interest from the MHRA. Any concerns are still escalated and action plans formed.
- Weekly meetings with the Executive Board (EB) to discuss progress and blockers have now been reduced to exception reports due to their confidence from aforementioned reduction in MHRA interest.
- A Demand and Capacity Plan (DCP) was presented to the EB, accepted after review, and presented to the MHRA in July. Grading (1-5, with 5 being critical) of staffing concerns formed part of that DCP.
- A draft Continuity Plan has been reviewed by One Dorset Pathology as is ready for dissemination as soon as its associated risk assessment document is completed.
- MHRA concerns regarding patient safety resulting from the risks of using the current paper-based traceability system should be allayed by the implementation of the Haemonetics BloodTrack electronic blood tracking system. The laboratory-based element should be installed by year's end with a view to roll-out Jan-Feb. The full vein-to-vein system (blood sampling and blood transfusion) elements will follow March- May with complete project closure in July.
- A gap analysis is being carried out by the locum HTL Manager against the current EDQM Guide to the
- preparation, use and quality assurance of blood components (as recommended by MHRA) which should help identify any areas that may be deficient but are not yet under scrutiny.
- Staff absence due to infection impacts on all areas of the recovery and continues to be a cause for concern.

5.3.5 Full update is provided within the appendices.

5.4 472: Community Paediatric Long Waits for ASD Patients (Scored as 4 Major x 5 Certain =20 Extreme)

5.4.1 The Service Manager has been trying to put on additional capacity using the funding (75k) the service received.

5.4.2 However, this appears to have been pushed back by finance due to the funding being received late in 21/22 which meant the services did not have time to spend it and subsequently it appears the money was not rolled over to this financial year.

5.4.3 This has been escalated to the Chief Operating Officer and Deputy Director of Finance. The service are hoping to get confirmation of the monies by the end of September 2022 which will allow additional capacity.

5.4.4 There are regular system meetings taking place due to the complexity of addressing the situation across the county.

5.4.5 A further update will be provided in the next report.

5.5 Emerging Risks from Divisions:

5.5.1 Urgent and Integrated Care

5.5.1.1 Pharmacy service

- **1502 Pharmacy Regional Quality Assurance Audit**
  (scored as 4 Major x 5 Certain = Score 20 EXTREME)
  Pharmacy Aseptic Service received it's audit from Pharmacy Regional Quality Assurance on 1st August. The draft report has been received, and the aseptic service has been rated as high risk to patient safety.

  This is currently a draft report, and the Aseptic Services Manager is responding to the draft. Following this, an Action Plan will be drawn up to address the deficiencies. There are no Critical deficiencies (those that require action within 24 hours), but there are 8 Major deficiency categories (those that require action within 3 months)

  This will be discussed at the September Medicines Committee. The Chief Medical Officer, Chief Operating Officer and the Divisional Director for Urgent and Integrated Care are aware of this issue. The action plan will be presented to the Executive team when completed.

- **662 Pharmacy Workforce - vacancy rate**
  (scored as 3 Moderate x 5 Certain = 15 (HIGH)
  There remains difficulty in recruiting to the vacant pharmacy roles.
  To mitigate this currently:
  - Workforce Paper has been submitted to SMT - July2022; HR and Workforce leads aware.
  - Relocation expenses and flexible working offered
  - Recruitment plans in place - jobs advertised on NHS jobs
  - Decentralised services withdrawn and continuity plans enacted.
  - Senior Management staff working operationally where possible
  - Senior Part-time staff working additional hours to support operational cover

5.5.2 Family Services and Surgical Division

5.5.2.1 There are no new emerging risks from the Division which the Committee are not already sited on or that are already detailed on the Corporate Risk Register.

5.5.3 Trust wide:

5.5.3.1 **1509 Mental Health patients delays in care pathway and services support**
(scored as 4 Major x 5 Certain = 20 EXTREME)
We are experiencing delays in patients that require Mental Health Act assessments or placement in a specialist unit being seen and/or placed.

5.5.3.2 This is leading to patients being held in the ED department for up to 72 hours with no MH support or interventions. NRTR patients awaiting MH beds are also

suffering harm from being in the wrong environment, which leads to deteriorating behaviours and staff being affected both physically and psychologically in supporting these patients in an unsuitable environment without specialist mental health nursing support.

5.5.3.3 In order to safely manage these patients and ensure both the individuals safety, the safety of the staff and the other patients on the ward we are having to use security as we have been unable to secure RMN support from either DHUFT or high cost agency.

5.5.3.4 Currently in order to try and mitigate this as far as possible we are:

- LAEP meetings
- Review of SLA with DHUFT re psychiatric liaison service
- Independent system reviews of individual cases
- Working with provider collaborative
- Escalation to executive level to enable exec to exec conversations within the system
- Legal action

6. De-escalation of Risk

6.1 <u>840 – Paediatric Diabetes Service Staffing (Current score 6 -Low risk Previous Score 20-Extreme)</u>

6.1.1 Clinical psychologist has been appointed and commences in post October 2022.

6.1.2 Clinical Psychologists have agreed to cover 4 hours week as an interim measure until Paediatric Diabetes Clinical Psychologist post is recruited to. This will cover the period from April - October 2022 only.

6.1.3 Division and Paediatric happy to de-escalate this risk back to Care Group level, but this will continue to be monitored and will be re-escalated as necessary.

7. 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 continue to work with the Divisions to review and challenge, open and active entries on the live risk register to ensure that scoring is correct and that risks are being reviewed and appropriately followed up and actions being followed through.

8. Recommendation

The Board 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

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance

Date: data correct as at 12.09.2022

Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register detail (Appendix 2)

Heat Map **(active risks only)** **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)
Impact/Consequence Score	5 Catastrophic	5	10	15	20 (1251)	25
	4 Major	4	8	12 (450, 690, 919↓)	16 (474)	20 (472,1221,1252)
	3 Moderate	3	6	9	12 (464)	15 (641)
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5
	KEY	(↓number) (↑number)	Risk score has decreased since previous report Risk score has increased since previous report **Please note that no arrow indicates no change to previous risk score.**			
	Managed/Tolerated risks	463 (High – next review date 28.02.22)Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff; and 468 (Extreme –next review date 28.02.22) Recruitment and retention of Medical staff across specialities				
	Closed	469 - Temporary Medical Workforce Planning & Capacity (this was reframed as 468) 456 - (Low) Patient Transport Provision & Urgent Patient Transfers 973 - (Very low) Public Disorder 709 - (Extreme) Failure to meet constitutional standards 710 - (Extreme) Follow up waiting list backlog 449 - (Moderate) Financial Sustainability 21/22 979 - (Low) Removal/reduction of education funding from HEE commencing April 21.				

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 Added to Risk Register 01/04/2022	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:13.09.2022
1252	**Financial Sustainability year 2022/23**	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective. However since then NHSI requested all deficit systems to resubmit operational plans for the 20.06.2022 demonstrating how they would achieve a break even position. The Dorset system have submitted a plan to reach breakeven, however, it contains significant risk in delivery and requires a full delivery of cost improvement programmes and financial improvement programmes. The current year to date position is £3.4m worse than plan for the Trust and delivering the planned year end position will be challenging to recover.		Local Manager	Claire Abraham
Current position As at 13.09.2022(data correct as at 13.09.2022)		TARGET RATING Target date:	Low (6) Consequence: Moderate Likelihood: Unlikely 31.03.2023
Mitigation: Exploring additional options to mitigate risks against plan not delivering, which will link back to the Trust risk appetite and Board decisions when escalated through FPC **Update:** There are a number of workstreams in progress across the Dorset system which should improve the position. Ongoing working across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan. Robust CEO and CFO support is in place via regular meetings to discuss the financial rigor governance and delivery of cost improvements. The CIP identified level continues to increase and now stands at 72%.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	30.09.2022

Movement on Risk Register: 	Risk Statement Added to Risk Register 05.05.2022 Escalated to Corporate Risk Register 12.05.2022	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:05.07.2022
1251	Critical failings in hospital blood bank	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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	Andrew Miller Sonia Gamblen
Current position As at 09.09.2022(data correct as at 08.09.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2023
Mitigation: • Action plan regularly reviewed • Rolling recruitment plan in place • Training plan in place. • Monthly updates supplied to MHRA • Electronic blood tracking system purchased. **Update:** • The MHRA asked for monthly updates, to include current staffing levels, training performance and progress against areas of concern within the Quality Management System (QMS). After dealing with their queries and concerns to the first two updates (May and June), there have been no further concerns/inquiries (July, August and September).		Next review date	09.10.2022

• Divisional meetings occurred daily following a team huddle within HTL. Now these meetings occur weekly, or by exception, due to a belief that the risk is now less given the lower level of interest from the MHRA. Any concerns are still escalated and action plans formed. • Weekly meetings with the Executive Board (EB) to discuss progress and blockers have now been reduced to exception reports due to their confidence from aforementioned reduction in MHRA interest. • A Demand and Capacity Plan (DCP) was presented to the EB, accepted after review, and presented to the MHRA in July. Grading (1-5, with 5 being critical) of staffing concerns formed part of that DCP. • A draft Continuity Plan has been reviewed by One Dorset Pathology as is ready for dissemination as soon as its associated risk assessment document is completed. • MHRA concerns regarding patient safety resulting from the risks of using the current paper-based traceability system should be allayed by the implementation of the Haemonetics BloodTrack electronic blood tracking system. The laboratory-based element should be installed by year's end with a view to roll-out Jan-Feb. The full vein-to-vein system (blood sampling and blood transfusion) elements will follow March- May with complete project closure in July. • A gap analysis is being carried out by the locum HTL Manager against the current EDQM Guide to the preparation, use and quality assurance of blood components (as recommended by MHRA) which should help identify any areas that may be deficient but are not yet under scrutiny. • Staff absence due to infection impacts on all areas of the recovery and continues to be a cause for concern. • Despite all the positive indicators, there is a realisation the MHRA will inspect at some point in the future so there are continual reminders there is no room for complacency. STAFFING • A skills mix review within the DCP has led to an overall increase in establishment for the HTL of 1.5WTE • An additional Band 7 BMS has been recruited. • Conversion of a rotational Band 6 BMS to being permanently within HTL is ongoing. • Creation of a new 0.5WTE Band 2 Transfusion Practitioner assistant role will allow the current Band 4 Associate Practitioner to perform more grade-appropriate tasks within the HTL . • Nothing lower than a Grade 2 staffing level has been reported since July, due to re-prioritising workloads, training, staffing HTL as a priority and the goodwill of the Pathology staff. • Recruitment of the permanent HTL Manager has begun again. The contract for the locum HTL Manager has been extended until April 2023 to help cover the HTL Manager onboarding and the implementation of the electronic blood tracking system. TRAINING • A locum HTL-trained BMS was employed to backfill the HTL training commitment. Unfortunately, due to illness they left mid-July. HTL-competent BMSs, working as locums, are in extremely short supply and take some time to train to in-house standards even when found.		

• The BMS trainee, scheduled for full competence by 28th October 2022, despite the loss of backfill, their and their trainer's illness, change of contract to as-and-when and their A/L, remains on the original target. • A second trainee has been brought in earlier than originally planned, but their illness has delayed the start of their training. • Competence in HTL requires a minimum of 10 days supervised practice, meaning a training commitment of ~280 days for the whole of Blood Sciences. A second Band 7 will provide resilience for training within HTL, as will the permanent Band 6 and having two bench-trained Band 4s. This should mean when fully established HTL should be able to handle more than one trainee at the same time. QMS • Outstanding SOP reviews, promised for completion to the MHRA by end July, were achieved and continue to be dealt with in a timely manner. • Outstanding Non-Conformities (NCs), promised for completion to the MHRA by end October, have been reduced month-on-month. New NCs continue to be dealt with in a timely manner. • The returning manager supporting the Quality Department has created an audit schedule, is regularly monitoring performance against MHRA and UKAS objectives, and helping those areas requiring additional support. • A second Band 7 will provide resilience for QMS maintenance within HTL, as will the permanent Band 6. • The increase in establishment will enable HTL staff to be released to perform audits. • The 10 highest risk procedures (as determined by number and severity of change requests) will be re-written by end-Sept		

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review and mitigations)	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed: 24.08.2022
919	Covid- 19	Previous Rating	Extreme (20)
This will impact on all of our strategic objectives.		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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	Mark Taylor from 27.05.2022
Current position As at 08.09.22 (data correct as at 13.09.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible **Undetermined**
Mitigation: • Regular weekly virtual IMT meeting • Filtering face piece class 3 (FFP3) respirators and fluid resistant surgical masks • Eye and face protection and disposable aprons, gowns and gloves • Outpatients and visitors required to wear masks within clinical areas, unless they are exempt. • FFP3 lead appointed and will be supported by the Health, Safety and Security manager and staff from the Divisions. **Update:** • Numbers of patients requiring ITU intervention remains low • IPC guidance changed to PPE in clinical areas only, but this continues to be monitored. • PPE is still available • Action cards revised		Next review date **All actions constantly reviewed following national and IPC guidance.**	30.09.2022

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 and current mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 09.02.2022
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	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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	James Male (service Manager)
Current position As at 09.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 30.06.2022
Mitigation: • Interviews for specialist grade took place 08.10.21. Post was appointed to start date 01.02.2022. Target date amended to reflect the start date. Staff member appointed and in post • Validation needed for ASD pathway and current waiting list • All Age Autism Review led by CCG underway • Specialist Grade, Community Paediatrics now in post • ASD funding awarded from the CCG to be spent in 21/22, to support patients awaiting ADOS assessment • Meeting to discuss ASD database arranged – 11/2 **Update:** Dorset CCG has undertaken a further review of ASD, Autism needs in the population and as such working with all providers and local authorities on the next steps		Next review date **ACTION RE APPOINTMENT COMPLETED** **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	30.06.2022 (OVERDUE FOR REVIEW _ CHASED WITH SERVICE) SEE NARRATIVE IN PARA

Movement on Risk Register:	Risk Statement **Date added to Risk Register 22.02.2022**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 05.07.2022
1221	Tackling the backlog of elective care	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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) **Likelihood:** Certain		Local Manager	All speciality leads
Current position As at 13.09.2022 (data correct as at 12.09.2022)		POST MITIGATION RATING (TARGET) Target date	Very Low (8) Consequence: Minor Likelihood: Likely 31.03.2025
Mitigation: • Escalation process in place if clinical priority needs reviewing • Validation of waiting lists to ensure capacity utilised for those remaining on the list • Harm review process in place to monitor and mitigate where possible **Update:** • DCH will achieve zero, 104 week waiters at the end of September and maintain this position • DCH has met the trajectory for 78 week waiters at the end of August and intends to continue the recover in line with the intention to have 0 78 week waiters by the end of March 2023. • 29% increase in Cancer referrals is putting pressure on waits to first seen appointments and growth in the waiting list. DCH closed to cancer referrals in the two most at risk areas – Maxillo-Facial and Gastroenterology and working with UHD on reducing waiting times. • The Trust has a £6.5 million insourcing plan, which year to date is £5,000 ahead of plan		Next review date	31.10.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed: 08.10.2021
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: Place **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 As at 13.05.2021 (data correct as at 13.05.2022)		TARGET RATING Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31.08.2022
Mitigation: • Estates managing ad-hoc issues as the arise; Communications on management of site security; Site security in place Update: • Contract finally awarded February 2022. This was delayed due to a challenge from an unsuccessful bidder. • Installation works have commenced on site, original programme planned for completion in July 2022, currently waiting on updated programme from installer due to delays in award and digital hardware lead in, following the dilapidation survey they have carried out as part of the enabling works. • We intend to start to roll out the replacement local door controller door by door / area by area on a rolling programme once the head end has been set up. Currently we are waiting on the digital service server hardware to arrive which is expected imminently. Door controllers are currently being programmed in advance for network ID`s and security VLAN has now been provided by Digital networks team.		Next review date	30.06.2022 (OVERDUE FOR REVIEW _ CHASED WITH SERVICE) CHASED AGAIN 13.09.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review and mitigations)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 13.09.2022
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic Objective: Place **Strategic Objective: Partnership** **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 As at 13.09.2022 (data correct as at 13.09.2022)		TARGET RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.12.2023
Mitigation: • Monitor other data for assurance on mortality, Escalation of any variance from plan for consideration of resources and prioritisation where possible. **Update:** • The department current focus is to ensure 21/22 coding is up to date by the end of the second week of May to avoid carrying incomplete months for the year. Coding Lead is fairly optimistic this deadline will be met. • This comes at a cost as coding have not started April 22 which needs to be complete by the first week in June to meet the PDR payment deadline which has been rolled forward as part of the elective recovery. • The latest SHIMI is inside the expected range following the reduction in backlog of patient notes. • The percentage of invalid of symptom / sign diagnosis which are effectively blank on the submitted forms has also reduced from 31.8% to 23%. The average is 13% so still some work to do. • Our mean depth of coding has also improved from the third worst in the country and is slowly recovering.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	31.10.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 01.11.2021
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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 As at 01.11.2021(data correct as at 03.11.2021)		TARGET RATING Target date:	Moderate (12) Consequence: Major Likelihood: Possible 31.11.2022
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 **ACTIONS ONGOING, BUILDING WORK CONTINUES TO ENLARGE FOOTPRINT. ADDRESSING FOOTPRINT VIA MASTERPLAN**	30.09.2022 (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 (now closed).		Low risk Moderate risk	Very Low risk Very Low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:13.09.2022
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective: Place **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 As at 13.09.2022 (data correct as at 13.09.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.08.2022
Mitigation: Triangulation of other data for assurance on mortality; SJR process; Medical Examiners escalation process; Learning from deaths Mortality report reviewing situation and learning. **Update:** • The latest SHIMI is inside the expected range following the reduction in backlog of patient notes. • The percentage of invalid of symptom / sign diagnosis which are effectively blank on the submitted forms has also reduced from 31.8% to 23%. • If the SHIMI continues to fall in the next month, the risk score will be adjusted to reflect improvement		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641**	31.10.2022

Movement on Risk Register: 	Risk Statement **Added to the Risk Register 16.09.2016 reviewed in line with national policy and national risk register annually (unless incident occurs)**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 15.09.2021
690	Malicious attack - Cyber-attack on the NHS / Internal ICT failure	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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		Local Manager	Simon Brown
Current position As at 10.05.2022 (data correct as at 10.05.2022)		TARGET RATING Target Date:	Moderate (12) Consequence: Major Likelihood: Possible 31.03.2025
PLEASE NOTE: EXTENAL RATING FROM NATIONAL RISK REGISTER OF CIVIL EMERGENCIES is Medium – low risk. POSITION: This risk is linked to the ICT and Emergency Planning risk register. Linked to this risk there are others which are specific to the Trust infrastructure and Firewalls. **Mitigation:** There are full mitigations and actions in place, and these risks are reviewed monthly to ensure no concerns to counter the risk. **Update:** DTI continue to raise awareness of the risks of a Cyberattack through regular Trust-wide communications. Communications have also gone out to enforce a password change – DTI have targeted staff who have a weak password that is identified by the use of algorithms.		Next review date **ACTIONS AND MITIGATION EFFECTIVE AND ONGOING**	30.09.2022

Report Front Sheet

1. Report Details			
Meeting Title:	Board of Directors		
Date of Meeting:	28 September 2022		
Document Title:	**GMC Survey Action Plan Update**		
Responsible Director:	Emma Hallett, Acting Chief People Officer	Date of Executive Approval	12 September 2022
Author:	Dr Paul Murray, Director of Medical Education		
Confidentiality:	N/A		
Publishable under FOI?	Yes		
Predetermined Report Format?	No		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	19 September 2022	Noted.

