Council of Governors - Part 1 - 08/04/2024

Mon 08 April 2024, 14:00 - 17:00

Trust HQ Boardroom and MS Teams

Agenda

14:00 - 14:05
5 min

1. Formalities

Eiri Jones

- 1 DCH CoG Agenda 08 04 24 PART ONE.pdf (2 pages)
- 1a CoG Minutes 12 02 24 Part One.pdf (9 pages)
- 1b CoG Actions PART ONE from 12 02 24.pdf (1 pages)

14:05 - 14:10
5 min

2. Chair's Update

Eiri Jones

14:10 - 14:40
30 min

3. Chief Executive's Report

Nick Johnson

- 3. DCHFT Powerpoint Presentation CoG April 2024 Draft.pdf (24 pages)

14:40 - 14:55
15 min

4. Finance Report

Chris Hearn

- 4. CoG Finance Report to February 2024.pdf (5 pages)

14:55 - 15:05
10 min

5. Reflections on Recent Governor Meetings

5.1. Membership Development Committee

5.2. Joint Governors Joint Strategy Engagement Workshop

15:05 - 15:10
5 min

6. Jenny Horrabin Welcome

- 6. JH Bio.pdf (1 pages)

15:10 - 15:25
15 min

7. Governor Matters

15:25 - 15:40
15 min

Break

15:40 - 16:25
45 min

8. NED Update, Feedback and Accountability Session

8.1. Claire Lehman - Reflections on Quality Committee, next steps

8.2. Stuart Parsons - Risks relating to the forward strategy

16:25 - 16:35
10 min

9. Quality Priorities

Jo Howarth

- 9a. Front sheet Quality Priorities 2024_25.pdf (2 pages)
- 9b. Quality Priorities 2024_25.pdf (2 pages)

16:35 - 16:45
10 min

10. Leadership Competency Framework

Nicola Plumb

- 10a. CoG Leadership Competency Framework April 2024.pdf (1 pages)
- 10b. NHS England NHS leadership competency framework for board members.pdf (18 pages)

16:45 - 16:50
5 min

11. Governor Election Update

Trevor Hughes

16:50 - 16:55
5 min

12. Standing Item: Closer working with Dorset HealthCare update

Eiri Jones

16:55 - 17:00
5 min

13. Closing Remarks

Eiri Jones

17:00 - 17:00
0 min

14. Appendix: information pack

- Gov Information Pack contents page.pdf (1 pages)
- Escalation Report FPC Feb 2024.pdf (2 pages)
- Escalation Report FPC March 2024 CH AT.pdf (2 pages)
- Escalation Report PCC Feb 2024 MB.pdf (1 pages)
- Escalation Report PCC March 2024 EH.pdf (1 pages)
- Escalation Report QC Feb 2024.pdf (2 pages)
- Escalation Report QC March 2024 - JH.pdf (2 pages)
- Escalation Report RAC March 2024 - SP.pdf (2 pages)
- 18e. DCH Charitable Funds Committee - Escalation Report (20.3.24).pdf (2 pages)
- Escalation Report WTC February 2024.pdf (1 pages)

Council of Governors
2.00pm to 5.00pm, Monday 08 April 2024
at Board Room, Trust Headquarters, Dorset County Hospital
and via MS Teams

Part One Agenda – Open Meeting

1.	**Formalities**		Eiri Jones (Trust Deputy Chair), Chair	2.00-2.05
	a) Welcome **Apologies for Absence:** Matthew Bryant, David Clayton-Smith, Terri Lewis, Barbara Purnell	Verbal		
	b) Declarations of Interest	Verbal		
	c) Minutes of Council of Governors Part One Meeting 12 February 2024	Enclosure		
	d) Actions and Matters Arising from those Minutes	Enclosure		
2.	**Chair's Update**	Verbal	Chair	2.05-2.10
3.	**Chief Executive's Report** To receive	Presentation	Nick Johnson, Deputy Chief Executive Officer	2.10-2.40
4.	**Finance Report** To receive	Enclosure	Chris Hearn, Joint Chief Finance Officer	2.40-2.55
5.	**Reflections on recent Governor meetings:** • **Membership Development Committee** (5th March) • **Joint Governors Joint Strategy Engagement workshop** (7th March) **and next steps**	Verbal	Kathryn Harrison Chair Nick Johnson	2.55-3.05
6.	**Jenny Horrabin Welcome**	Verbal	Nick Johnson Jenny Horrabin	3.05-3.10
7.	**Governor Matters** a) Nursing apprenticeships with DHC b) Assurance around length of wait to access first clinic appointments To be covered in the CEO Report: c) Nil	Verbal	Jean-Pierre Lambert Judy Crabb	3.10-3.25
	Break 3.25-3.40			
8.	**NED Update, Feedback and Accountability Session**	Verbal/ Presentation /Questions	Claire Lehman Stuart Parsons	3.40-4.25