3. Purpose of the Paper	The purpose of this update is to provide the People and Culture committee with an overview of the most recent GMC National Training Survey results and the changes and developments within medical education.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
4. Executive Summary	The GMC National Training Survey is undertaken in March to May each year. This report outlines the areas of excellence and those areas that were low outliers. Two patient safety concerns were raised (in Orthopaedics and Oncology) and action plans are in place. The report also summarises the changing landscape of medical education and the next steps for DCH.							
5. Action recommended	The Board is asked to note the action plan update.							

6. Governance and Compliance Obligations				
Legal / Regulatory Link			**No**	
Impact on CQC Standards		**Yes**		Well lead domain
Risk Link		**Yes**		Areas of under-performance are highlighted which, if not effectively addressed, could present a risk to the alignment to the NHS People Plan, the provision of high-quality patient services and/or to the Trust's financial position.
Impact on Social Value		**No**		
Trust Strategy Link		**How does this report link to the Trust's Strategic Objectives?** *Please summarise how your report will impact one (or multiple) of the Trust's Strategic Objectives (positive or negative impact). Please include a summary of key measurable benefits or key performance indicators (KPIs) which demonstrate the impact.*		
Strategic Objectives	People	The Trust aspires to provide high quality educational opportunities to all trainees. In the case of medical trainees, they are an important factor in both current and future workforce plans.		
	Place			
	Partnership			
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?** *Please summarise how your report contributes to the Dorset ICS key objectives.* *(Please delete as appropriate)*		

Improving population health and healthcare	**Yes**		High quality training will help to produce a sustainable workforce supply.
Tackling unequal outcomes and access	**Yes**		
Enhancing productivity and value for money	**Yes**		
Helping the NHS to support broader social and economic development	**Yes**		
Assessments	**Have these assessments been completed?** *If yes, please include the assessment in the appendix to the report..* *If no, please state the reason in the comment box below.* *(Please delete as appropriate)*		
Equality Impact Assessment (EIA)		**No**	
Quality Impact Assessment (QIA)		**No**	

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

GMC Survey 2022 Action Plan Update

September 2022

Dr Paul Murray

Director of Medical Education

• 2022 GMC Survey of doctors in training - results, updates and actions

•Future developments in Education

Our doctors

• A mix of consultants, doctors in training (almost exclusively from Wessex Deanery), and Locally Employed Doctors (LEDs: Staff Grades, Specialty Doctors (SAS grades), Trust Doctors, ‘F3s’, Associate Specialists, Fellows); and now Medical Support Workers

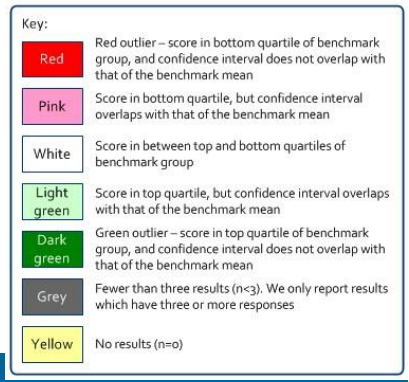
• Deanery trainees are here for between 6 months and 2 years

• 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

• Rotas are increasingly dependent on the recruitment of Locally Employed Doctors in addition to deanery posts

The GMC National Training Survey (NTS)

- Annually, March-May
- No longer compulsory (may explain lower response rates), DCH response rate was 62.5% (Wessex 63.3%, Nationally 76%)
- 18 sets of questions relating to work in and out of hours
- Results can be broken down by Specialty (eg for all doctors at all grades in Surgery) or by Programme (eg only the higher Specialty Trainees in Paediatrics)
- Results are measured against a national mean score and flagged accordingly: Green = national 'above' outlier, Red = national green = tending above, pink = tending below
- Yellow boxes indicate no data for this question



Overall Results for DCHFT

Indicator	2018	2019	2021	2022
Overall Satisfaction	79.27	80.36	78.29	73.31
Clinical Supervision	89.76	88.08	89.98	88.30
Clinical Supervision out of hours	86.92	84.23	86.24	83.42
Reporting systems	76.25	76.73	77.10	71.38
Work Load	55.61	50.70	58.16	47.14
Teamwork	76.22	76.91	75.00	75.31
Handover	66.48	68.94	69.13	65.56
Supportive environment	76.63	74.34	72.81	75.56
Induction	79.12	78.34	78.92	74.75
Adequate Experience	79.72	80.23	79.28	71.25
Curriculum Coverage	77.30	78.19	76.04	
Educational Governance	76.79	74.41	76.26	69.58
Educational Supervision	86.99	87.22	89.38	83.28
Feedback	71.47	75.89	76.39	64.96
Local Teaching	71.19	71.81	63.87	63.24
Regional Teaching	69.73	65.27	67.45	65.55
Study Leave	56.63	65.17	61.67	55.78
Rota Design	56.03	55.25	61.10	47.40
Facilities			72.64	75.06

Excellence! (Green Outliers)

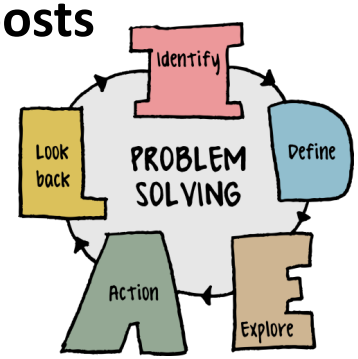
- Paediatrics – all posts
- Supervision, educational governance and supportive environment in Respiratory Medicine
- Supportive environment and facilities in Internal Medical Training (IMT)
- Speciality O+G – supportive environment, teamwork, workload and facilities, facilities and workload in all posts
- Educational governance and supportive environment in Geriatrics
- Adequate experience in ED F2 posts
- Regional teaching in surgery
- Educational Supervision in Core Surgery
- Study leave and teamwork in Core Anaesthetics.
- Facilities across **all of DCHFT posts**

Low Outliers (Red scores)

- OOH clinical supervision in surgical posts
- Adequacy of experience in cardiology posts
- Workload, induction and reporting systems in ED GP posts
- Induction, experience and feedback in Medicine GP posts
- Overall satisfaction and handover in O+G posts,
- Adequacy of experience and overall experience in O+G speciality posts
- Handover and overall satisfaction in O+G GP

- Clinical supervision OOH and workload in medicine F1 posts
- Feedback in surgery F1
- Clinical supervision and feedback in surgery F2

- **Adequacy of Experience across all of DCHFT posts**



Concerns relating to patient safety

• In **Trauma and Orthopaedics**, concerns related to acuity and management of patients at weekends

•Action plan:

- to provide traffic light system for identification and prioritisation of workload
- Cross divisional discussions about orthogeriatric support and junior rotas/staffing

- In **Medical Oncology** – senior supervision of patients on Fortuneswell Ward
- Action Plan:

- Discussed with Medical Division, creation of new Standard Operating Procedure to ensure clear lines of responsibility

Action Plans for Red Outliers

- General Surgery, F1 medicine, GP medicine, O+G, Cardiology, ED GP posts
- Results shared and action plans are being prepared, encouraging co-design with junior staff
- To report back to Medical Education Committee, September 20th
- Escalation to departmental and divisional management if progress not made
- In year feedback from doctors in training via Junior Doctor Forum, Exception Reports and End of Placement surveys
- Next GMC Survey will be in May 2023 – encourage trainer responses via Medical Educator Refreshers and trainees via Junior Doctor Forum engagement

Progress from previous surveys

- O+G – marked improvement in score for Local Teaching, now above average for workload and facilities, teamwork and supportive environment

- Marked improvement from low outlier for Educational supervision in urology (54 risen to 90)

- Ongoing issues with F2 surgery but several areas of improvement seen

2022 Trainer Survey

- Response rate of 40% (Wessex average was 34%)
- Detailed report yet to be published by GMC
- Ongoing work to compare ESR with HEE approved supervisor lists to target recruitment of new supervisors/trainers and ensure good governance/support educational revalidation

Over the last 6 years…

- ED recognised as a site for Emergency Medicine training, plans for DCH to be part of Radiology training Academy
- Significant increase in medical staffing, mostly in LED group; appointment of consultant lead for LEDs, establishment of appraisal system for LEDs
- DCH has never had as many learners as now; use of other posts to work alongside doctors- PAs, ANPs, Specialist nurses plus UHS medical students
- Involvement of junior doctors in management decisions – rota design, induction planning, redeployment, Junior Doctor Forum
- Exception reporting, with results driving change
- Supported Return to Training (SuppoRTT) scheme; appointment of consultant lead for SuppoRTT and LTFT training, increased opportunities for LTFT training at all levels of training
- Joined up thinking around medical staffing in DCH and across Dorset working with Recruitment, DME, Business Managers, Chief Medical Officer

The future?

• Expansion of Medical Student and Doctors in training numbers and further medical students, meaning an increased requirement for Supervision, appraisal, space and accommodation, Action plans in areas of concern; areas of good practice asked to share the learning

• "Recovery" funding – Successful bids include anaesthetic and Emergency Medicine training.

• Must ensure active and quorate Junior Doctor Forum

• Continuing work on LEDs – aim to provide parity of experience (to include supervision), differential attainment, CESR academy?

•Ongoing focus on Wellbeing and support – med student debt now estimated £106k. BMA campaign for pay restoration

• Continuing to champion involvement of junior doctors in management, service design, leadership

Thank you

For your ongoing commitment to teaching, training and supervising

Meeting Title:	**Board of Directors**
Date of Meeting:	**28th September 2022**
Document Title:	**Well Led Review Action Plan Update**
Responsible Director:	**Nick Johnson, Interim Chief Executive**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	Not Confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Trust Board	January 2022	Submit comments on draft report and prepare an action plan in response.
Senior Leadership Group	16th March 2022	Consider involvement of non-clinical divisions in the action plan Meetings with divisional triumvirate on Divisional and Care Group Governance actions. SLG members to input to the draft action plan Return an update in 6 weeks' time
Trust Board	30th March 2022	Final version of the Report presented. Action Plan to be presented for approval in may 2022.
Senior Leadership Group	April 2022	Further discussion with Divisional triumvirates and Executives to make additions to the Action Plan.
Executive Management Team and Management Action leads	Monthly	Monthly updates to actions and assurances obtained and reported to Board Bi-monthly.

Purpose of the Paper	This paper provides updates to Action Plan in response to the Well Led review undertaken in Quarter 3 2021/22 by PriceWaterhouseCoopers received from identified action leads, divisional teams and the Executive Team.						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The Action Plan outlines the planned responses and timescales to the nine action recommendations arising from the Well Led review and is presented to the Board of Directors for assurance and information. Action Progress RAG ratings have been updated to green where the identified action has been implemented. The Board is reminded however, that delivery of the desired outcomes may not be realised until 2023. E.G., Action - increased scrutiny of the financial position relating to the Cost Improvement Programme and Underlying Deficit position. A number of actions have been implemented to ensure close management and greater scrutiny and monitoring of the position, although delivery of the cost improvement programme is not expected until 2023. Key action progress areas are: 3.1: Strategic priorities have been narrowed and agreed: Patient Flow, EL Recovery & Fiscal Sustainability. Strategic discussions ongoing at ICS level regarding agency spend. Development of Strategic Services Review. Updated BAF now in its 6th iteration, expanded to pull in all Board committees. Balanced						

	scorecard developed and ready to be rolled out. 3.2: New Corporate Planning Cycle Developed and taken to EMT & SLG. 3.4: Proposed new corporate planning cycle going to EMT 25/08/2022 3.5: A range of workstreams in progress to develop Trust narrative and commence stakeholder engagement plan. Assurance rated Amber from Red 4.1: Commercial Plan have been approved by EMT & SLG 6.7 Care Group Governance – Care Group Compliance Audit commencing. 8.2: Maternity Voice Partners are recruited and active in LMNS
Action recommended	The Senior Leadership group is invited to note the updated actions.

Governance and Compliance Obligations

Legal / Regulatory	N	Foundation Trusts are required to commission an independent external review of their Well Led arrangements every three years.
Financial	N	Funding for the review has been previously approved.
Impacts Strategic Objectives?	N	Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust Strategy.
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	Foundation Trusts are required to commission an independent external review of their Well Led arrangements every three years.
Impacts Social Value ambitions?	Y	Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust's social value ambitions.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Dorset County Hospital
NHS Foundation Trust

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

WELL LED ACTION PLAN

Well Led Review 2021 – Board Action Plan

RAG Key			
Action Progress	Green = Recommendation action complete	Amber = Recommendation action in progress	Red = Recommendation action not fully developed
Level of Assurance	Green = Full assurance	Amber = Partial assurance	Red = No collated assurance

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
1	**Leadership**	Strengthen oversight and scrutiny by the board and subcommittees over aspects of finance and performance, in particular, ensuring there is adequate assurance over financial plans to deliver sustainability, including the internal accountability processes for delivering plans.	September 2022	**Medium**	1. Promote opportunities for greater NED scrutiny and challenge on the financial and deficit positions		Paul Goddard	Claire Abraham		Operational Plan approved by committee and Board. Annual Budgets approved by committee and Board Monitoring of annual operational performance and finance plans via the standard reports and recorded within Minutes. A formal subgroup has been formed to undertake deeper dives on financial hot topics, with CEO and CFO Financial scrutiny meetings continue to be held with all Divisional and Corporate Budget leads.
					2. Regular reports to FPC on CIP trajectory delivery and the underlying deficit position going forward into 2022/23		Paul Goddard	Claire Abraham		Finance Reports to FPC include CIP progress and monitoring for onward escalation to Board. Underlying deficit position is routinely reported to FPC.
					3. Develop a medium term financially sustainable strategy of which DCH will be a part		Paul Goddard	Paul Goddard		DCH is playing into the wider Dorset ICS medium term financial plan. The sharing of underlying financial forecasts and assumptions, to inform the production of the medium-term financial plan, will take place in early September. This is being coordinated by

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										the ICB CFO and involves all CFO's and deputies within the system. The preliminary outputs of this work will be shared with the FPC and Board.
					4. Enhanced financial monitoring in place, sub-group of FPC		Paul Goddard	Paul Goddard		Sub group approved at May FPC.
Responsible Committee:		Finance and Performance Committee								
2	**Board Development**	Provide training and support for incoming NEDs, including tailored induction to meet individual needs. Ensure there are Board sessions tailored to support the development of a high-performing and cohesive team to manage transition through period of change.	September 2022	**Medium**	1. Complete NED recruitment process review and agree with Governors.		~~Dawn Harvey~~ Emma Hallett	Trevor Hughes		Revised NED recruitment process agreed with Governors. Flexible induction programme to meet individual needs in place.
					2. Board Development Programme for 2022/23 to commence with individual Myers Briggs self-assessments and team discussion in April 2022. This will inform the future Development Programme		~~Dawn Harvey~~ Emma Hallett	Julie Barber		Individual 1-1 debriefs took place during March & April. Board Development session introduced MBTI Team Map, to highlight potential blindspots. Facilitated discussion showcased insights. MBTI App distributed post-session, to support effective communication utilising insights & learning about self and others. To be used as a springboard for further development.
Responsible Committee:		Board								
3	**System Working**	In order to accelerate progress in the Integrated Care System towards clinical and financial sustainability, DCH should consider how it communicates	September 2022	**Medium**	1. Develop the DCH Strategy narrative and promote discussion and sharing of financial		Nick Johnson	Paul Lewis Phil Davis Ciara Darley		Weekly System Sustainability meetings in place with Directors of Finance and Chief Operating Officers.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		with system partners. This should include: • Ensuring System Partners have a good understanding of DCH's challenges and plans to tackle these			and other plans via various system mechanisms. Invite ICB representatives to attend DCH Board & Senior Leadership meeting where appropriate.					Weekly CEO calls and Senior Leadership Team meetings in place. Attendance by Head of Strategy at ICS Planning meeting. Awaiting ICS Strategy, DCH Strategy aligned to the 4 aims of the ICS and is published on the external DCH website. Closer working through GIRFT HVLC workstreams September update: Strategic priorities for DCH have been narrowed and agreed by Exec and taken to SLG: Patient Flow, EL Recovery & Fiscal Sustainability. Strategic Discussions at ICS level on Agency – moving towards for single Tariff and agreed process, eliminating Off framework ICB meeting and discussing financial sustainability at Strategic level
		• Ensuring DCH is communicating in a way that is impactful - consider who is giving the messages and in what forum.	September 2022	**Medium**	2. Stakeholder Messaging Strategy to be developed. Develop regular key messages for sharing. Agree with Trust Board key messages &		Nick Johnson	Phil Davis		September update: • New Corporate Planning Cycle developed and taken to EMT & SLG, which includes engagement sessions for DM/CG leads as they move into business planning for FY23/24 in Sep and Oct 2022. • Development of Strategic Services Review, extensive