	• Claire Lehman – Reflections on Quality Committee, next steps • Stuart Parsons – Risks relating to the forward strategy			
9.	**Quality Priorities**	Enclosure	Jo Howarth	4.25-4.35
10.	**Leadership Competency Framework**	Enclosure	Nicola Plumb	4.35-4.45
11.	**Governor Election Update**	Verbal	Trevor Hughes	4.45-4.50
12.	**Standing Item: Closer working with Dorset HealthCare update**	Verbal	Chair	4.50-4.55
13.	**Chair's Closing Remarks and Date of Next Meetings:** • Joint NED/COG workshop • 2nd May 2024, 1pm to 5pm • Council of Governors, 2pm on 10 June 2024		Chair	4.55-5.00
14.	**Meeting Closes**			5.00

Appended to the papers is an information pack for the Governors.

Council of Governors Meeting: Part One
Dorset County Hospital NHS Foundation Trust

Minutes of the meeting of Monday 12 February 2024
in Trust HQ Board Room and via MS Teams

Present: David Clayton-Smith (Chair)

Public Governors
Sarah Carney (West Dorset) (virtual)
Kathryn Harrison (West Dorset) (Lead Governor)
Steve Hussey (West Dorset)
Stephen Mason (Weymouth and Portland) (virtual)
Maurice Perks (North Dorset) (virtual)
Kevin Perry (West Dorset) (virtual)
David Taylor (West Dorset)
Lynn Taylor (North Dorset) (virtual)

Staff Governors
Jack Welch (virtual)

Appointed Governors
Tony Alford (Dorset Council)
Jean-Pierre Lambert (Weldmar)
Barbara Purnell (Friends of DCH)

In Attendance: Claire Abraham (Deputy Chief Finance Officer) (virtual) (item CoG23/092)
Abi Baker (Deputy Trust Secretary) (minutes)
Margaret Blankson (Non-Executive Director)
Jo Howarth (Chief Nursing Officer)
Alastair Hutchison (Chief Medical Officer)
Nicola Plumb (Chief People Officer) (virtual)
Anita Thomas (Chief Operating Officer)
Dave Underwood (Non-Executive Director)
Bea Webster (Admin Support) (up to CoG23/094)

Apologies: Simon Bishop (East Dorset)
Matthew Bryant (Chief Executive Officer)
Judy Crabb (West Dorset)
Chris Hearn (Chief Finance Officer)
Trevor Hughes (Head of Corporate Governance)

CoG23/086 **Welcome and Apologies for Absence**
The Chair welcomed everyone to the meeting, both in person and virtually. There were apologies from Simon Bishop, Matthew Bryant, Judy Crabb, Chris Hearn, and Trevor Hughes.

CoG23/087 **Declarations of Interest**
The Chair reminded governors that they were free to raise declarations of interest at any point in the meeting should it be required.

CoG23/088 **Minutes of the Previous Meeting held on 13 November 2023**
The minutes of the previous meeting held on 13 November 2023 were accepted as a true and accurate record.

CoG23/089 **Actions and Matters Arising**

The action log was approved, noting the updates provided in the action log.

SC noted that a question she had raised at the last meeting had only been partially answered. She reiterated her question about the closure of Poole emergency department (ED) and maternity unit, and whether an impact assessment had been undertaken. JH confirmed that an impact assessment had been completed but noted that mothers had a choice over where they received care. She further noted that Poole maternity unit remained open, but it was Bournemouth that had closed. There were two maternity units in the county and had been for some time. With regards to the closure of the Poole ED AT outlined that a working group was assessing the impacts of this and it was yet to be decided what would replace the Poole service.