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					positives relating to ICS/ICB					discussions with Divisional and CG Managers (and Theatres Manager) ongoing, to compliment their own planning. • BAF updated and improved, in 6th iteration – expanded to pull in all Board committees to review risks relevant to them. • Balanced Scorecard developed and just about to be rolled out to simplify monitoring of key Perf metrics at Finance, Perf, People, Quality level. • Strategy Dashboard, worked up after EMT feedback, pending completion in Sep-22, will sit alongside BAF and be key tool in demonstrating delivery plan and progress for Trust Strategy.
		• A Board to Board session with acute partners to build relationships and set out the processes to accelerate progress	September 2022	**Medium**	3. Set up a meeting via the IC Provider Collaborative.		Nick Johnson			Regular updates on system issues and collaborative working within CEO updates to Board. Provider collaborative progress
		• Training to service managers and clinicians on system working, including the leadership skills and capabilities required to	November 2022	**Medium**	4. Linked to People Plan – development and roll out of the Management Matters		~~Dawn Harvey~~ Emma Hallett	Julie Barber Paul Lewis Phil Davis Ciara Darley		QI Lite/QSIR - continued roll out Knowledge from SLG re ICS working to projects involving this group.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		deliver successful cross-system projects			Programme for all staff stepping into management post – bands 6 and above. Leadership engagement events twice a year					**Management Matters** – focus groups completed, at design stage. On target for October launch. Bi-annual **Leadership Summits** agreed, first one 5th September. Agenda covering: (1) Strategic oversight, ICS, DHC & collaborative working. (2) Operational Finance & Performance, financial challenges/thinking & working differently (3) How we do Assurance at DCH – difference between reassurance & assurance, environment more focused on finance & performance August update: - A new Corporate Planning Cycle has been put forward (taking in EMT in Jul), with a task & finish group - This plans for engagement sessions which will teach teams developing business plans, budget, workforce plan and digital plan about how to combine their plans under the Trust Strategy umbrella and ICS Agenda. September update: Proposed new Corporate Planning cycle going to EMT 25/08/2022.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		• As the strategy development process comes to an end, consider ways to communicate the outputs with external stakeholders.	September 2022	**Medium**	5. Communication & stakeholder engagement plan		Nick Johnson	Paul Lewis		Strategy and ICS sessions with staff and staff groups. Trust leadership summit 5 Sep 22 West Dorset Clinical Collaborative Sep 22 ICB SLT? ICS transformation directors – Sep 22 Work in progress to develop the Trust narrative and commence plan.
Responsible Committee:		Board								
4	**Strategy Refresh**	As the Clinical, Digital and People Plans refresh is completed, the Trust should ensure all other enablers are aligned to the strategy. This should include recruitment, appraisals, performance management, policies and procedures.	November 2022	**Medium**	1. Review of recruitment, appraisals, performance management, policies and procedures.		Nick Johnson ~~Dawn Harvey~~ Emma Hallett	Paul Lewis Phil Davis Ciara Darley		Recruitment and appraisals on track Clinical Plan aligned to the Strategy and any new business cases will also need to be aligned (monitored through Strategy and Transformation SLG) Annual refreshing of Clinical Plan will support alignment to the Trust Strategy and ambition is for this to be complimentary to the Business Planning Process. September update: • Commercial plan has been approved by EMD & SLG • Linkage will be built between Strategy Dashboard and the Projects therein – directly to the People

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										and Clinical plans – via delivery on the KPIs against Strategic objectives
Responsible Committee:		Quality Committee – Clinical Plan Finance and Performance Committee – Digital Plan People and Culture Committee – People Plan								
5	**Performance Management**	The Trust should strengthen accountability at all levels, and in particular, ensure performance management is balanced between quality, operations and finances, while still managing its focus on wellbeing and support to staff.	September 2022	**Medium**	1. Single Oversight Framework Slide pack reporting by Care Groups to Divisional meetings to cover Quality of Care, Finance and Use of Resources, Operational Performance, Strategic Change and Leadership / Improvement Capability.		Anita Thomas	Adam Savin		The Board and committees triangulate well with cross referrals on actions and Escalation Reports to the Board. Comprehensive reporting provided to committees facilitate scrutiny. Slide deck in play and will be presented via Performance meetings in June 2022.
					2. Establish Performance Indicators against new contract standards for the respective Strategic Plans; reporting on these to respective committees.		Anita Thomas Paul Goddard Nicky Lucey ~~Dawn Harvey~~ Emma Hallett ~~Stephen Slough~~ Ruth Gardiner	Adam Savin		Performance Dashboards being further developed – see 5.3 Quality metrics agreed at Quality Committee and with the system (See Quality Committee Reports) Work underway to develop Balanced Scorecard and Strategic Dashboard, pending BI Team approval of an SPC solution.
					3. Develop and implement Care Group level Performance Dashboards in support of		Anita Thomas	Adam Savin		

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					quarterly reporting requirements.					
Responsible Committee:		Finance and Performance Committee.								
6	**Care Group Governance**	The Trust should leverage the Divisional leadership teams to reinforce the expectations of the structure, content, attendance and recording of Care Groups governance meetings. Ensure that where divisional or Care Group leaders are unable to attend meetings, suitable deputies attend in their place and this is recorded in the Minutes.	September 2022	**Medium**	1. See 5 above re Performance Management Framework.		Anita Thomas	Divisional Managers		Care Groups completing Slide packs for Divisional meetings.
					2. Identify Care Group clinical leaders to lead Care Group meetings.		Anita Thomas	Divisional Managers		
					3. Implement a programme of divisional and care groups leadership development – consider Myers Briggs or 4OD.		Anita Thomas	OD Team		Management Matters focus groups completed. Moving to design stage. Divisional Leadership development likely to be aligned with Intro session for Management Matters, as a self- discovery/reflective session underpinned by EQ & assessment tool. Exec Lead proposed cohorts could use either psychometric tool to pilot different benefits e.g. clinical leads to use MBTI. Decision to be made in August.
					4. Implement fortnightly Care Group Business / Governance meetings to review Single Oversight Framework / Performance Framework domains in rotation and quarterly		Anita Thomas	Divisional Managers		

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					reporting up to Divisional Business Governance meetings					
					5. Standard Agendas for Care Group meetings to be re-established.		Anita Thomas	Divisional Managers		
					6. Care Group action plans outlining how the above will be delivered to be developed.		Anita Thomas	Divisional Managers		Clear systems, process and infrastructure in place at care group level. Divisional teams re-energising local communications and meetings
					7. Audit divisional and Care Group meetings to ensure these are happening, are quorate and are covering score card domain subjects		Anita Thomas	Corporate Governance Team		Audit currently in planning phase with a view to completing over the summer. Assurance report presenting outcomes anticipated in September 2022. September Update Audit commenced
Responsible Committee:		Divisional Performance Reviews with Executives – see also section 5								
7	**Leadership Visibility**	Implement a more structured approach to Board visibility across the organisation for example through periodic Executive briefings	September 2022	**Low**	1. Re-energise the Executive Walkabouts Programme and Staff Wellbeing visits		~~Dawn Harvey~~ Emma Hallett			Wellbeing and safety walk arounds Weekly CEO communications to all staff
					2. Recommence NED Safety Visits Programme to site in May 2022 in line with national guidance which were paused in	Complete	Nicky Lucey	Kerry Little	Updates as per evidence summaries and minutes of committees/board etc	Recommenced as per plan and change in guidance (May 2022) Structured programme in place and recorded in the CEO Office NED feedback to Board

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					line with national guidance.					
					3. Review of Team Brief.		~~Dawn Harvey~~ Emma Hallett	Susie Palmer		Team briefing has been reviewed and re-launched as a hybrid meeting in response to feedback from attendees. The number of slides and speakers have been reduced and the meeting is open to all staff who wish to attend. A new addition is the Hospital Hero certificates being presented at the end of the meeting. September update: Hybrid Team Brief launch has been delayed due to Covid and infection prevention controls.
Responsible Committee:		People and Culture Committee – visibility and wellbeing Quality Committee – Non-Executive Director Safety Walkabouts and feedback								
8	**Patient Communications**	Ensure communications to service users and the public are simple, easy to read and jargon-free.	September 2022	**Medium**	1. Patient group restarted and reviewing all patient information produced locally	Complete – in terms of groups and networks re-established since covid	Nicky Lucey	Ali Male	Patient experience group minutes and reports to QC, safeguarding minutes (reference Learning disabilities and MCA)	Patient Experience Group notes and partnership with Healthwatch Dorset, independent providers (such as charities) and Patient and Public engagement groups. Dorset Abilities co-design work on ED build and accessible information People First Dorset collaboration on Learning Disabilities and Autism (see Safeguarding Group notes and annual report) Young Volunteers work with Dorset Council and Healthwatch Dorset to help with transition work stream Dorset Parent and Carer council supporting transition for young people into adult services.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					2. Maternity Voices Partners (part of the LMNS Transformation Programme in place	Complete	Nicky Lucey	Jo Hartley	Part of LMNS governance and nots/programme tracker. Reports into QC	MVP now recruited and active in the LMNS and linked to specific Trust Maternity Service. Recent MVP visit to the maternity service was very positive with detailed feedback from service users provided. Co-production of patient information ongoing.
Responsible Committee:		Quality Committee.								
9	**Clinical Audit**	Divisional clinical audits to be aligned to Trust's key priorities, in addition to national standards.	September 2022	**Medium**	1. Letter sent from CMO to Divisional Directors and Divisional Managers		Alastair Hutchison	Stuart Coalwood & Andy Miller		Email available on request
					2. Divisional teams to present outline plan to June Quality Committee		Alastair Hutchison	Stuart Coalwood & Andy Miller		See minutes of meeting
Responsible Committee:		Quality Committee.								

Meeting Title:	**TRUST BOARD**
Date of Meeting:	**28 September 2022**
Document Title:	DCH Charity Annual Reports and Accounts period ended 31/03/22
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 2022	May 2022	Annual Report and Accounts reviewed and supported by members of the Charitable Funds Committee via email in May 2022

Purpose of the Paper	Approval of 2021/22 Annual Report and Accounts for the Charity following review by Charitable Funds Committee and final Audit review meeting on 20/09/22.							
	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 2022 with the follow up meeting between Ian Carrington from Edwards & Keeping and Paul Goddard (Chief Financial Officer) took place on 20 September 2022. There were no changes requested by External Audit to the 2020/21 Annual Report and Accounts.							
Action recommended	a) Review the 2021/22 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 2022 are: £1,508,000. The Charity spent £482,000 in 2021/22. £1,220,000 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 2021/22 and demonstrates compliance with the objects of the Charity in preparation for completing the Final Annual Report and Accounts in April 2022.
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 2021/22 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 2022

Registered Charity No. 1056479

Dorset County Hospital NHS Foundation Trust Charitable Fund

Annual Report and Accounts for the year ended 31 March 2022

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
NatWest Bank PLC
Government Banking Team
NatWest European Operations Centre
Brampton Road
Newcastle-under-Lyme
Staffordshire
ST5 0QX

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 2022

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 2022.

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 2022. 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. However, with a focused fundraising strategy our Charity has achieved a 16% increase in income compared to the preceding year. However, this was still 14% lower than the charitable income target we had set for this year, reflective of the ongoing challenge across much of the charitable sector. The majority of our income has been received from grants and legacies; with community and events income starting to re-build. We have received valuable support from the NHS Charities Together COVID-19 Appeal, providing grants for staff well-being initiatives. We have also been heartened by the level of on-going support received from our valued donors and the wider community. 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 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:

- Successful completion of the DCH Chemotherapy Appeal to redevelop the Hospital's existing Chemotherapy Unit.
- Launch of the Charity's Greatest Need Appeal supporting care areas across the hospital.
- On-going grant funding from NHS Charities Together COVID-19 Appeal.
- Raising the Charity's profile and income through the media and use of social media.
- Securing major grants from local trusts and charities.
- Funding a range of initiatives and projects to support our care areas and staff welfare.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

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 visitors to our beautiful county 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 2022 (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 2022 (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 eight designated, unrestricted funds: Cardiac, Stroke, Urology, Diabetes, Critical Care, Emergency Department, Ophthalmology, Dermatology Fund, Kingfisher Ward, Purbeck Ward, DCH Radiotherapy Fund, 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, Ilchester Integrated Assessment Unit, The Stoke Club Legacy Fund, Bereavement Fund 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
The COVID-19 pandemic has continued to have a significant impact on the Charity's targeted income for 2021/22. It has been a challenging year for fundraising, though the Charity has adapted to the prevailing environment and exceeded the previous year's income. The majority of our income has been received from grants and legacies; with community and events income starting to re-build. We have also received valuable support from the NHS Charities Together COVID-19 Appeal, providing grants for staff well-being initiatives.
Ward and speciality charitable funds continued to receive donations specifically for charitable activities within those areas.

The Charity Team continued working a hybrid model with a mix of working remotely and in the office. Plans focused on maintaining financial sustainability and generating new fundraising opportunities, to build back as we move through and beyond the pandemic.

Development of the Charity
The Charity has undertaken the following key activities:

a) Against the backdrop of the impact of the pandemic and the prevailing economic situation, the Charity has developed its Business Plan 2022/23 a part of its overall Strategy 2022-25. The Charity's strategy will focus on maintaining the Charity's financial sustainability within the context of the challenging economic environment; whist capitalising on new fundraising opportunities including a new major Capital Appeal.

b) The Charity successfully completed its Chemotherapy Appeal in December 2021, raising £850K for the redevelopment of the hospital's existing Chemotherapy Unit.

c) The Charity also launched its Greatest Need Appeal, an on-going annual appeal supporting all areas of the hospital, wherever the need is greatest.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

d) Promotion of the Charity's fundraising brand statement – 'The Power of Giving', which will underpin the Charity's annual fundraising programme.

e) Dorset County Hospital was the lead charity for the NHS Charities Together Stage 2 Community Partnership (Dorset) grant application. We were notified that NHSCT had approved the £365K grant in March 2022. This grant will benefit NHS projects working with community partners across Dorset, assisting communities to recover from the impact of the pandemic with a focus on addressing health inequalities. The grant will be received in instalments over a two-year period. Dorset County Hospital Charity will receive £55K from this grant during 2022/23-23/24 for the Dorset County Hospital Active Hospitals project.

f) We commenced work on our NHSCT Stage 3 Recovery grant application and aim to submit this in early 2022/23. We were also notified of the forthcoming NHSCT Development grant to support NHS Charities' operational and development costs. This grant round will open during 2022/23.

g) Dorset County Hospital Charity has been planning for a new major Capital Appeal to support enhancements to the hospital's planned new Emergency Department and Intensive Care Unit. The draft Capital Appeal Plan was approved by Trust Board (Corporate Trustee) in March 2022 and the three-year appeal will commence early 2022/23.

h) The Charity's new website was launched at the start of 2021/22.

i) A new donor database CRM (Donorfy) was introduced which will transform the Charity's ability to integrate its digital fundraising, marketing and donor communications.

j) On-going management of DCH Arts in Hospital programme and DCH Arts in Hospital Manager.

k) The Head of Charity & Social Value has lead on implementation 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.

Significant Projects

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:

- £70,000 funding from Dorset Health Trust enabled the Charity to purchase a EBUS Additional Scope for respiratory patients at Dorset County Hospital.
- £20,000 funded the purchase of an Ultrasound Machine for Rheumatology at Dorset County Hospital.
- £10,000 funded the purchase of a VAB Biopsy Machine.
- £100,000 grant commitment made to contribute towards the expansion of the Fortuneswell Outpatient Pharmacy to improve the cancer patient experience. Fortuneswell Cancer Trust Charity have pledged a further £50,000 to coincide when the buildings works commence during financial year 2022/23.
- 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 2022 (continued)

Thanking our Supporters

2021/22 proved to be a further challenging year for the Trust and for DCH Charity. The continuing Covid pandemic and national restrictions limited fundraising opportunities, but our resourceful and generous donors and supporters continued to support the Charity wherever possible.

A programme of re-engagement with our fundraisers commenced which will continue throughout 2022. Early signs suggest that significant fundraising opportunities remain within the local community particularly where emotive projects are identified and communicated to the public.

To name just a few of our incredible community fundraisers: thank you to Maiden Castle Farm for their fantastic Sunflower Trail, which raised over £24,000 for the Special Care Baby Unit. Their donation has funded a Cerebral Function Monitor for the unit. Also, thank you to the Martinstown Circle Supper community for donating £2,000 to our Chemotherapy Appeal from various fundraising activities during 2020-2022. Special thanks to all members of the Caravan and Motorhome West Dorset Centre for raising over £3,000 for our Chemotherapy Appeal.

A former patient, Owen Clark, ran the London Marathon in 2021, raising over £1,000 for our Cardiac Unit as a way of 'giving back' to DCH and the unit who cared for him.

We are also grateful to our corporate supporters and the wider community for the generous gifts donated to our patients and their families and to staff at DCH. The gifts are always thoughtful and carefully chosen. We know they mean so much to everyone at the hospital and make a huge difference.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

Members of DCH staff continue to support the Charity which is more appreciated than ever due to the ongoing pressure they are working under. In particular we thank Cheryl Heard who ran the London Marathon on behalf of DCH both virtually in 2020 and again in London in 2021. Cheryl raised over £3,000 for our Chemotherapy Appeal.

The launch of our Greatest Need Appeal has provided a further opportunity to engage with fundraisers and DCH staff. This engagement will include the continued promotion of support for specialist care areas at DCH.

A special thank you goes to Conny Sargent and her colleagues from the Covid Testing Unit for raising £1,436 for the Greatest Need Appeal. They walked from Weymouth Pavilion to Dorset County Hospital in July 2021. Conny, who since 2018 has raised nearly £4,000 for the hospital, is an inspiration to us all and we are very grateful for her continued dedication in fundraising for the hospital. A team of DCH staff also ran the Weymouth Half Marathon in March 2022 and between them raised over £1,000 for our Greatest Need Appeal.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

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

- NHS Charities Together
- Battens Solicitors
- District 1200 Rotary Clubs and the Rotary Foundation
- Lions Clubs
- Dorchester Round Table
- DCH Staff fundraisers
- Community events across our region
- Local corporate supporters

Our thanks also go to the many organisations and networks which continue to help support and promote the work of DCH Charity. Although some media organisations have closed since the onset of the pandemic, it is hoped that increased publishing activity online will take its place. Online support from these organisations will be encouraged as part of our ongoing social media strategy and will continue to help to promote the work of the Charity and raise its profile in the local community. Key organisations include:

- Dorset Echo
- Lyme Regis and Bridport News
- BBC Radio Solent
- Greatest Hits Radio
- Poundbury Magazine
- Dorset Chamber for Business
- Weymouth and Portland Chamber for Business
- Dorvil Business Network
- Humphries Kirk Business Breakfasts

It is also important to acknowledge the importance of those who have chosen to support DCH Charity by leaving a gift in their Will. This makes up a significant portion of our income. We would like to thank everyone who has already pledged to leave such a gift, and the relatives of those who have already done so. Gifts in Wills help to ensure that we can continue to meet the future needs of Dorset County Hospital.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

DCH Charity is grateful to all the donors, supporters, volunteers and fundraisers, local businesses and partner organisations who continue to support the Charity. Without their generous contributions of time, effort and funding it would be impossible for DCH Charity to continue to achieve its purpose of enhancing patient care at Dorset County Hospital.

Financial Review

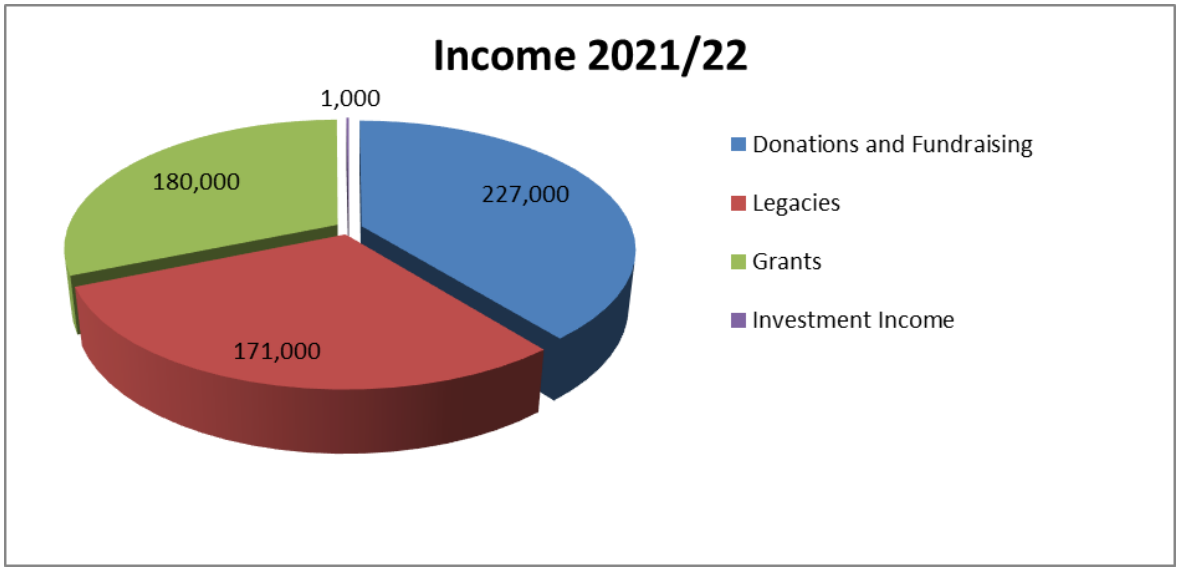
A review of our finances, achievements and performance

The net assets of the Charitable Fund as at 31 March 2022 were £1,508,000 (2021: £1,411,000).

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

Income

Total income was £579,000 (2021: £500,000) which was an increase of £79,000 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 £578,000 (2021: £500,000) – 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 £180,000 (2021: £186,000) – The Charity received grants for medical equipment for the benefit of patients at Dorset County Hospital.

- The outpouring of support for the NHS through 2021/22 during the pandemic has been amazing. We were inundated with donations of clothing, 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 £24,000.

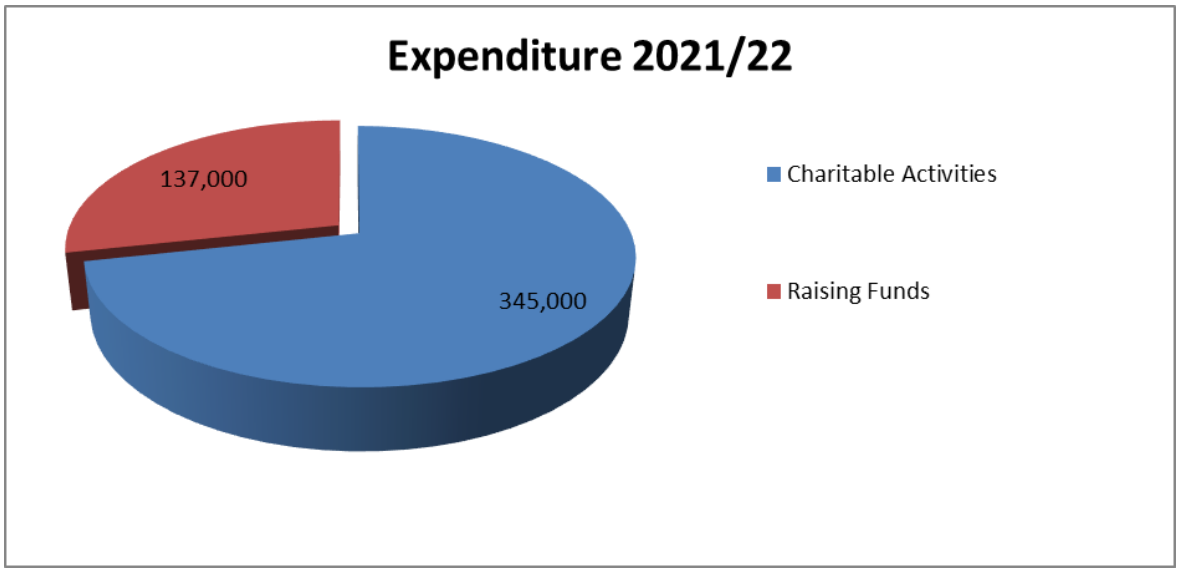
- Legacies £171,000 (2021: £64,000) – The Charity values the major support it receives from those who remember our work through their wills. Legacies make a lasting difference, benefiting future generations of patients.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

- Donations and fundraising £227,000 (2021: £250,000). The rest of our donations and fundraising comes from collecting boxes and personal donations to fundraising events in the community. We are fortunate to receive generous donations for the benefit of the patients at Dorset County Hospital.

Expenditure
Of the total resources expended of £482,000 (2021: £300,000), expenditure on direct charitable activity was £345,000 (2021: £200,000) across a range of programmes. The pie chart shows that our largest area of spend was on charitable activities:



Raising funds expenditure of £137,000 (2021: £100,000) related to the cost of the fundraising office (including fundraising staff) and fundraising events.

Charitable activities expenditure of £345,000 included the Charity donating to Dorset County Hospital NHS Foundation Trust assets of £325,000 (2021: £54,000). These covered contributions to building schemes and medical and surgical equipment. It also donated furniture and fittings of £15,000 (2021: £40,000), artwork expenses of £nil (2021: £3,000) and staff welfare and amenities of £4,000 (2021: £69,000). Patients' welfare and amenities were £1,000 (2021: £34,000). Support costs for charitable activities totalled £35,000 (2021: £44,000) 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.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

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

Investments

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

Bank and cash balances at the year-end totalled £1,737,000 (2021: £1,584,000) of which £1,736,000 (2021: £1,583,000) was held in an interest earning account with the Government Banking Service. £800 was held as Petty Cash at the end of March 2022.

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 2022 (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 April 2022. 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. The reserves target of £200,000 has continued to be used throughout 2021/22 to ensure that the charitable funds are not over committed.

Total funds at 31 March 2022 were £1,508,000 of which £1,220,000 related to restricted funds and unrestricted funds totalled £288,000. The Reserves (unrestricted funds) were therefore £88,000 above the target reserves. The Charity will be working with Fund Representatives to ensure that funds above the target reserve are spent in accordance with donors wishes.

In the longer term, the Dorset County Hospital Charity Fundraising Strategy 2022-2026 establishes 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 2022-2026 is moving forward.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (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 2022/23 as part of its longer-term Charity Strategy 2022-25. The key activities for 2022/23 will include:

- We will continue to promote our Greatest Need Appeal supporting all areas of the hospital.
- We will commence the initial phase of our major Capital Appeal raising funds in support of the hospital's new ED/ICU build providing enhancements to both facilities.
- We will receive first year grant instalments from the NHS Charities Together Stage 2 Community Partnerships programme for NHS-related projects across Dorset including Dorset County Hospital. We will submit grant applications to NHS Charities Together Stage 3 Recovery grants (£65K allocated for DCH Charity) and Development grant (£30K allocated for DCH Charity) programmes.
- We will continue to support and promote our fundraisers as Community and Events fundraising activity re-builds.
- We will grow the contribution Individual Giving makes to our annual income including proactive promotion of contactless donations, payroll giving scheme and legacy giving.
- 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 continue 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 Dorset County Hospital FT's Social Value programme, contributing to the wider health and well-being of our community.

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

Structure, Governance and Management

The Dorset County Hospital NHS Foundation Trust Charitable Fund was entered on the Central Register of Charities on 28 June 1996 as registered Charity number 1056479. At 31 March 2022, the Charity comprised 42 individual funds. The notes to the accounts distinguish the types of fund held and disclose separately details of the income, expenditure and balances associated with these funds.

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

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

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

Unrestricted Funds:

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

Restricted Funds:

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

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

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

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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

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

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

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

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

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

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

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

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

Fundraising Performance

During the year total donations, legacies and grants came to £578,000 against an original plan of £675,000. We fell short of our plan because many of our main fundraising activities slowed or stopped during the year due to the pandemic. The majority of our income has been received from grants and legacies; with community and events income starting to build. We have also received valuable support from the NHS Charities Together COVID-19 Appeal. In light of the on-going impact of the pandemic and prevailing economic situation, we have further developed our strategy for the Charity 2022-25, together with our Business Plan 2022/23, with prudent plans to grow 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 2022 (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 2021/22 and up to the date this report and accounts were approved and signed were:

Mr M Addison	Chairman
Mr S Parsons	Non-Executive Director (from 11 December 2021)
Mr D Perera	Non-Executive Director (from 1 January 2022)
Ms E Jones	Non-Executive Director (from 1 January 2022)
Ms M Blankson	Non-Executive Director
Ms J Gillow	Non-Executive Director
Prof S Atkinson	Non-Executive Director
Mr I Metcalfe	Non-Executive Director (until 30 November 2021)
Mr D Underwood	Non-Executive Director
Mr S Tilton	Non-Executive Director
Ms P Miller	Chief Executive Officer (until 31 January 2022)
Mr P Goddard	Chief Financial Officer (until 8 October 2022)
Mr C Hearn	Chief Financial Officer (from 3 October 2022)
Prof A Hutchison	Chief Medical Officer
Mrs I Robotham	Chief Operating Officer (until 17 October 2021)
Mrs A Thomas	Chief Operating Officer from 1 October 2021)
Ms D Harvey	Chief People Officer (until 12 August 2022)
Ms N Lucey	Chief Nursing Officer (until 21 October 2022)
Mr N Johnson	Deputy Chief Executive and Director of Strategy, Transformation and Partnerships, Acting Chief Executive Officer from 1st February 2022
Mr S Slough	Chief Information Officer 9until 31 August 2022)

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 2022; 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 2022 (continued)

Name	Position	6 May 2021	29 June 2021	25 Aug 2021	3 Nov 2021	28 Feb 2022
Mr D Underwood	Non-Executive Director. Chair of Charitable Fund Committee	✓	✓	✓	✓	✓
Mr M Addison	Chairman and Non-Executive Director.	✓	✓	✓	✓	✓
Mr P Goddard	Chief Financial Officer until 08/10/22	✓	✓	-	-	✓
Mr C Hearn	Chief Financial Officer from 03/10/22	-	-	-	-	-
Mrs I Robotham	Chief Operating Officer until 17/10/21	✓	✓	✓	-	-
Mrs A Thomas	Chief Operating Officer from 01/10/21	-	-	-	-	✓
Ms N Lucey	Chief Nursing Officer until 21/10/22	-	✓	✓	✓	✓
Mr N Johnson	Deputy Chief Executive	✓	✓	-	✓	-
Ms M Blankson	Non-Executive Director	-	✓	✓	-	✓
Mr S Tilton	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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Trustee's Annual Report for the year ended 31 March 2022 (continued)

information about the Charity, including the governing document, the Charitable Fund Committee terms of reference, past Trustee Annual Report and Accounts, scope and policies and minutes, and information about Trusteeship generally, including Charity Commission booklet CC3, The Essential

Trustee and CC20 Charity Fundraising: a guide to trustee duties. The Chairman gives new members of both the Board of Directors and the Charitable Fund Committee a briefing on the current policies and priorities for the charitable funds; a guided tour of the Dorset County Hospital Foundation Trust's facilities; and any additional training that their role may require.

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

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

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

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

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

Approved on behalf of the Corporate Trustee
Signed

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 2022 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 2022, and of its results for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

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

Conclusions relating to going concern

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

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

Other information

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

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

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

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

We have nothing to report in this regard.

Matters on which we are required to report by exception

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

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

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement [set out on page 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.

……..
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 2022

	Note	Unrestricted funds £000	Restricted funds £000	Total funds 2022 £000	Total funds 2021 £000
Income from:					
Donations and legacies	4	371	207	578	500
Investments	6	1	-	1	-
Total income		372	207	579	500
Expenditure on:					
Raising funds	7	117	20	137	100
Charitable activities	8				
Medical and surgical equipment		220	105	325	54
Furniture and fittings		11	4	15	40
Artwork expenses		-	-	-	3
Patients' welfare and amenities		1	-	1	34
Staff welfare and amenities		4	-	4	69
Total expenditure		353	129	482	300
Net income / (expenditure)		19	78	97	200
Transfers between funds		-	-	-	-
Net movement in funds for the year		19	78	97	200
Reconciliation of funds					
Funds brought forward at 1 April 2021		269	1,142	1,411	1,211
Funds carried forward at 31 March 2022	18	**288**	**1,220**	**1,508**	**1,411**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Balance Sheet as at 31 March 2022

	Note	Unrestricted funds £000	Restricted funds £000	Total funds 2022 £000	Total funds 2021 £000
Current assets					
Debtors	14	36	59	95	4
Cash and cash equivalents	15	385	1352	1,737	1,584
		421	1,411	1,832	1,588
Liabilities					
Creditors: amounts falling due within one year	16	(133)	(191)	(324)	(177)
Net current assets		288	1,220	1,508	1,411
Net assets		**288**	**1,220**	**1,508**	**1,411**
The funds of the charity					
Restricted income funds		-	1,220	1,220	1,142
Unrestricted funds		288	-	288	269
Total funds	18	**288**	**1,220**	**1,508**	**1,411**

Signed

Chris Hearn, 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 2022

	Note	Total funds 2022 £000	Total funds 2021 £000
Cash flows from operating activities:			
Net cash provided by operating activities	17	152	176
Cash flows from investing activities:			
Interest received	6	1	-
Net cash provided by investing activities		1	-
Change in cash and cash equivalents in the year		153	176
Cash and cash equivalents at 1 April 2021	15	1,584	1,408
Cash and cash equivalents at 31 March 2022	15	**1,737**	**1,584**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2022

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. 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 2022 (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 2022 (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 2022 (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 2022 is based on valuation data as 31 March 2021, updated to 31 March 2022 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 2022 (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 2021

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

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2022 (continued)

2b Balance Sheet as at 31 March 2021

	Unrestricted funds £000	Restricted funds £000	Total funds £000
Current assets			
Debtors	2	2	4
Cash and cash equivalents	313	1,271	1,584
	315	1,273	1,588
Creditors: amounts falling due within one year	(46)	(131)	(177)
Net current assets	269	1,142	1,411
Net assets	269	1,142	1,411
Total funds	**269**	**1,142**	**1,411**

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 £345,000 (2021: £200,000) is detailed in note 8. At 31 March 2022 the Charity had made £243,000 (2021: £147,000) 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 2021/22 due to the finance team supporting the hospital with additional COVID-19 NHS reporting requirements (2021: £nil) 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: £157,000).

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 2022 (continued)

4. Income from donations and legacies

	Unrestricted funds £000	Restricted funds £000	Total funds 2021 £000	Total funds 2021 £000
Donations and fundraising	160	67	227	250
Legacies	104	67	171	64
Grants	107	73	180	186
	371	**207**	**578**	**500**

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 42 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 2022 £000	Total funds 2021 £000
Cash on deposit	**1**	**-**	**1**	**-**

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 2022 (continued)

7. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted funds £000	Total 2022 £000	Total 2021 £000
Fundraising office*	10	(1)	9	(19)
Support costs	107	21	128	119
Total	**117**	**20**	**137**	**100**

*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 2022 £000	Total funds 2021 £000
Medical and surgical equipment	292	33	325	54
Furniture and fittings	14	1	15	40
Artwork expenses	-	-	-	3
Patients' welfare and amenities	1	-	1	34
Staff welfare and amenities	3	1	4	69
	310	**35**	**345**	**200**

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

	2022 £000
Opening balance at 1 April 2021 (see note 16)	171
Additional commitments made less unused amounts reversed during the year (see note 8)	310
Amounts paid during the year	(167)
Closing balance at 31 March 2022 (see note 16)	**314**

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 2022 (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 2022 £000	Total funds 2021 £000
Governance costs				
Audit fees	-	5	5	5
	-	**5**	**5**	**5**
Other support costs				
Fundraiser	128	29	157	157
Bank charges	-	1	1	1
	128	**35**	**163**	**163**

	Unrestricted funds £000	Restricted funds £000	Total funds 2022 £000	Total funds 2021 £000
Raising funds	107	21	128	119
Charitable activities	24	11	35	44
	131	**32**	**163**	**163**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2022 (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

	2022 £000	2021 £000
Salaries and wages	132	132
Social security costs	13	13
Employers pension contribution	12	12
Total	157	157

The average headcount during the year was 3.43 (2021: 3.96) 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 (2021: none).

13. Auditor's remuneration

The auditor's remuneration of £4,920 (2021: £4,680) related solely to the audit with no additional work being undertaken (2021: nil).

14. Analysis of current debtors

	2022 £000	2021 £000
Trade debtors	-	-
Accrued income	95	4
	95	4

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 2022 (continued)

15. Analysis of cash and cash equivalents

	2022 £000	2021 £000
Cash in hand	1,737	1,584

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

	2022 £000	2021 £000
Creditors falling due within one year		
Trade creditors	5	1
Accruals for grants owed to NHS bodies	314	171
Other accruals	5	5
	324	**177**

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

	2022 £000	2021 £000
Net income / (expenditure) for the year (as per the statement of financial activities)	**97**	**200**
Adjustments for:		
Interest receivable	(1)	-
Decrease in debtors	(92)	6
Increase / (Decrease) in creditors	148	(30)
Net cash provided / (used in) by operating activities	**152**	**176**

Dorset County Hospital NHS Foundation Trust Charitable Fund

Notes to the accounts for the year ended 31 March 2022 (continued)

18. Funds

	At 1 April 2021 £000	Income £000	Expenditure £000	Transfers £000	At 31 March 2022 £000
Unrestricted funds					
General Purpose*	16	279	(257)	-	38
Staff General Purpose*	1	1	-	-	2
Patients General Purpose*	-	-	-	-	-
Emergency Department	5	-	(1)	-	4
Cardiac	26	39	(15)	-	50
Critical Care	14	5	(10)	-	9
Diabetes	2	-	-	-	2
Stroke	21	3	(3)	-	21
Urology	5	1	(1)	-	5
Kingfisher Ward	23	11	(13)	-	21
Purbeck Ward	2	-	-	-	2
DCH Radiotherapy Fund	6	4	(1)	-	9
Dermatology Fund	1	-	-	-	1
Ilchester Integrated Assessment Unit	1	-	-	-	1
Ridgeway Ward	3	-	-	-	3
Dementia Fund	1	-	-	-	1
Forget-me-not Suite	6	4	-	-	10
Maud Alexander Ward	2	-	-	-	2
Colorectal and Lower GI	6	-	-	-	6
Breast Care	1	1	-	-	2
Lulworth Ward	2	-	(1)	-	1
Hinton Ward	2	2	(1)	-	3
Prince of Wales Ward	7	1	(1)	-	7
DCH Therapies	5	-	(1)	-	4
Haemodialysis	5	1	(1)	-	5
Barnes Ward	3	-	-	-	3
Ophthalmology	3	1	(3)	-	1
COVID-19 Apppeal	99	4	(42)	-	61
The Stroke Club Legacy Fund	-	10	-	-	10
Bereavement Fund	-	5	(2)	-	3
DCHC Christmas Appeal	1	-	-	-	1
	269	**372**	**(353)**	**-**	**288**
Restricted funds					
Children's Services Trust*	17	3	(1)	-	19
Art in Hospitals*	2	-	-	-	2
Cancer Services*	23	49	(26)	-	46
West Dorset Cancer Centre Campaign	575	66	(47)	-	594
Post Graduate Education & Research*	-	-	-	-	-
The Lillian Martin Ophthalmology Fund*	-	-	-	-	-
Special Care Baby Unit*	42	28	(42)	-	28
Renal Fund*	433	46	(15)	-	464
Diabetic Fund*	-	-	-	-	-
COVID-19 NHS Charities Together	50	-	2	-	52
NHS Charities Together Operation Support	-	15	-	-	15
	1,142	**207**	**(129)**	**-**	**1,220**
Total funds	**1,411**	**579**	**(482)**	**-**	**1,508**

*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 2022 (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 2021/22.