CoG23/090 **Chair's Update**

DCS provided an update on his activities since the last meeting, highlighting the following:

- NHS England Regional Director for the South West, Elizabeth O'Mahony, and Medical Director, Michael Marsh, had visited the Trust shortly after the last meeting where they heard about the developments in the ED and critical care unit. They also met with staff and discussed staff wellbeing. Michael Marsh had been complimentary about the open dialogue of medical staff at the Trust.
- Induction meetings with newly elected Governors
- DCS and MBr had presented the long-service awards for members of staff who had worked at the Trust for 25 years or more. They had also delivered mince pies around the hospital prior to Christmas.
- The Chairs and Chief Executives (CEOs) within the Dorset system met on a regular basis, with a particular focus at present on finances within the system. These meetings offered the opportunity to work closely and collaboratively with system colleagues.
- A three-way Board meeting was scheduled for 21st February with Board members of the Trust (DCH), Dorset HealthCare (DHC) and University Hospitals Dorset (UHD). This meeting would offer an opportunity for Board members to start to work together and to discuss provider collaboratives.
- A 'spade in the ground' ceremony at DHC had taken place on 15th December for their New Hospital Programme, with Lord Markham in attendance. DCS had updated Lord Markham on the New Hospital Programme at this Trust and the developments in the ED.
- DCS had met with the chairs of the network of friends, who were keen to support DCH and DHC with work around the Trust membership and the public.
- DCS had presented a paper to the Integrated Care Partnership (ICP) on the topic of creative health. This had been positively received and DCS would be assembling a small group across the system to begin this work.
- A Joint Board meeting was scheduled for DCH and DHC on 6th March where an update on the development of the joint strategy would be heard, which would ultimately help shape the NEDs objectives. DCS thanked those governors who had contributed to the development so far.

CoG23/091 **Chief Executive's Report Q3**

AH presented the CEO report in MBr's absence. AH shared a presentation to the Council, which would be circulated following the meeting.

The Trust and DHC had appointed three substantive joint executive roles in recent weeks, with the roles commencing on 1st February:

- Nick Johnson was now the Joint Director for Strategy, Transformation and Partnerships
- Chris Hearn was now the Joint Chief Financial Officer
- Nicola Plumb was now the Joint Chief People Officer

The Dorset and Somerset Integrated Care Boards (ICBs) were now working on a joint approach to commissioning a new electronic patient record (EPR). Joint leadership arrangements for the project had been agreed and consideration was being given to whether this joint approach could meet the needs of both Dorset and Somerset. The team had recently visited Manchester which had installed an EPR system called EPIC across 10 hospital sites in September 2022. The reception to the system had been positive, although it clearly involved a great deal of learning, preparation, and development which continued well after installation.

Dorset ICS have completed the first pilot working with Portland community and neighbourhood teams as part of the place-based community approach to plan services needed at community level with a focus on proactive and preventative health. As part of the pilot the ICS held an event on Portland on 1 December 2023 to showcase feedback and provide the opportunity for additional comments. A co-production event with local people, communities and other stakeholders is being planned for February 2024 and a one year on event is planned with Island Community Action and residents of Portland in April 2024. It was hoped this would provide a model for other areas of Dorset in the future. SC requested that governors be given the opportunity to be involved in this work, such as the events in February and April. AH undertook to ask NJ if this was possible.

Action: AH

KH asked what the future was of the Dorset Care Record (DCR), particularly the patient portal element, and asked whether this could be seen as another digital system that had not worked. The meeting heard that the DCR had been an attempt to align primary and secondary care health records and in this sense had been very successful, acting as a bridge between two systems that did not communicate. The patient portal was an important part of the DCR, but if a new EPR was developed with Somerset it was likely this would eventually disappear and be replaced by a similar patient portal in the new EPR system.

Asked about the timescale for implementing the EPR system, AH advised that a decision on whether a joint EPR system would be progressed was to be made by the end of the financial year, this would be followed by a tendering process and at least 12 months preparation for installation. As such any new system would not be implemented until approximately the end of 2026. The public and governors would be engaged with in the development process.

AH outlined the two key system priorities; reducing waiting lists and doing so within the restricted financial climate the NHS was facing.

<u>Operational Performance</u>

AT provided an update on the Trust's operational performance, noting:

- The Trust was working towards a plan of no patients exceeding 52 weeks from referral to treatment (RTT) by the end of the next financial year. However, this was behind plan due to the sustained industrial action this year.
- Ambition to reach 76% of patients in ED being seen and discharged within 4 hours of admission had been consistently met this financial year
- Ambulance handover delays have been challenged, but the Trust remains one of the best performing in the region with an average handover of half

an hour. Patients presenting at ED by any method (e.g. walk-in or ambulance) were assessed for acuity and admitted in order of clinical need.
- Significant increase in ED demand in year
- Impact of industrial action on meeting trajectories for elective work
- Growing demand in a number of specialties, particularly in cancer. Elective patients were seen in priority order, then chronological order.
- Positive work ongoing to meet the 62-day standard for cancer care, within the context of a small surge of patients in December. AT, JH and AH were working hard to address the quality impact of those waits.
- The Trust was struggling with echocardiograms; this reflected a national picture with the limited cardiac physiologist workforce. This reduced workforce was looking at how to provide the most effective care to patients.