20. Contingency Assets

The Charity was notified via Smee & Ford legacy notification service on 31 March 2021 of a residuary beneficiary legacy for the Kingfisher Ward Charitable Fund at Dorset County Hospital but the value could not be reliably measured at 31 March 2022 when the solicitors were collecting the assets and liabilities of the Estate.

The Charity was notified via Andrew Eastham Legal Services on 2 September 2021 of a residual beneficiary legacy for the Royal Eye Infirmary (Ophthalmology Charitable Fund) at Dorset County Hospital but the value could not be reliably measured at 31 March 2022 when the solicitors were collecting the assets and liabilities of the Estate.

The Charity was notified via Smee & Ford legacy notification service on 15 September 2021 of a residuary beneficiary legacy for the General Purpose Charitable Fund at Dorset County Hospital but the value could not be reliably measured at 31 March 2022 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.

Meeting Title:	**Quality Committee**
Date of Meeting:	23rd August 2022
Document Title:	**Mortality Report: Learning from deaths Qtr 1 2022-23**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	17th August 2022	None specific

Purpose of the Paper	To inform the Quality Committee of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The Trust's SHMI reported in Q1 (5 months in arrears - rolling years to Dec, Jan & Feb 22) fell into the 'Expected Range' (1.12, 1.11 and 1.11 respectively). SHMI continues to be influenced by delays in coding (as explained in the previous Q2 report), although a completed and updated HES submission was made by the final 2021/22 deadline of 19/05/22. No other local or national indicators suggest excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are used to examine the care of an appropriate sample of people who died whilst in-patients, and to learn from any good practice or lapses in care identified. The DCH Medical Examiners review every death and highlight any obvious causes for concern. DCH is now taking on the ME function for community deaths, and has recruited 5 additional MEs for this work, with NHSE funding. NHSE expects all Trusts to have this service fully operation by April 2023.
Action recommended	The Quality Committee is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website 3. **Not publish** appendices 1 and 2 which contain patient-related data

Governance and Compliance Obligations

Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of various data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be under-reported or unnoticed if data quality is poor • Other mortality data sources (primarily from national audits) are regularly checked for any evidence of unexpected deaths.
Decision to be made?	N	
Impacts CQC Standards?	Y	An elevated SHMI will raise concerns with NHS E&I and the CQC. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 and elective tariff incentivisation targets have adversely influenced coding and therefore recent SHMI figures are inaccurate.
Impacts Social Value ambitions?	N	

Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports (not published).

1.1 Family Services and Surgical Division Report - Quarter 1 Report

Structured Judgement Review Results: The Division had 38 deaths in quarter 1 that require SJR's to be completed. Across the Division 32 SJRs have been completed in quarter 1, 30 of which were completed for SJRs reported in previous months.

SJRs in process: The current number of outstanding SJR's for the Division is 56 (as of 4/7/22). The availability of the notes for these patients is being re-checked to ensure clinical staff can complete this work.

January 22	February 22	March 22	April 22	May 22	June 22
1	5	4	10	9	16

Feedback from SJR's completed in quarter 1:

	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	1	4	2	24*	3	2
1 Very Poor	0	0	0	0	0	0
2 Poor	3	2	0	0	1	2
3 Adequate	7	3	5	0	6	4
4 Good	8	11	9	3	15	14
5 Excellent	13	8	3	4	6	10

*being checked for accuracy

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
3	0	2	5	15	7

Avoidability of Death Judgement Scores:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	6	23*

*2 SJRs found to have missing final scores.

Action Recommendations:

No Action required	Further Learning req'd	Referred to Trust Group / Committee	Repeat SJR from specific specialty	*Incomplete scoring
26	2	1	1	2

Report completed by: Richard Jee – Divisional Mortality Lead
Michelle Purdue – Interim Quality Manager

1.2 Division of Urgent & Integrated Care – Quarter 1 Report

Structured Judgement Review Results: 165 deaths, 32 SJR's requested from these deaths and 45 were completed in total (completed SJR's not necessarily from this quarter).

	April	May	June	Total YTD
Deaths	66	53	45	**164**
In month deaths requiring SJR	17	7	8	**32**
Completed SJR's	14	18	14	**46**

Total outstanding SJR's (not including nosocomials) = **27**
Outstanding SJR's >2 months (prior to 18/07/2022) = **15**

21 Nosocomial deaths (not included in above figures) will be reviewed by James Metcalf and a summary report will be written for HMG (9 reviewed so far on 13/06/22), 12 still to review).

Phase of Care score from 45 completed SJR's in Quarter 1:

	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	6	28	44	7	0
1 Very Poor	0	0	0	0	0	1 *
2 Poor	0	0	0	0	2	0
3 Adequate	7	6	1	0	1	7
4 Good	29	22	9	0	22	26
5 Excellent	9	11	7	1	13	11

*Overall SJR score of 6, definitely not as a result of healthcare, however brought to HMG 11/05/2022 due to issues with inadequate DNAR/TEP completion.

Overall Quality of Patient Record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
1	0	2	7	22	13

Avoidability of Death Judgement Score

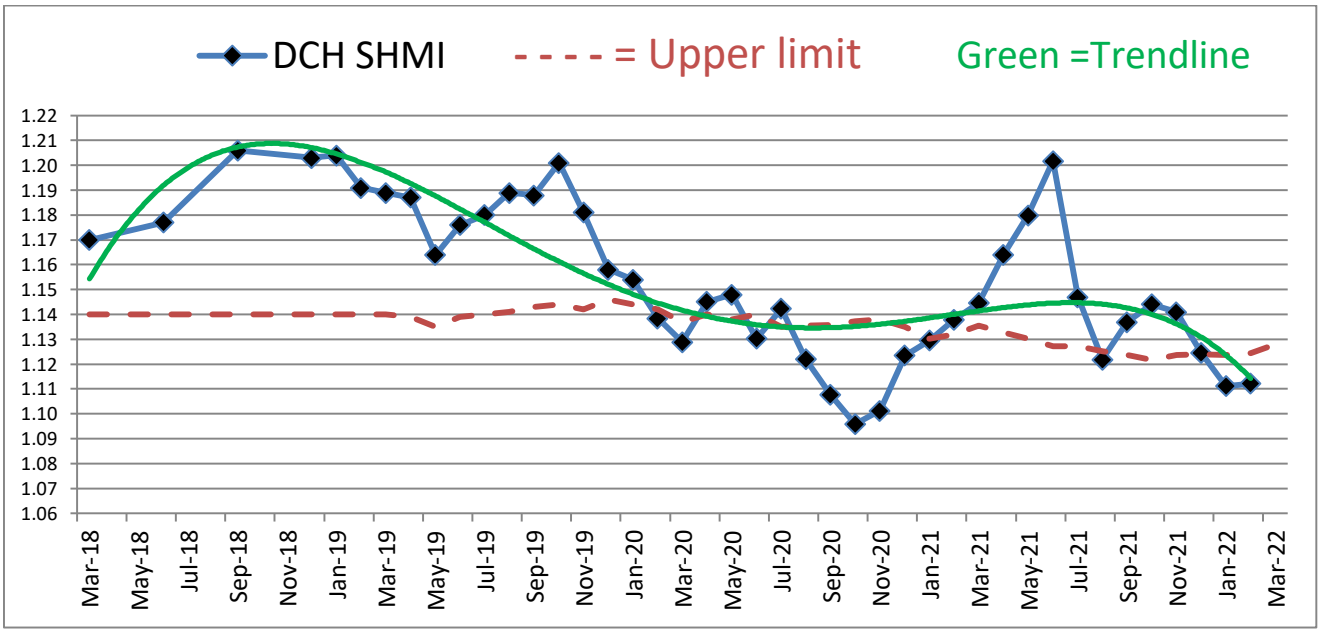
Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	1	1	1	42

Jemma Newman, Quality Manager,
Sonia Gamblen, Divisional Head of Nursing & Quality
James Metcalfe, Divisional Director

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. The SHMI for the rolling years from October 2020 to June 2021 showed a clear reversal of the previous trend to improvement, but the latest data has stabilised around a SHMI of around 1.11 which is within the 'Expected Range'. However, we know that our data continues to be adversely influenced by difficulties in the Coding Department. Revised data was submitted for the end of year HES submission in mid May but will not feed through into the SHMI calculations until October 2022. Our senior coder - Sue Eve-Jones – has now left DCH to continue working for GIRFT. We would like to express our thanks to Sue, and we continue to try to appoint a replacement. The latest published SHMI is shown below:



SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady improvement in DCH's SHMI as a result of investment in the coding department which resulted in more accurate and timely coding returns to NHS Digital.

For a full explanation of recent coding difficulties please see the previous Q2 2022 report published on the DCHFT internet site.

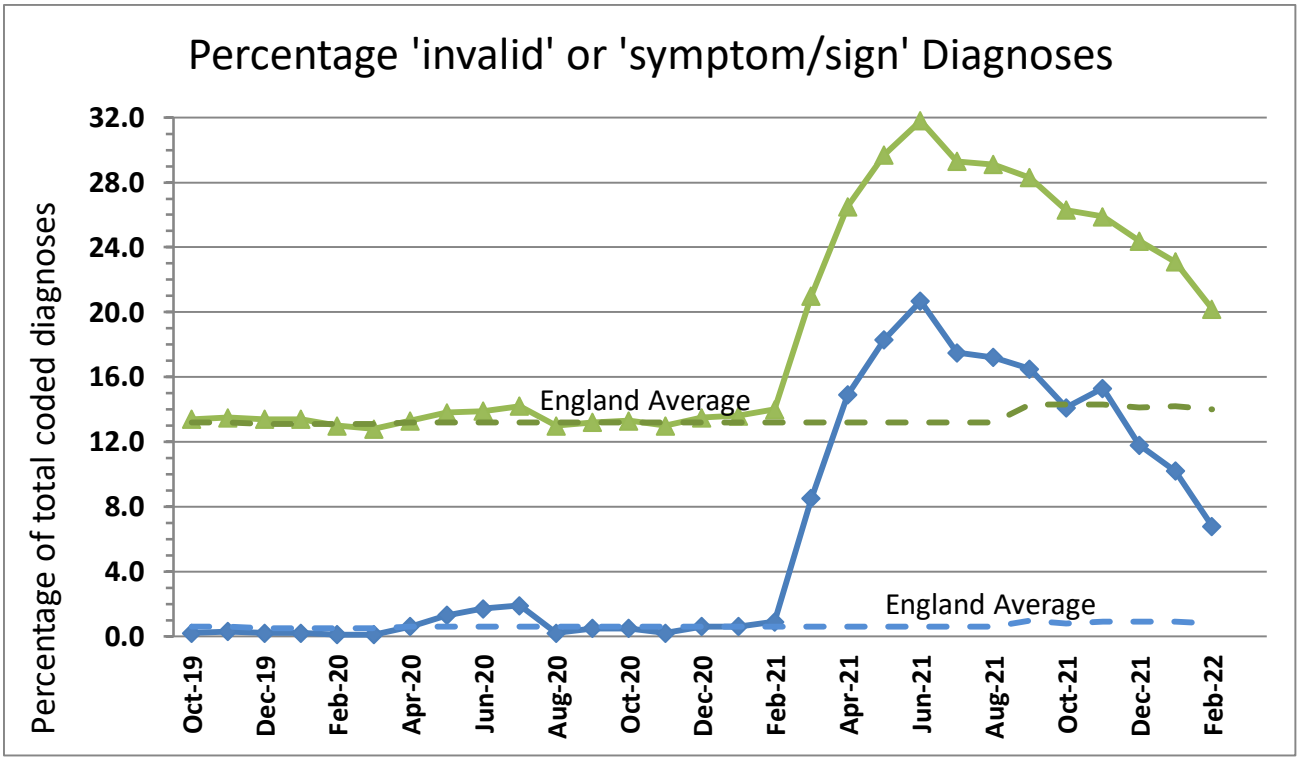
2.2 Percentage of provider spells with a primary diagnosis which is a symptom or sign: NHS Digital states "*This indicator presents the percentage of finished provider spells with a primary diagnosis which is a symptom or sign (identified by ICD-10 codes beginning with the letter 'R'). A high percentage of provider spells with a primary diagnosis which is a symptom or sign compared to other similar trusts may indicate problems with data quality or timely diagnosis of patients*".

DCH has recently had a very high but reducing number of spells with a primary diagnosis which is a symptom or sign – for example either no entry at all (uncoded), or 'chest pain' rather than 'myocardial infarction' – at 31.8% for June 2021 but improving progressively since then to a latest figure of 20.2% for February 202. The England average is around 13%, and the increase seen in DCH data is largely due to uncoded cases which therefore have no recorded diagnosis. Such uncoded in-patient 'spells' are attributed a very low risk of death, since a symptom or sign only, does not suggest a life-threatening illness. This significantly reduces our expected number of deaths and hence increases the SHMI value.

2.3 Percentage of provider spells with an invalid primary diagnosis code: NHS Digital states "*This indicator presents the percentage of finished provider spells with an invalid primary diagnosis code*

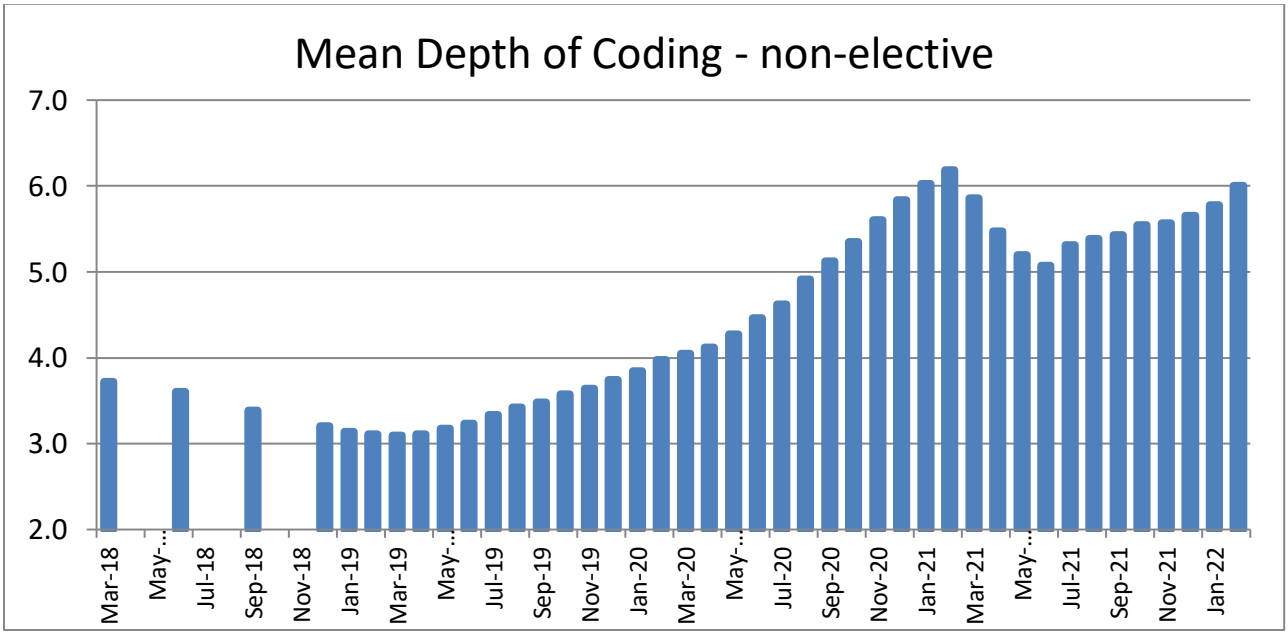
(identified as those spells where the primary diagnosis is given by the ICD-10 code R69X). A high percentage of provider spells with an invalid primary diagnosis code compared to other trusts may indicate a data quality problem."

This metric is a subgroup of 2.2 above. A 'spell' is a continuous period of in-patient care. The graph below shows the change in these two metrics of coding accuracy over the past 30 months:



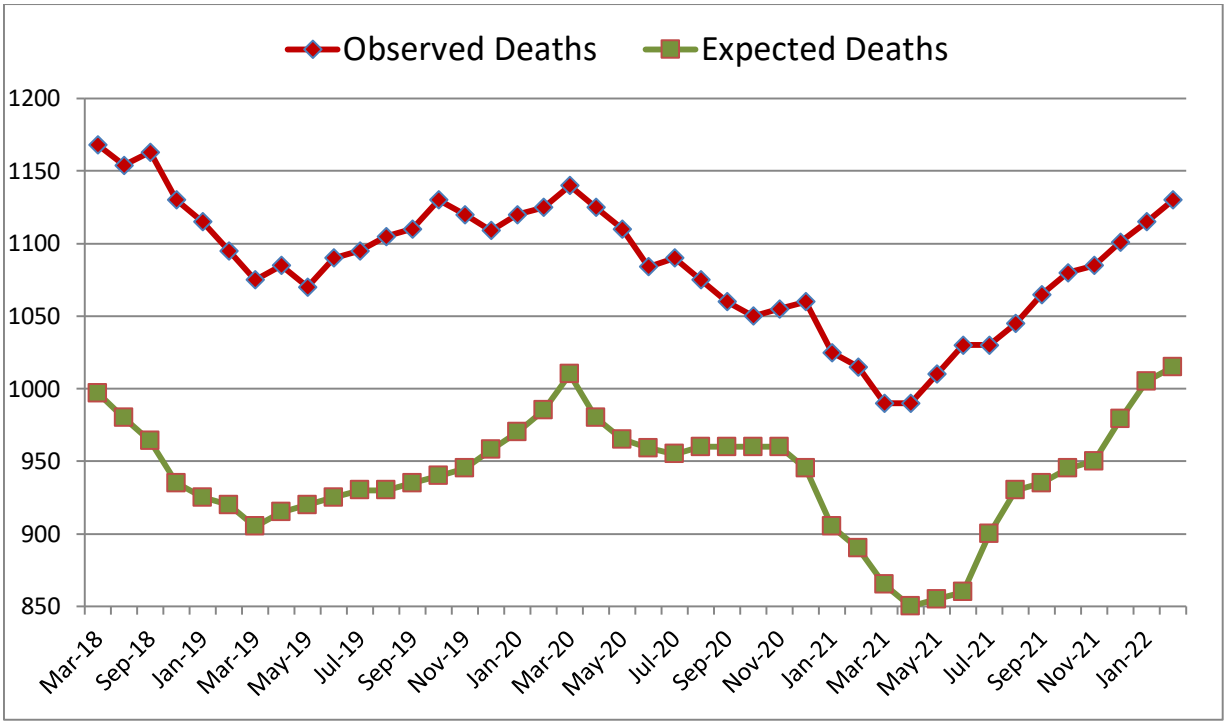
2.4 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts.*"

DCH's depth of coding had been improving steadily up to February 2021 (see graph below), the fell but is now improving and this almost certainly reflects the same backlog problem in the coding department.