AT provided further clarification around the work ongoing to meet the 62-day standard for cancer care, noting that the Trust was looking to make as many productivity gains as possible, such as theatre utilisation. The opening of the new outpatient assessment centre at South Walks House would introduce new ways of working which would increase productivity by 30%.

SC asked why there was an increased demand in ED and in cancer referrals. In terms of ED, AT noted the aging population which had been sedentary during Covid-19. A review of all patients in the hospital indicated that 87% had complex needs, either in their care or home affairs. Delays elsewhere in the health and care sector could that ED was the only option for some patients. AT described the introduction of a care provider from the local authority into ED to assess patients on arrival to determine if the patient could be supported at home. The first three weeks of this initiative saw 28 patients who were able to be supported at home, instead of admitted to hospital. The Acute Hospital At Home (AHAH) service also supported patients in their homes. In terms of cancer patients AT described that people were living longer with cancer and therefore often developed secondary cancer or required ongoing healthcare needs.

The meeting heard about the work of virtual wards, of which AHAH was an example. AH acknowledged the need to consider whether the service was right for each patient and that just as many staff were needed to support a virtual ward as an in-hospital ward, in order to monitor and visit as frequently as needed.

AT left the meeting.

AH provided an overview of the summary hospital-level mortality indicator (SHMI). The Trust's SHMI had historically be high which suggested that more patients were dying than should be, but the Trust's own review of data indicated this was not accurate. AH described the nuances of the SHMI, noting the role of accurate coding in scoring the Trust. A great deal of work had gone in to ensuring that the Trust was not seeing unexpected deaths and ensuring coding was up to date, and AH confirmed that for the last eight months the Trust's SHMI had been in the expected range.

<u>People</u>
NP noted the following:

- Improvement in sickness absence in January
- Reduction in high-cost agency usage, increase in bank and off-framework agency usage
- Working with DHC to increase the number of bank worker nurses
- A broadly stable position, but continued pressures in some teams and

services, particularly those with specialist skill posts. Work continued to consider how to resolve these issues e.g. the introduction of housekeeper role for wards, to modernise the role of Health Care Support Assistants

KH raised a question on behalf of JC, regarding the low appraisal rate. NP felt that this was reflective of the operational pressures across the hospital but noted that the need for appraisals was a continual dialogue with staff. NP recognised the importance of appraisals in showing people they were valued, in retaining staff, and in supporting their career development.

The meeting further heard details of:

- The positive direction of the reducing vacancy rate and increasing retention rate
- The way in which the Trust was creating capacity through apprenticeships and other schemes encouraging people to join the workforce
- The efforts to develop different models of care and opportunities for career progression
- Targeted work on Health Care Support Worker retention
- The recruitment of internationally educated nurses
- A pilot scheme to fund support workers to train as registered nurses.
- The Trust's housing and pastoral support available to staff
- NHS England funding received for two posts solely focused on retention

<u>Place</u>
AH outlined the five pillars of the ICS and the two 'places' in Dorset centred around the east and west of the county. With regards to the pillar relating to deprivation, it was noted that there were a number of pockets of deprivation across the county and that the work ongoing in Weymouth and Portland would be applied to other areas as needed. This line of work was not something that the Trust was actively involved in.

<u>Partnerships</u>
The meeting heard about the work of the provider collaborative and the various networks across the system, including the ways in which the two acute Trusts provided specialist services for the whole of the county.

AH outlined the Working Together Programme, noting that the four flagships of the programme were all making steady progress.

Asked about the healthcare provision to the asylum seekers on the Bibby Stockholm barge in Portland, the meeting heard that this was provided by primary care, and the Trust had very little involvement.

LT asked for detail on the number of exit-interviews completed. NP advised that this stood at approximately 30% and recognised the important information they could provide. Attendees further considered the importance of non-clinical staff and that detail on this workforce was routinely included in People and Culture Committee papers and discussions.

Finally, AH reported the positive position of the Trust's New Hospital Programme, which had recently had its full business case approved, including additional funding to cover the increased costs due to inflationary pressures. There were still some final approval routes to go through, but this was a positive step. The meeting commended the work of the team in getting to this point.

CoG23/092 **Finance Report Q3**

Claire Abraham drew the governors' attention to the previously circulated paper, outlining the trust's financial position at the end of Quarter 3. In particular, she highlighted that:

- A deficit position of £0.6 million in month away from plan, and £8.9m away from plan year to date
- This position is largely driven by the impact of industrial action, use of high-cost agency staff to meet demands, inflationary pressures, and efficiency delivery challenges
- Introduction of the executive led Value Delivery Board and reviews across the Trust to attempt to meet efficiency targets
- Cooperative working across the Dorset system to address high-cost agency spend
- Increased rigour and oversight of recruitment across the Dorset system
- Cash position of £10m at December, impacted by heightened expenditure and timing of recent payments which is being closely monitored.

SM asked how the Trust held staff to account in contributing to the efficiency targets. CA noted that she and CH had met with divisional and corporate staff some months ago and held regular recovery support meetings to understand the drivers of the financial position. Communications around efficiency targets were very well articulated through senior leadership group, Finance and Performance Committee, and Trust-wide communications, recognising that it was everyone's responsibility. The Transformation Team were also supporting with targeting specific areas. JH highlighted the 86% reduction in off-framework agency spend in the last 12 months, partly due to the daily meetings she had with matrons to challenge off-framework use.

CoG23/093 **Governor Matters**

a) Effectiveness of Patient Initiated Follow Up (PIFU)

KH asked on SB's behalf about the effectiveness of PIFU; did Executive and Non-Executive Directors think it was a good initiative and were there were any studies that supported the NHS requirements?

AH answered the most services in the Trust were adopting PIFU, with the view that patients were able to book a follow up appointment with a consultant when they felt they needed it. PIFU worked better in some specialities than in others, noting the difficulty in having sufficient clinic space to be able to start to offer PIFU. Asked whether patients felt reluctant to utilise PIFU as they did not want to be a 'nuisance' AH reflected on the importance of a good personal relationship between patients and clinicians to encourage patients to make contact when needed. JH confirmed that PIFU was not the only option, and when there was a high risk of deterioration patients were given routine follow up appointments.

b) Board Sub-Committee minutes for Governors

KH asked whether papers of Board Sub-Committee could be routinely shared with all Governors. DCS did not feel this was appropriate and AB advised that this was not something that was standard practice across the NHS. However, sub-committee escalation reports were routinely shared at the Council of Governors at DHC and it was suggested that this be replicated at DCH to further align the processes between the two Councils. AB undertook to include Board Sub-Committee escalation reports in future Council of Governors papers.

Action: AB

c) NED assurance regarding low appraisal rates

Discussed above.

CoG23/094 Reflections on recent Governor meetings

Update from Membership Development Committee

KH had little to update, noting that the next meeting was in March. The had been little in the way of membership activities recently and governor enthusiasm to support this work was minimal. KH was happy to arrange and support membership events if governors could commit to supporting them, either in a local community space or in the former Friends of DCH shop in the hospital.

The next edition of the governors e-bulletin to members was due to be published in March with contributions from JW and KP. KH sought contributions from governors for the next bi-annual edition.

Update from Governor Workshop

DCS noted that this workshop had in part considered how the membership could be developed. The Head of Communications at DHC was beginning to look at what support she could offer across both Trusts. DCS suggested a meeting with himself, KH, the Head of Communications at DHC and the DHC Lead Governor to take this forward.

Update from the Joint Strategy Engagement Session

DCS felt that this session had been positive with a good level of energy and participation from governors. KH asked if any notes had been taken of the session which could be shared with governors who had not been able to attend. AB would look in to this.

Action: AB

CoG23/095 NED Update, Feedback and Accountability Session

Dave Underwood – the NED role

DU shared a presentation detailing a year in his life as a NED. This included:

- Attending Board and subcommittees to seek assurance from the organisation. The introduction of Statistical Process Control (SPC) charts in to Board and committee reports was improving the assurance provided
- His particular responsibilities relating to his roles as Senior Independent Director (SID) and Freedom to Speak Up (FTSU) champion, and the various walkabouts he had participated in
- His responsibilities as chair of Charitable Funds Committee
- The requirements of him as the lead digital NED
- His contributions to matters relating to the Governors, including attending Council of Governors meetings and supporting NED recruitment

In summary, over the last 12 months DU had attended 213 meetings on 129 days, 36 of which were on site. This was not atypical for other NEDs who had other responsibilities and portfolios. DU described that the NEDs provided good value to the Trust and sought assurance in many forms.

DU described that when he participated in walkarounds they were usually formally organised, although he did also take the opportunity to gauge the feel of the hospital whenever he transited through. He had conversations with staff on the walkarounds and had since bumped in to some of those staff. While NEDs did not have the same presence as an executive director, some staff did know who they were. Governors had recently been invited to join walkarounds and DU encouraged them to take up the offer. MB echoed that when she was on site she would strike up informal conversations with staff.