2.5 Expected Deaths (based on diagnoses across all admissions per rolling 12 months):

The chart below shows observed and expected deaths over the past 3 years (rolling years from March 18 to February 22), and whilst both observed (actual) and expected deaths have increased (as total number of in-patients increases post covid-19), the expected deaths have increased faster as a result of partial recovery of coding practice, thereby improving the SHMI ratio.



2.6 Communication with NHS Digital:

From: CLINICAL INDICATORS, Hscic (NHS DIGITAL) <clinical.indicators@nhs.net>
02/08/2022

Good morning Alastair,

Thank you for your query. The HES data that you have submitted will be used in the 'Annual Refresh' HES data, which is referred to as M14. This hasn't yet been released so we are still using M13 data for the 2021/22 financial year. The Annual Refresh data for the financial year 2021/22 will be released on the 22nd September 2022, and therefore will impact the October SHMI publication release.

I hope this helps. If you have any further questions, please let me know and I will be happy to help.

Best wishes,
Emily

Emily Davison
Higher Information Analyst
Pronouns: she/her
clinical.indicators@nhs.net

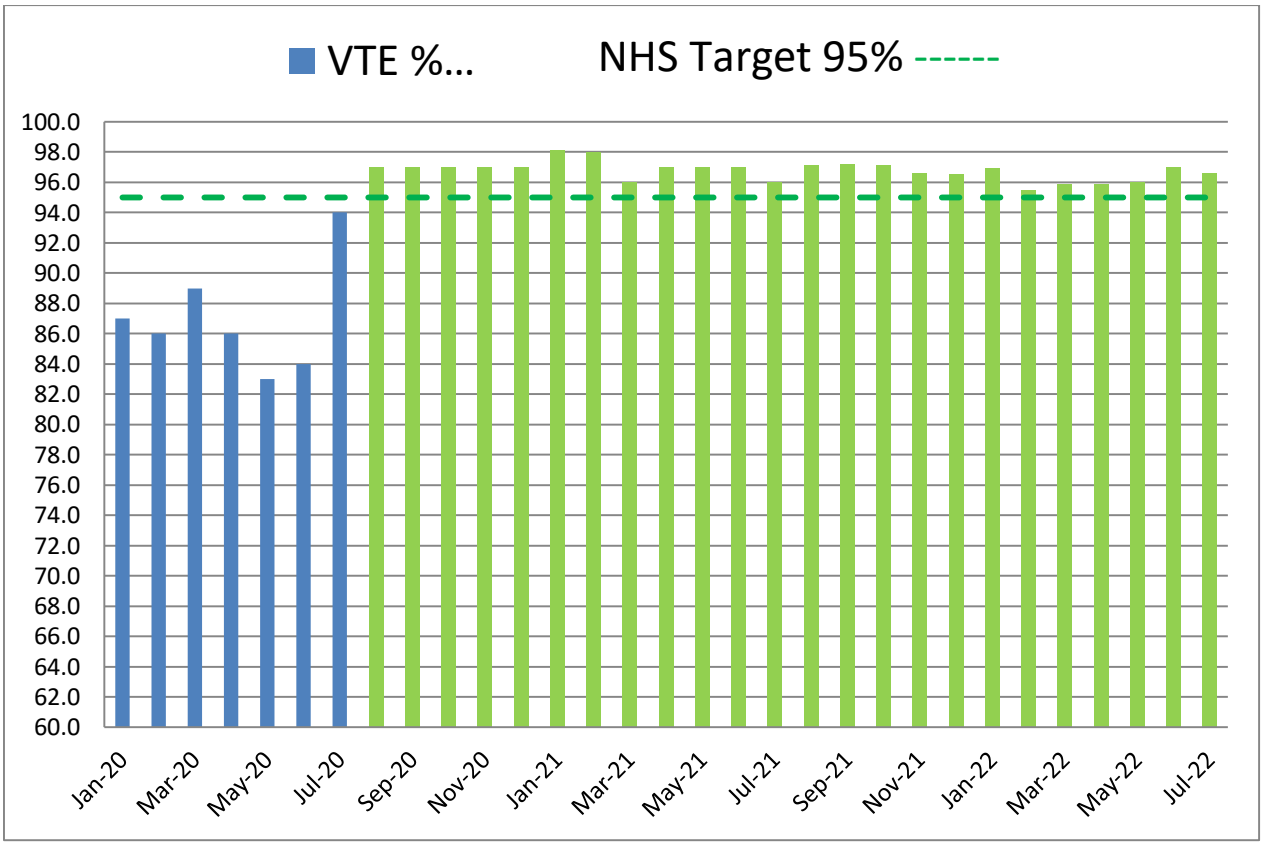
NHS Digital

3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care and it continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies which report on Trusts' individual performance. However much of this data has also been interrupted by covid-19 and has not yet caught up again.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

DCH VTE risk assessment recording reached 97% in August 2020 with the introduction of a more accurate reporting system, and after a process of data cleansing which removed a number of duplicate reports in Surgery it is clear that the Trust is now achieving the required standard. Dr Aruna Arjunan has taken over as chair of the VTE Group and is auditing compliance with the VTE prophylaxis policy which has been recently revised.

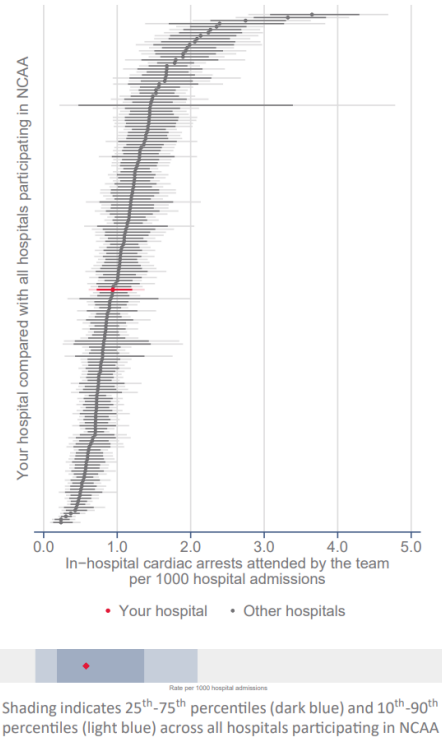


3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH including data from January 2022 to March 2022 was published on 17/06/2022. A total of 16 cardiac arrest calls were recorded for this latest quarter, giving a total of 62 for the year to April 2022.

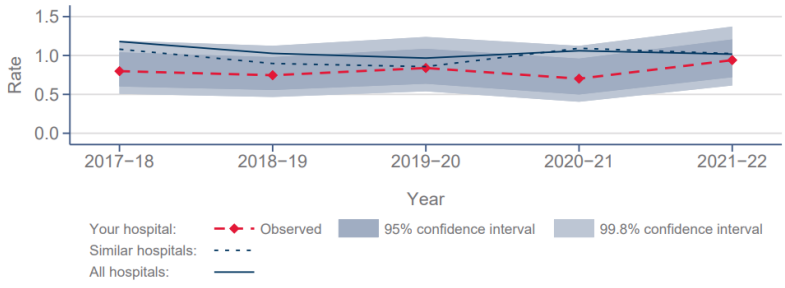
The graph below represents the number of in-hospital cardiac arrests attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower on the chart is better. The table to the right gives more detail by quarter year, and the graph below it summarises the past 5 years.

Rate of cardiac arrests per 1000 hospital admissions



Shading indicates 25th-75th percentiles (dark blue) and 10th-90th percentiles (light blue) across all hospitals participating in NCAA

	Hospital admissions	Eligible team visits	Rate per 1000 hospital admissions	95% confidence interval	99.8% confidence interval
Quarter 1	16897	23	1.36	(0.86, 2.04)	(0.65, 2.49)
Quarter 2	16736	10	0.60	(0.29, 1.10)	(0.18, 1.44)
Quarter 3	16623	13	0.78	(0.42, 1.34)	(0.28, 1.71)
Quarter 4	15677	16	1.02	(0.58, 1.66)	(0.41, 2.08)
Full year	65933	62	0.94	(0.72, 1.21)	(0.61, 1.37)



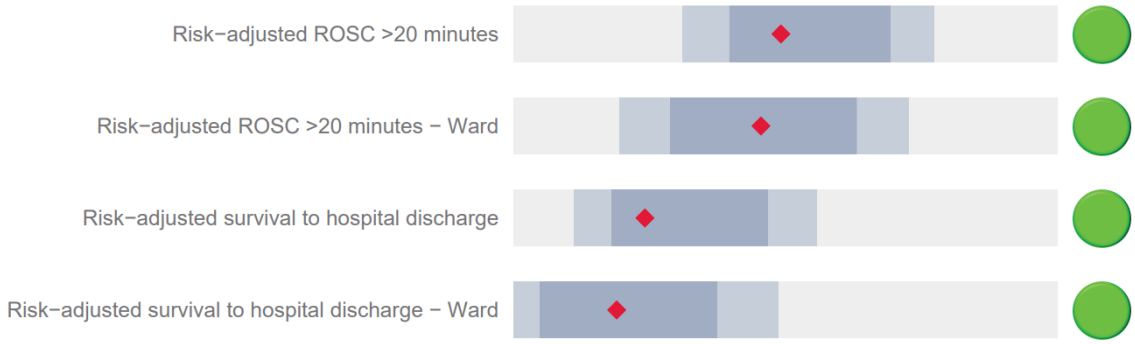
Definition

- Hospital admissions: Total includes elective, non-elective, day cases, babies born in your hospital and neonates
- Eligible team visits: All reported in-hospital cardiac arrests attended by the team
- Observed rate: The total number of cardiac arrests attended by the team divided by the total number of admissions to your hospital multiplied by 1000 to give a rate per 1000 hospital admissions
- Confidence interval: Reflects the degree of uncertainty surrounding your observed rate, given the total number of admissions to your hospital

©Resuscitation Council (UK) & ICNARC

The graph below shows two outcome measures:
a) Return of Spontaneous Circulation (a measure of resuscitation effectiveness) and
b) Survival to Discharge.
These and all other measures in the report get a 'green' indicator for the 12 month period (Q1 to Q4 2021/22).

Risk-adjusted outcomes: Dashboard



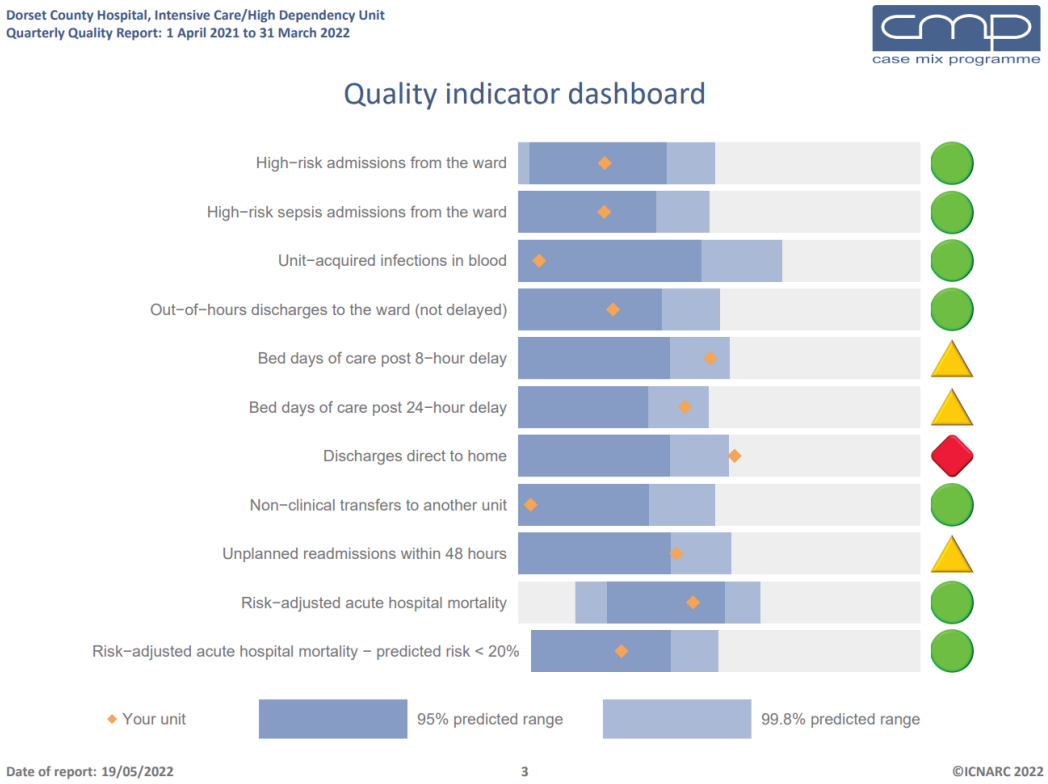
3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. It has been announced that data collection will restart in Spring 2022 for publication in Summer next year.

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

The results suggest that patients admitted to DCH in 2018/19 tended to be more ill than the national average but had a lower death rate and shorter length of stay, with fewer readmissions.

3.3 ICNARC Intensive Care survival latest data published 19 May 2022; n = 640 patients.
The amber and red indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home. This is an indicator of DCH bed pressures.

Unplanned readmissions will be audited to provide a detailed analysis.

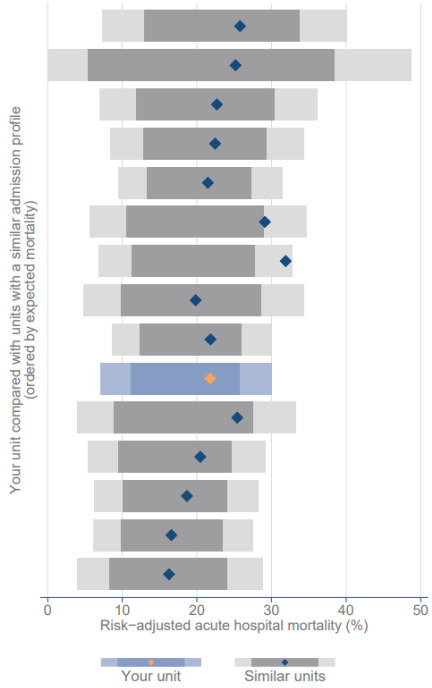


The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit, Q1 to Q4 2021/22. They compare observed and expected death rates in a similar fashion to SHMI.

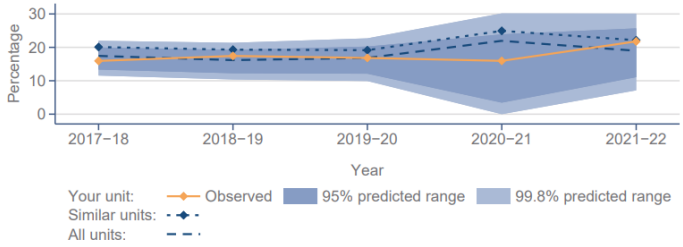
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2021 to 31 March 2022

case mix programme

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range
Quarter 1	145	136	14.7	15.5	(9.3, 21.5)	(6.3, 25.4)
Quarter 2	157	153	24.8	18.8	(7.6, 29.6)	(2.0, 36.5)
Quarter 3	178	166	25.9	20.6	(8.8, 31.9)	(2.8, 39.2)
Quarter 4	160	142	20.4	18.3	(10.4, 25.9)	(6.5, 30.8)
Full year	640	597	21.8	18.5	(11.1, 25.7)	(7.1, 30.1)



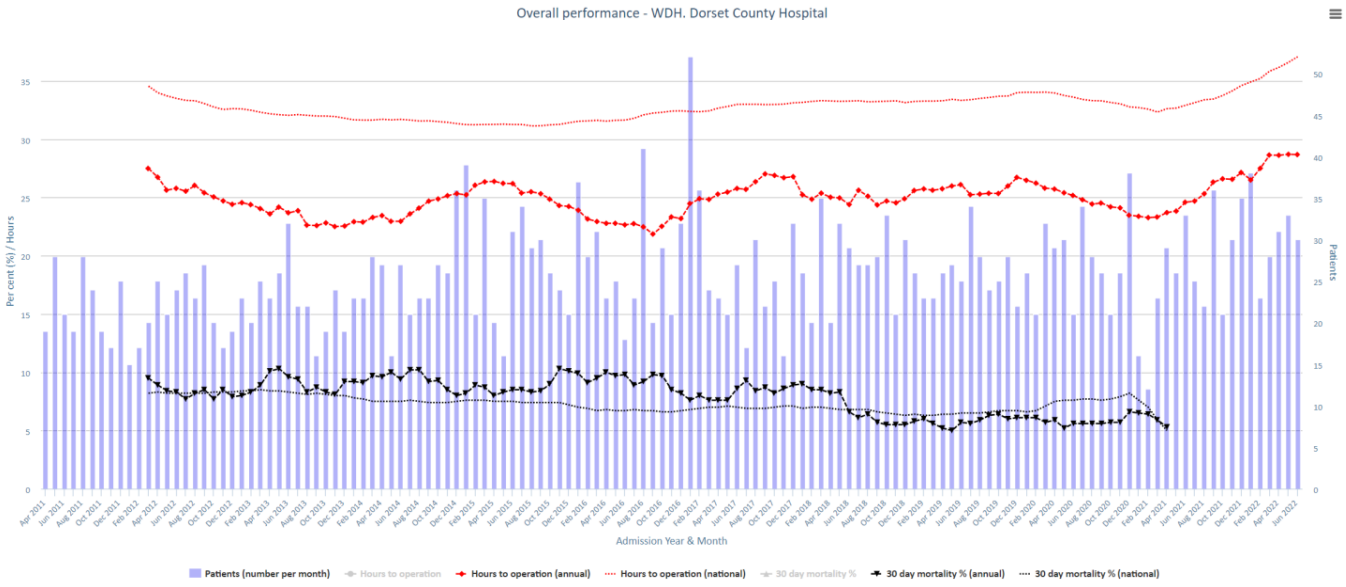
Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC$_{H-2018}$ model for eligible admissions to your unit
- Predicted range: We expect a unit’s observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Date of report: 19/05/2022 13 ©ICNARC 2022

These results are within the expected range and have improved slightly compared to the last quarter.

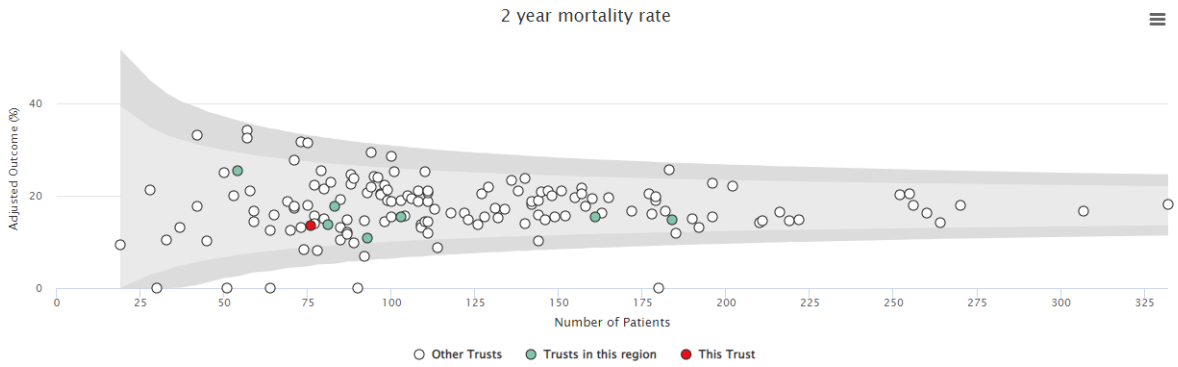
3.5 National Hip Fracture database to April 2021. Mortality data has apparently been delayed by contract negotiations with NHS Digital, and therefore this report only adds 2 months to the previous data which is now over 12 months in arrears.



The latest national average annualised mortality for hip fracture is 5.0%, with DCH’s annualised mortality at 5.3% to April 2021 (latest available data). ‘Hours to operation’ remains significantly better than the national average for Q1 (28.6 vs 35.8 hours).

3.6 National Bowel Cancer Annual audit

No new data has been published for the year 2019/20 since the Q3 report. The graph below shows the latest available 2 year survival data for patients admitted in financial year 2019/20, compared to all other NHS Trusts, with other Wessex Trusts in green.



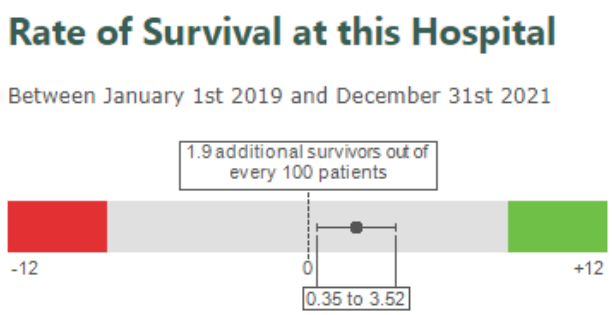
Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	76	13.5%	15.9%
Other trusts within the region: Wessex			
Hampshire Hospitals NHS Foundation Trust - Basingstoke and North Hampshire Hospital	83	17.7%	14.2%
Hampshire Hospitals NHS Foundation Trust - Royal Hampshire County Hospital	81	13.7%	11.6%
Isle of Wight NHS Trust	54	25.5%	20.8%
Portsmouth Hospitals NHS Trust	184	14.7%	11.6%
University Hospital Southampton NHS Foundation Trust	161	15.4%	14.9%
Poole Hospital NHS Foundation Trust	93	10.8%	13.8%

3.7 Getting it Right First Time; reviews in Qtr 1

No GIRFT reviews have taken place in Qtr 1

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. No new data has been published since the previous Q3 Learning from Deaths report. The data below is therefore unchanged and reports up to December 2021 only.



Rate of Survival Breakdown at this Hospital

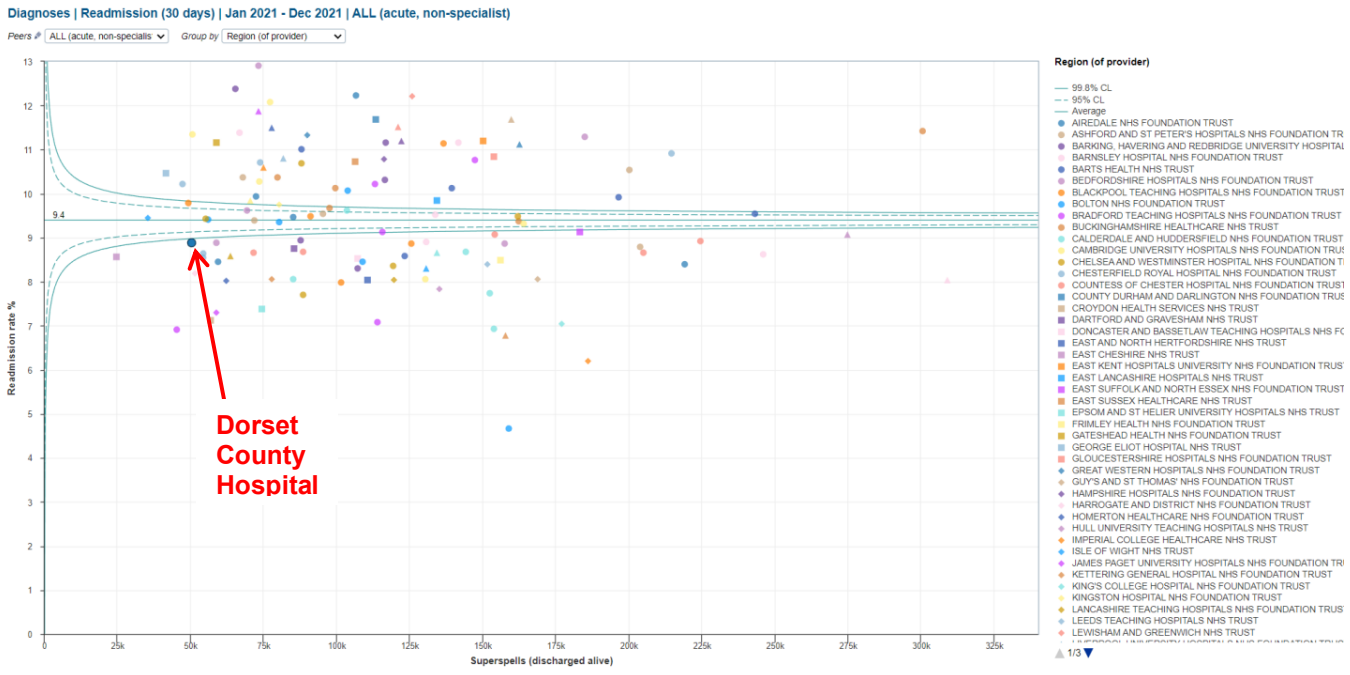
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	518	508	514	1.1	0.8
90 - 95	190	176	177	0.4	0.1
80 - 90	112	95	102	5.4	0.5
65 - 80	46	34	33	-2.2	-0.1
45 - 65	15	8	14	34.3	0.8
25 - 45	4	1	2	10.4	0.2
0 - 25	4	0	0	-12.9	-0.2
Total	**889**	**825**	**842**	**1.9**	**1.9**

Unexpected deaths in minor/moderate injury
Usually due to poor management of co-morbidity and/or complications

Unexpected survivors with more serious injury
Usually indicates good initial resusitation and the treatment of head injury in Neurological Centres

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors. In this data there were 17 more survivors than expected.

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



A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However, DCH's readmission rate continues to be significantly lower than the average of other acute Trusts.

3.10 Dr Foster Safety Dashboard

This dashboard has been temporarily withdrawn by Dr. Foster, but will apparently be reinstated later this year.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:

a) Poor quality of some admission clerking notes, particularly in surgery - the hospital clerking proforma has been revised, and the continuation note paper has had reminder watermarks added to remind staff to date, time, print name/GMC no. The introduction of the 'AGYLE' electronic patient record software occurred in the Emergency Dept. at the end of Q4 and, as this is rolled out across the Trust, it will be fully auditable and replace written records. This will solve many of the legibility and quality issues that exist with written records. UHD are now considering adopting AGYLE for their A&E department, creating a single software system across the Dorset Acute Trusts and based at DCH.

b) Morbidity and Mortality meetings - standardization and governance (see next item).

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Urology dates are to be confirmed – data not available at time of writing.

Specialty	Contact	April	May	June	July	Aug	Sep
Cardiology	Helen Dell	12/04/22	24/05/22		05/07/22		
Renal	Kathleen O'Neill	04/2022	x	29/06/22	27/07/22		
Vascular	James Metcalfe						
Diabetes							
Oncology	Abi Orchard		20/05/22	17/06/22	15/07/22	19/08/22	
Haematology	Sarah Attfield, Jill McCormack						
ED &Acute Medicine	Andy Brett & James Ewer			16/06/22			
Respiratory (Quarterly M+M)	Marianne Docherty	26/04/22	24/05/22	28/06/22	26/07/22	23/08/22	27/09/22
Elderly Care & Stroke	James Richards Harold Proschel	X	13/05/22				

Specialty	July	August	September	October	November	December
Anaesthetics						
Gastroenterology	6th July 2022	3RD August 2022	7th September 2022	5th October 2022	2nd November 2022	7th December 2022
Breast Surgery	Hosted by YDH – Checking on future dates					
General Surgery + Colorectal	8th July 2022	5th August 2022	2nd and 30th September 2022	28th October 2022	25th November 2022	23rd December 2022
Orthopaedics	8th July 2022	5th August 2022	2nd September 2022			
Perinatal	27th July 2022	24th August 2022	21st September 2022	19th October 2022	23rd November 2022	TBC
Urology						
ENT	15th July 2022	26TH August 2022	23rd September 2022	TBC	TBC	TBC

6.0 LEARNING FROM CORONER'S INQUESTS Q1

DCH has been notified of 14 new Coroner's inquests being opened in the period April 2022 – June 2022.

7 inquests were held during Quarter 1. 3 inquests were heard as Documentary hearings, not requiring DCH attendance. 2 required the clinician to attend Court in person. 2 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 56 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 1 pre-inquest review was listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. The coroner has requested from May 2022 that witnesses attend the court room at the Town Hall, Bournemouth in person. Authority will be required, if we wish the clinician to attend remotely.

7.0 LEARNING FROM CLAIMS Q1

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs.

Claims pattern this Quarter:

New potential claims	12
Disclosed patient records	10
Formal claims	9 clinical negligence, 0 employee claim
Settled claims	3 clinical negligence, 0 employee claim
Closed - no damages	4 clinical negligence, 0 employee claim

8.0 SUMMARY

SHMI is expected to improve in the coming months since the backlog of uncoded notes has been cleared, and updated HES data for 2021/22 was submitted to NHS Digital by the deadline of 19th May 2022. However this will not change previously published figures which will remain on record although they are known to be inaccurate. The 5 month SHMI publishing delay means that the DCH SHMI will not accurately reflect in-patient activity until October 2022 at the earliest (see email from NHS Digital above).

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although several previously regular national mortality reports are themselves having difficulty in producing timely data. In particular TARN, ICNARC and NCAA data continue to be reassuring since unexpected deaths would be likely to show up first in these acute care audits.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Meeting Title:	Board of Directors
Date of Meeting:	28 September 2022
Document Title:	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Apr 2022 – Jun 2022)**
Responsible Director:	Chief Medical Officer
Author:	Kyle Mitchell, Guardian of Safe Working

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	22 August 2022	Noted and approved.

Purpose of the Paper	The production of a quarterly Guardian of Safe Working (GoSW) report to the Board is a requirement of the 2016 Junior Doctor Contract. The report is also shared with the Local Negotiating Committee for Medical and Dental staff.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	A summary of key issues relating to safe working hours and rota gaps for Junior Doctors in training for quarter 1 (2022/2023)							
Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the GoSW paper.							

Governance and Compliance Obligations

Legal / Regulatory	Y	
Financial	Y	
Impacts Strategic Objectives?	Y	
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Title of Meeting	**People and Culture Committee**
Date of Meeting	**22 August 2022**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (April 2022 – June 2022)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Exception Reports have been submitted as relatively consistent (and low) rates across the first quarter since their inception.
- Junior Doctor and Educational Supervisor engagement remains excellent.
- On two occasions in this quarter, Exception Reports were escalated as being of Immediate Safety Concerns and there was prompt escalation and engagement from divisional leadership. One occasion in particular really exemplifies how Exception Reports can be used to escalate Junior Doctor concerns and prevent a culture of acceptance of unsafe working.
- The Guardian raises no issues relating to safe working of junior doctors during this quarter.

2. Introduction

All eligible doctors in training at the Trust between October and December 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.

The provision of quarterly report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

3. High level data

Number of training post (total):	188
Number of doctors in training post (total):	163.4
Annual average vacancy rate among this staff group:	18.6

Exception reports

Exception reports by department				
Specialty	No. exceptions carried over from last report	**No. exceptions raised**	No. exceptions closed	No. exceptions outstanding
Respiratory Medicine	*3*	**7 (1 ISC)**	10	0
Geriatric medicine	*3*	**7**	9	1
Cardiology	*0*	**6**	6	0
Obs & Gynae	*1*	**5**	6	0
Acute Medicine	*0*	**4 (1 ISC)**	2	2
Renal Medicine	*0*	**3**	3	0
Accident & Emergency	*0*	**2**	2	0
General Medicine	*7*	**1**	7	1
T&O	*5*	**0**	5	0
General Surgery	*2*	**0**	2	0
Total	*21*	**35**	52	4

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	13	11	22	2
FY2	0	12	12	0
CT2	0	4	4	0
ST1	8	8	14	2
Total	21	35	52	4

4. Work schedule reviews

Upon the submission of an Exception Report that suggests a mismatch between a junior doctor's work schedule and the actual clinical demands required in that post, it is the responsibility of that doctor's educational supervisor to trigger a *Level 1 (Work Schedule) Review*. Example outcomes of such a review include no requirement for change, a prospective requirement to adjust existing work schedules, or even institutional change. The Exception Report is closed at Level 1 if the junior doctor and educational supervisor agree an outcome, or escalated to *Level 2 Review* (with involvement of Guardian/DME and service management) if the junior doctor is not in agreement with the outcome. *Level 3 Review* constitutes a formal grievance hearing with HR representation.

Exception Reports taken to Level 1 Work Schedule Review

Specialty	F1
Acute Medicine	1

Rota	Total
AP 2021 F1 Medical 06/04/22 – 02/08/22	1

No work schedule reviews remain open, and none were escalated beyond Level 1.

5. Immediate Safety Concerns.

Two Exception Reports were highlighted as being of Immediate Safety Concern (ISC). Both were promptly escalated and scrutinized, and, where appropriate, there was active involvement of both Divisional Manager & Director.

One concern really exemplified effective speaking-up on the part of a Junior Doctor. The doctor felt that initial efforts to highly a problem of unsafe working (due to an inadequate doctor-to-patient ratio) was not adequately listened to or addressed. Having submitted an ISC, and with involvement of the Educational Supervisor, Foundation Program Director, and Guardian of Safe Working, not only were the issues around staffing levels acknowledged and addressed, but there has also been a discussion within the division (led by the Divisional Manager) about receptiveness to concerns.

6. Vacancies

Appendix 1 details all vacancies among the medical training grades during the previous quarter reported for each month, split by specialty and grade.

7. Fines

There were no fines levied during this period.

8. Issues arising

As previously described in the Guardians Annual Report 2022, social distancing has compromised the utility of the Junior Doctors' Forum (JDF). This has been exacerbated by the inability to appoint a senior trainee to the Chief Registrar role. Initial enthusiasm on the part of the Guardian regarding the trajectory for the pandemic, and the timescale to return to non-socially distanced formal JDF, have been shown to be unrealistic. Consequently, there is, for the time being, acceptance that the only viable way to provide a semblance of an effective JDF is in a socially distanced capacity using the lecture theatre and remote video links. The Doctors Mess committee have engaged in efforts to promote the JDF and encourage attendance.

9. Summary

An element of flexibility has always been part of how all doctors, including those in training, work. The 2016 Contract formalises arrangements to recognise, record and remunerate

this. The Guardian has identified no breaches in the Trust's compliance with these contractual arrangements and no specific concerns regarding the safe working components of the 2016 Junior Doctors Contract.

10. Recommendation

The Guardian asks the committee to note this report, consider it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract and approve its submission to the Trust Board.

APPENDICES

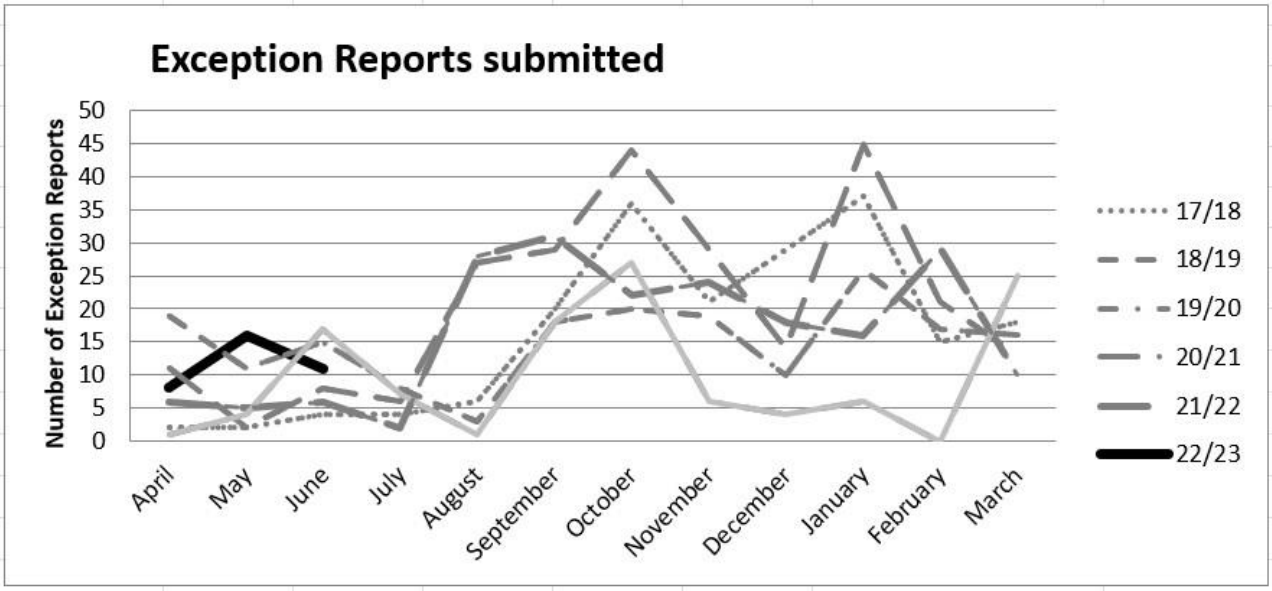
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