Asked what his proudest achievement and main challenge was, DU reflected on the implementation of SPC charts which he had encouraged for some time, as it provided genuine assurance. his biggest challenge was the DCH Charity capital appeal which had a targe of £2.5m over the next two and a half years, with £300,000 pledged to date.

Margaret Blankson – ICB People Plan

MB shared a presentation on the topic of the Trust's implementation of the ICB People Plan, noting that there were numerous examples of this, and this was evident in the papers submitted to January's People and Culture Committee meeting.

MB outlined the role of the ICB as a statutory body responsible for developing the health needs of the Dorset population through coordinating and commissioning provider services. The development of the ICB was focused on collaboration between health and social care partners; a shift away from the old model of competition. MB further outlined the characteristics and core purpose of the ICB, detailed on the slides, drawing particular attention to the social and economic development that the ICB offered in recognition of the various factors that determined health. She reflected on the deprivation, rurality and limited transport links in the county, noting how this could impact an individual's ability to access healthcare.

Within this context the Dorset ICB had developed a People Plan which had four key priorities. MB focused on priority three 'developing our people' and the role of the People and Culture Committee in ensuring that the priorities were focused on by the Trust. MB described the use of staff surveys, walkarounds, and updates to committees to gain assurance on these issues, as well as meeting with the Chief People Officer and divisional leads if she required further assurance.

MB further detailed the work ongoing to improve the rate of appraisals across the Trust, noting the clear identification and articulation of the problem by operational staff and the continued oversight of the matter at People and Culture Committee. MB reflected that appraisal rates had been particularly low in one particular area when she joined the Trust. The people team had worked with that department to improve this learning from this experience could be applied more widely across the Trust. MB stressed the importance of appraisals for individuals in setting the tone and culture of the organisation. She invited governors to ask questions.

SM asked who was responsible for ensuring appraisals were undertaken. MB advised that it was every line manager's responsibility and for that reason management training was available to all managers to help develop their confidence in having appraisal discussions. It was recognised that, across the Trust, there was a degree of variability in workload prioritisation and where appraisals sat within that, and the continued operational pressures were noted. JH added that appraisals were not the only opportunity for staff to have one-to-one

conversations with their managers and it was important to also develop an open culture, not just appraisal rates. NP further added that there was an onus on individuals as well to ensure that their appraisals were booked in. The results of the Staf Survey would shortly be published, and the headlines would be returned to the Council of Governors for information.

CoG23/096 **Governor Committees:**

a) Membership (for noting)

The report was taken as read, and AB noted that membership had been portioned out as fairly as possible, based on the expressions of interest governors had made in December 2023. There were some vacancies in three of the four governor committees, and AB encouraged governors to come forward if they wished to fill any of those vacancies. In particular, Membership Development Committee had a few vacancies and met most frequently.

b) Terms of Reference (for approval)

The report was taken as read. AB highlighted that there were no material changes to the Terms of Reference; changes reflected the new terminology of Deputy Chair as opposed to Vice Chair as well as some typographical errors. Changes were clearly marked in red. The Terms of Reference were approved as presented.

CoG23/097 **Fit and Proper Persons Test and Declaration of Interests for Governors**

AB advised that in line with the Trust's provider licence Governors needed to complete an annual Fit and Proper Persons Test self-declaration and to declare any interests that may impact their role as a governor. AB would contact governors in the coming weeks in this regard and noted that the details were published on the Trust's website as part of good governance. Governors were asked to provide the information by the timescale outlined.

CoG23/098 **Chair's Closing Remarks and Date of the Next Meeting.**

The next Council of Governors meeting open to the public was scheduled for 2pm on Monday 08 April 2024, in the Trust HQ Boardroom and virtual via Teams.

The Chair thanked everyone for their attendance and contributions and closed the meeting.