APRIL 2022 – JUNE 2022

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Apr 22	May 22	June 22	Average Q1
Paediatrics	ST3	Sept	0	0	0	0.0
Paediatrics	ST4+	Sept	0.4	0.4	0.4	0.4
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	0	0	0	0.0
ED	ST3+	Sept and Feb	1	1	1	1.0
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	1	1	1	1.0
Surgery	ST3+	Oct	1	1	1	1.0
Orthopaedics	ST3+	Sept	1	1	1	1.0
Anaesthetics	CT1/2	Aug	1.2	1.2	1.2	1.2
Anaesthetics	ST3+	Aug and Feb	0.4	0.4	0.4	0.4
Medicine	CT1/2	Aug	3.8	3.8	3.8	3.8
Medicine COE	ST3+	March	0.4	0.4	0.4	0.4
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	1	1	1	1.0
Medicine Resp	ST3+	Aug	1	1	1	1.0
Medicine Cardio	ST3+	Feb	1	1	1	1.0
Medicine Renal	ST3+	Aug	1	1	1	1.0
Haematology	ST3+	Sept	0	0	0	0.0
Med/Surg	FY1	Aug	1	1	1	1.0
Med/Surg	FY2	Aug	0	0	0	0.0
GPVTS	ST1	Aug & Feb	2	2	2	2.0
GPVTS	ST2	Aug & Feb	0.4	0.4	0.4	0.4
GPVTS	ST3	Aug & Feb	0	0	0	0.0
Orthodontics	ST3+	March	0	0	0	0.0
Total			18.6	18.6	18.6	18.6

Appendix 2 – Exception Report submission since introduction of the 2016 Contract



NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

THURSDAY 1 SEPTEMBER 2022

MINUTES

A meeting of the ICB Board was held at 10am on Thursday 1 September 2022 in the Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG

Present:
Jenni Douglas-Todd, ICB Chair (JDT)
Cecilia Bufton, ICB Non-Executive Member (CB)
Jonathon Carr- Brown, ICB Non-Executive Member (JCB)
Spencer Flower, Leader Dorset Council and ICB Local Authority Partner Member (West) (SF)
Nick Johnson, Interim Chief Executive Officer, Dorset County Hospital NHS Foundation Trust (NJ) (nominated Deputy for the NHS Provider Trust Partner Member (University Hospitals Dorset)) (virtual)
Paul Johnson, ICB Chief Medical Officer (PJ)
Drew Mellor, Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East) (DM)
Patricia Miller, ICB Chief Executive (PM)
Rob Morgan, ICB Chief Finance Officer (RM)
Vanessa Read, Interim Chief Nursing Officer (VR)
Dr Manish Tayal, Interim ICB Non-Executive Member (MT)
Kay Taylor, ICB Non-Executive Member (KT)
Dan Worsley, ICB Non-Executive Member (DW) (virtual)
Simone Yule, GP and ICB Primary Care Partner Member (virtual) (SY)

Invited Participants:
Neil Bacon, Chief Strategy and Transformation Officer (NB)
Sally Banister, Deputy Director Integration (SB) (part)
Louise Bate, Manager, Dorset Healthwatch (LB)
Sam Crowe, Director of Public Health (SC)
David Freeman, ICB Chief Commissioning Officer (DF)
Dawn Harvey, ICB Chief People Officer (DH) (part)
Leesa Harwood, Associate ICB Non-Executive Member (LH)
Dr Maggie Kirk, Medical Director, The HealthBus Trust (MK) (part)
Steph Lower, Corporate Office Manager (minute taker) (SL)
Stephen Slough, ICB Chief Digital Information Officer (SS)
Dean Spencer, Chief Operating Officer (DS)
Natalie Violet, Business Manager to the ICB Chief Executive (NV)
Dr Forbes Watson, Chair, Dorset GP Alliance (FW)

Action

1. Apologies

- John Beswick, ICB Non-Executive Member
- Dawn Dawson, Acting Chief Executive – Dorset Healthcare and ICB NHS Provider Trust Partner Member
- Siobhan Harrington, Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
- Matt Prosser, Chief Executive, Dorset Council - participant
- Andrew Rosser, Chief Finance Officer, SWASFT – participant
- Ben Sharland, GP and Primary Care Partner Member

The Chair advised that Dr F Watson had stepped down from his ICB Board non-executive member role having been appointed as Chair of the Dorset GP Alliance. It was planned this role would become one of the two ICB Board Primary Care Partner Members. In the interim, pending the completion of the required process, Dr Manish Tayal, Associate Non-Executive Member would undertake the role of Interim Non-Executive Member.

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of members present.

3. Declarations of Interest, Gifts or Hospitality

3.1 There were no Declarations of Interest made at the meeting and the Chair reminded

4. Minutes

4.1 The Part 1 minutes of the meeting held on 20 July 2022 were **approved** as a true record subject to the following amendment:-

- Paragraph 7.1.6 – to remove the word ‘no’ from the final sentence to read ‘….to ensure unmet needs were identified’. — SL

Louise Bate joined the meeting.

5. Matters Arising

DRAFT

5.1	8.5.3 – the Board directed that a post meeting note be provided regarding the provision of a more comprehensive response in relation to urgent appointments for the eating disorder service and how the statistics had declined over the last couple of quarters.	DF
5.2	8.7.3 – work was progressing regarding the future timings of annual reports being brought to the ICB Board.	
	Nick Johnson joined the meeting virtually.	
5.3	The Board **noted** the Report of the Chair on matters arising from the Part 1 minutes of the meeting held on 20 July 2022.	
6.	**Patient Story**	
6.1	The Chief Commissioning Officer introduced Dr Maggie Kirk, Medical Director for the HealthBus Trust, a charity that provided accessible and appropriate healthcare to people experiencing homelessness in Bournemouth and the surrounding areas. The Board received a video which showed the vital work and included hearing first-hand experience from people who had accessed the service.	
6.2	The integrated GP-led service was launched in December 2016 and had a close relationship with a multi-disciplinary team and other providers of homeless services. All had a common aim but there was a need to continue to become more joined up. The service also needed to be better integrated into the NHS to ensure it remained sustainable.	
6.3	One of the key priorities of the ICB would be to reduce health inequalities and the HealthBus was a good example of the great work already being done. Dr Kirk would liaise with the Director of Public Health accordingly regarding the development of the Integrated Care Partnership Strategy.	MK/SC
6.4	The average life expectancy in Dorset was 83 years but for the individuals needing the support of the HealthBus, the average was 43 for men and 47 years for women.	
6.5	Marginalised communities often felt invisible and as a result did not seek help when needed and there was a need to safeguard people from becoming homeless in the first place.	
	Simone Yule joined the meeting virtually.	

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6.6 Taking a cohort of individuals from August 2020-21 the positive effects of the specialist focused care could be seen with an increase in the engagement with specialist homeless care and a reduction in the use of Accident and Emergency.

Dawn Harvey joined the meeting.

6.7 Core20PLUS5 was a national NHS England and Improvement approach to support the reduction of health inequalities for the most deprived 20% of the national population at both national and system level and identified five focused clinical areas that required accelerated improvement. Alongside people experiencing homelessness, this would include groups such as vulnerable migrants, Gypsy, Roma and Traveller communities and sex workers. With a common thread between all groups, the Chief Clinical Commissioning Officer would link with Dr Kirk to gain her valuable insight. PJ

6.8 GP practices were experiencing issues with the number of registered patients experiencing homelessness adversely affecting their ability to meet their health improved targets under the Quality and Outcomes Framework (QOF) which was the performance part of the GP contract. It was agreed this issue be raised nationally. DF

6.9 Unresolved dental issues remained a challenge. The charity Dentaid supported the HealthBus with a mobile dental service every few months to provide access to essential dental treatment. One barrier in attracting more NHS dentists was the current national dental contract which was not fit for purpose. National negotiations were underway regarding changes to the contract. Recognising the commissioning for dental services would come to the ICB from April 2023, the Board directed a further paper be brought to a future meeting setting out the challenges and proposed actions. DF

6.10 The HealthBus service actively networked and there was good recognition from elsewhere that it was a tried and tested mechanism of delivering accessible healthcare.

6.11 There was a need to consider what could be done in the short-term to enable consistency in the service. There were already a number of practical next steps underway including a review of the provision around people experiencing homelessness with some planned Autumn workshops.

7. Chief Executive Officer's Report

7.1 The Chief Executive introduced her report.

7.2 The key issues were set out in detail in the report, but a summary of the highlights included:-

- The Operational Pressures Escalation Levels Framework (OPEL) method used by the NHS to measure hospital stress, demand and pressure was at a Level 4 for the Dorset system leaving organisations unable to deliver comprehensive care. The system was likely to remain at this level throughout the winter period.
- It was hoped implementation of a number of transformation programmes would support the prevention of unnecessary hospital admissions.
- There had been a reduction in emergency activity requiring hospital conveyancing which had assisted the South Western Ambulance Service NHS Foundation Trust (SWASFT) in delivering their quality standards. Work was ongoing to understand the reasons for the reduction.
- NHS England had published its winter resilience expectations. ICBs would be measured against a number of targets which would be incorporated into the Performance report for the next Finance and Performance Committee and ICB Board meetings.
- NHS England had published new statutory guidance on working with people and communities. The guidance aimed to support ICBs to meet their public involvement legal duties and the new 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources. A number of podcasts would be developed nationally to explain why the principle of co-design and community-driven services were important as opposed to consultation and would lead to a needs-based approach.
- The statutory guidance on Integrated Care Partnerships including the production of the Strategy had been published. Locally the work on the Dorset Integrated Care Strategy continued. Once a draft Strategy had been developed the strategic imperatives would be fed into the Health and Well-Being Board plans and development of the ICB 5-year joint plan with health partners. Running concurrently would be the development of the enabling plans, including the financial strategy which would need to align with the clinical and digital plans. It was recognised external support may be required for this broader system piece of work.

- The system was experiencing ongoing issues regarding access to the right mental health provision for children, young people and adults. A system-wide workshop was held recently with good engagement from all but a robust plan was needed for this crucial piece of work.
- There was concern regarding the effect of the cost-of-living crisis on health services and the impact for the Dorset population, not only during the winter period but in the medium term/long-term. Discussions were ongoing with the two local authorities to enable a joined-up approach and consideration was being given as to how to use health/local authority estate to create accessible warm spaces for people.
- The additional cost of the NHS pay awards 2022-23 had led to NHS England and the Department of Health and Social Care to reprioritize centrally held budget and there was a need to ensure an appropriate message be shared with the Dorset public regarding what services would be available within the fixed cost envelope.

7.3 The Board **noted** the Chief Executive Officer's report.

8. Items for Decision

8.1 Annual Governance Statement

8.1.1 The Interim Chief Nursing Officer introduced the Annual Governance Statement report.

8.1.2 The Statement covered the final three months of Dorset Clinical Commissioning Group to 30 June 2022. Due to the timescale for submission the Statement had come to the Board prior to the Risk and Audit Committee. If approved, the Statement would be taken to the September Risk and Audit Committee for completeness.

8.1.3 The narrative was based on a nationally mandated template so there was no content regarding the closedown of Dorset Clinical Commissioning Group and handover to the ICB. It was noted this would be included in the Annual Report and Accounts.

8.1.4 There were a number of minor spelling/formatting errors within the Annual Governance Statement and the Interim Chief Executive Officer, DCHFT would highlight these to the Interim Chief Nursing Officer. NJ

8.1.5 The Board **approved** the Annual Governance Statement.

9. Items for Noting

9.1 Quality Report

9.1.1 The Interim Chief Nursing Officer introduced the Quality Report.

9.1.2 The report format remained work in progress and would be reformatted to align more to the ICB's risks. Consideration was being given to a future joint report with the Chief Medical Officer.

9.1.3 A key focus of the system Quality Surveillance Group remained the pressures in urgent and emergency care. including an ongoing review of any potential harm due to delays created by the ongoing pressures.

9.1.4 The first Dorset case of a MRSA bloodstream infection in 2022-23 had been recorded. The root cause analysis did not identify any learning themes or lapses in care with the case being deemed unavoidable.

9.1.5 Delays in Initial Health Assessments for children continued with performance not reaching the required standard. Ongoing discussions were being held with the providers to improve the position.

9.1.6 Action plans were in place to improve mandatory safeguarding training compliance across all providers. This had been a repeated issue for a number of years. The improvement of services for children and young people would be a key priority for the ICS, particularly those who were vulnerable. All NHS providers were asked to prioritise this improvement and to ensure actions put in place were sustainable. There was no associated risk appetite and the ongoing training issues needed to be addressed as a priority.

9.1.7 In relation to ICB staff, training compliance was good. It was recognised some individuals would require a higher level of training than currently undertaken and this would be addressed.

9.1.8 It was anticipated there would be an increase in CQC inspections which had re-commenced post pandemic. Support would be offered to practices in preparation for this. There were several CQC inspections being undertaken elsewhere across the system and any lessons learned/knowledge would be shared.

9.1.9 Concern remained regarding the care sector and the availability of care packages both in the individual's own home and residential/nursing homes.

9.1.10 The new Patient Safety Incident Response Framework (PSIRF) had been launched and implementation work was underway.

9.1.11 It was planned to have an integrated Performance report that joined up the cause and effect of the four pillars of performance to enable an understanding of the consequences when certain areas are not delivered. This will set out the issue, action being taken, the proposed timeline and the impact. Further work was needed to access all the data required to enable production of a single report that could be aggregated for the different audiences.

9.1.12 Progress had been made regarding the University Hospitals NHS Foundation Trust (UHD) discharge summaries backlog however, a new risk has emerged regarding the completion of very old discharge summaries. UHD would explore a risk-based approach to reduce this risk with a review in early September including an agreed completion timescale.

9.1.13 The Board **noted** the Quality Report.

9.2 Performance Report

9.2.1 The Deputy Director (Integration) introduced the Performance Report.

9.2.2 The most significant issue affecting a wide range of metrics was the system flow with the number of "no criteria to reside" patients remaining high.

9.2.3 The Patient Administration System merger issues at UHD meant the elective metrics derived from the overall waiting list could not be relied upon. This created a significant risk that the overall position for Dorset could be inaccurate. The Board noted there did appear to be a reduction in duplicate records.

9.2.4 A focus remained on reducing long waiters. Action plans were in place and most 104-week waits had been addressed. As a helpful collaborative indicator, there was a suggestion that future reports contain information regarding mutual aid offered across Dorset and outside of Dorset. SB

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9.2.5 The diagnostics waiting list continued to reduce with 21% of patients waiting 6 weeks or more against a target of 1%. Dorset remained the best performing system in the South West.

9.2.6 Concern was raised regarding the continued reduction in the GP workforce versus increased demands including digital access. There was optimism regarding the long-term position with a record number of trainee GPs, but a need to enable the role to remain attractive to encourage individuals to stay once training was completed. However, there was a recognition that more needed to be done to attract GPs and retain them by making the role more attractive. The implementation of the Fuller review would counter some of this but not all.

9.2.7 More needed to be done as a system to address the broader workforce challenges and this would be taken forward by the Chief People Officer. To work effectively as a system there needed to be a joined-up approach with a single workforce across Dorset and joined up recruitment which would be more cost effective.

9.2.8 There needed to be clear public messaging regarding primary care waits for routine appointments to reset expectations.

9.2.9 In relation to the eating disorder service and Child and Adolescent Mental Health Services (CAMHS) service issues, there was a query whether it would be feasible to utilize the mental health schools' teams more effectively to support the wider mental health areas.

9.2.10 Many of the issues raised would need to be remitted to the relevant Committees and the Chief Executive Officer would consider how this could be taken forward.

9.2.11 The immediate priority was to ensure the system was able to manage the winter period safely and the ICB Executive Directors would be looking to agree a number of priority areas for focus until March 2023 whilst concurrently working on the more comprehensive long-term plans.

Sally Banister left the meeting.

9.2.12 The Board **noted** the Performance report.

9.3 Finance Report

9.3.1 The Chief Finance Officer introduced the Finance report.

9.3.2 By way of background, NHS Dorset had a financial allocation of £1.6Bn a year.

9.3.3 All ICBs nationally had been asked to submit a balanced financial plan for 2022-23. In doing this, Dorset ICB had identified financial risks of £88M including unidentified efficiencies of £42M. This would need to be managed in order to achieve a break-even position. The ICS had an ambitious efficiency programme for 2022-23 with the main workstream areas being agency costs, Covid-19 costs, elective care recovery/productivity and urgent and emergency care. It was noted NHS Dorset ICB was delivering proportionately more efficiencies than other ICBs in the South West region.

9.3.4 As at month 3 (June 2022) the ICS was reporting an £8.6M deficit against a break-even position, of which £5.9M related to NHS providers within the system.

9.3.5 The system capital funding plans submitted demonstrated a balanced plan except for the car park at DCHFT which did not currently have a funding source. Discussions with regional colleagues remained ongoing.

9.3.6 The Board noted that for the remainder of the current year, Bournemouth, Christchurch and Poole Council had taken a joint approach with the ICB in relation to funding adult and children social care with percentage contributions fixed at the beginning of the contract to more easily predict the year-end costs. The offer was made for a similar approach with Dorset Council.

9.3.7 The system financial position emphasized the need for better integrated working between partner organisations with an ‘open book’ process and sharing of information to enable the system to get into the right place.

9.3.8 The Board **noted** the Finance report.

9.4 Learning Disabilities Mortality Review (LeDeR) Annual Report 2021-22

9.4.1 The Interim Chief Nursing Officer introduced the LeDeR Annual Report 2021-22.

9.4.2 This was the third required Annual LeDeR report and the first following publication of the changes to the national policy.

9.4.3 In the past 12 months, there had been one grade 4 focused review. There had been no adverse impact on the outcome but there had been learning aspects from the review.

9.4.4 There were several recommendations and learning from the initial reviews in relation to aspiration pneumonia, end of life care planning and the use of Restore 2 (a physical deterioration and escalation tool designed to support care/nursing homes).

9.4.5 Reviews could only be undertaken if a notification was received, and work was ongoing to ensure the health and social care sector was familiar with the LeDeR process.

9.4.6 There was a query regarding the proportion of professionals within the Speech and Language Therapy team working in dysphagia (swallowing) and the associated capacity/access. The Interim Chief Nursing Officer agreed to provide further detail. VR

9.4.7 The Board **noted** the LeDeR Annual report 2021-22.

Sam Best joined the meeting virtually.

9.5 **Special Educational Needs and Disabilities (SEND) Update**

9.5.1 The Chief Commissioning Officer introduced the SEND Update.

9.5.2 The report highlighted the ongoing work with significant multi-factorial challenges to address. There were particular challenges within the Bournemouth, Christchurch and Poole Council area and the ongoing need to keep improvements moving within the Dorset Council area.

9.5.3 Discussions continued with the two local authorities to join up resources to help improve the service. There were a number of key areas of work including developing clearer system governance, developing effective partnerships and developing models of integrated commissioning.

9.5.4 There was a need to invest in early intervention to enable improvement on an individual's future well-being. Listening to families and carers regarding the patient's best interests and needs, which would help improve life expectancy, as would progressing the work on equality, diversity and inclusion (EDI) as a means to changing the perceptions of those with learning disabilities and the quality of their lives.

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9.5.5	The Board approved the change in timing of the next SEND annual report to May 2023.	SL
9.5.6	The Board **noted** the SEND update.	

10. Items for Consent

10.1 There were no items for consent.

11. Public Questions

11.1 There were no written questions from members of the public received prior to the meeting.

12. Any Other Business

12.1 There was no further business.

13. Date and Time of Next Meeting

13.1 The next meeting of the ICB Board would be held on Thursday 3 November 2022 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

14. Exclusion of the Public

To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

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