Council of Governors Meeting – Part One

Presented to the meeting of 08 April 2024

Meeting Dated: 12 February 2024				
Minute	**Action**	**Owner**	**Timescale**	**Outcome**
CoG23/091: Chief Executive's Report Q3	AH to speak to NJ about Governors joining co-production events in Weymouth and Portland in February and/or April.	**AH**	February 2024	
CoG23/093: Governor Matters	Board Sub-Committee escalation reports to be included in future Council of Governors meetings.	**AB**	April 2024	Complete.
CoG23/094: Reflections on recent Governor meetings	Any notes or materials from the Joint Strategy Engagement Session to shared with Governors.	**AB**	February 2024	Complete. Slides and summary of discussions shared with Governors 15/02/2024

Council of Governors

CEO Report

Dorset County Hospital update

From 01 April 2024 Dorset County Hospital and Dorset Healthcare FT welcomes Dawn Dawson into the Joint Chief Nursing Officer

System update

2023/24 Financial and Operational delivery plan

In line with the re-baselined system allocation, NHS Dorset have implemented the steps to support delivery on the agreed plan. However, NHS Dorset Integrated Care System has continued to face a very challenging financial and operational position over the start of 2024 impacted by the continued Industrial Action, the high operational demand and the winter pressures. The full impact of this on our financial and operational plan delivery is being fully worked through but this will significantly impact how we end 2023/24. How we end this financial year is really important to not only give us the best start to 2024/25 but also in ensuring we deliver the best possible care to the population of Dorset.

Martha's Rule

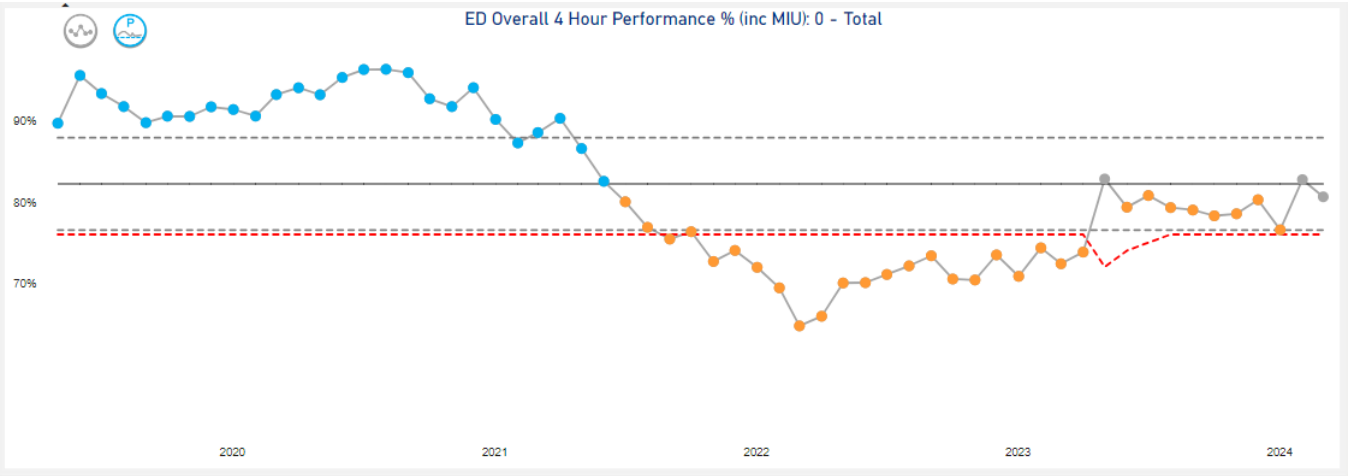
NHS England has announced the roll out of Martha's Rule in hospitals across England from April 2024, enabling patients and families to seek an urgent review if their condition deteriorates. This is planned to be rolled out to at least 100 NHS sites and will give patients and their families 24/7 access to a rapid review from an independent critical care team if they are worried about their or a family member's condition. NHS Dorset looks forward to the opening of the pilot across the NHS.

System Priorities

- A clear focus on the priority operational standards achieving improvement across all areas and full delivery wherever possible.
- Reducing agency costs as a minimum to levels agreed in the cost improvement plan.
- Accelerating cost improvement programmes in all areas with a view to achieving our financial targets this year.
- Commencing delivery of the five year forward plan five pillars and the creation of integrated neighbourhood teams. These two programmes are key to transforming care and reducing the overall cost of health and social care.
- Continuing to support the delivery of the primary care transformation plan as part of this transformation work.
- Further developing our system NHS medium term financial plan with the goal of sustainably breaking even within the next few year. This will be supported by detailed transformation plans which support more efficient ways of work and improved access for communities. It is important this plan signals a change in the ICB's investment portfolio in line with the transformation plans agreed.
- Working with local authority partners to develop further integrate our ways of working and care delivery to support all partners in becoming financially sustainable.

Patients

What's been happening - Patients- UEC



Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
4 hour performance (all)	82.84%	79.38%	80.81%	79.31%	79.02%	78.30%	78.60%	80.30%	76.60%	82.80%	80.60%
4 hour performance trajectory	72.00%	74.00%	75.00%	76.00%	76.00%	76.00%	76.00%	76.00%	76.00%	76.00%	76.00%
Variance	10.84%	5.38%	5.81%	3.31%	3.02%	2.30%	2.60%	4.30%	0.60%	6.80%	4.60%

- Performance against the 4-hour standard has met trajectory every month for this financial year and better than the national average
- Demand at the front door has increased by 8.61% compared to last year
- Ambulance handover delays since mid-December DCH have been unable to validate the handover delays against the SWAST report this has been escalated and is affect other providers in the South-West region. Prior to this DCH was one of the best performing trusts in the Region.

What's been happening Patients- Elective

W/L total size	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Total W/L trajectory	20371	20486	20402	20323	20256	20161	20038	19917	19866	19721	19523
Total W/L actual	20352	20047	20388	20904	21005	21079	20991	21033	21067	20975	21023
Variance	-19	-439	-14	581	749	918	953	1116	1201	1254	1500

- Total waiting list size has increased slightly since April 2023, but is 1,500 patients worse than trajectory

- Referral volumes are 4.78% up compared to last year and 11.09% compared to pre-covid (2019/20). Referral growth at an aggregate level doesn't provide a clear picture on what this means for performance, as peaks in one specialty with reductions in others, don't equal each other out, i.e. lower cardiology referrals doesn't release capacity to address increasing dermatology referrals.

- The ICB has completed postcode analysis and are reporting a growth rate for DCH of 4.4%, with UHD seeing a reduction of -4%, this analysis has only been completed at an aggregate level. The growth in referral demand for DCH has come from postcode drift, partly due to better waiting times for first outpatient appointments in some high-volume specialities such as OMF, Gynaecology and Orthopaedics

What's been happening Patients- Elective

- Patients are treated in clinical priority order, followed by chronological order. The increase in demand has been disproportion for urgent and suspect cancer investigation, which has resulted in slower reduction in waiting times, than we had planned for.

- To reflect the impact of growing demand and the loss of activity due to industrial action, NHS England requested a revised trajectory for the second half of 2023/24.

- The trust has maintained the position of zero patients waiting over 104+ weeks for 2023/24

- The trust had forecasted to have zero patients, waiting over 78+ weeks at the end of March 2024, however the impacts of industrial action since end of December, has meant the Trust will now have 28 breaches at the end of March.

- The number of patients waiting over 65+ weeks, is forecasted to be at 500 at the end of March 2024, against the plan of zero. DCH is on track to improve against the trajectory in line with the previous three months performance

65+ week waiters	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
65+ww trajectory	409	375	335	298	258	221	181	141	509	564	510
65+ww actual	234	254	267	271	336	401	481	375	374	413	383
Variance	-175	-121	-68	-27	78	180	300	234	-135	-151	-127

What's been happening Patients - Cancer

- Year to date, suspected cancer referrals are 4.45% up on the previous year, and 33.34% up on the reporting year 2019/20 (our baseline year).

- Performance against the 28 day to diagnosis standard has been above 70% since July 2023, except for January (cumulative lost capacity over festive period and IA) fluctuations of a few percentage points each month, achievement of the 75% is on track for March 2024.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
FDS op plan	69.66%	72.02%	69.13%	68.98%	69.44%	71.50%	71.49%	74.10%	75.30%	75.64%	75.95%
Actual	68.90%	54.00%	62.50%	72.50%	72.30%	70.00%	74.85%	74.15%	73.75%	69.69%	77.65%
Var	-0.76%	-18.02%	-6.63%	3.52%	2.86%	-1.50%	3.36%	0.05%	-1.55%	-5.95%	1.70%

- Reducing the backlog (>62days) of patients waiting on an open urgent suspected cancer pathway. DCH attained the planned trajectory September to November. Seasonal variation saw performance off plan for December and January. Performance for February was just above plan due to the impact of industrial action, DCH will meet the March trajectory.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
62+ day op plan	70	70	75	78	80	83	83	83	83	80	75
Actual	74	107	109	95	90	82	80	83	96	112	80
Var	4	37	34	17	10	-1	-3	0	13	32	5

Quality

- Availability of EDS remains under target – review of DATIX indicates no harm reported but work around data quality underway. Targeted work is underway with EDAU to clarify process and performance data.
- Complaints received – Early Resolution pilot continues with objective to roll out Trust wide.
- Trust remains under trajectory (positive indicator) for all healthcare acquired reportable infections. IPC have fully integrated PSIRF into investigation/audit processes
- In March, patients falling more than once constituted 50% of all incident reported. Work is ongoing to review the approach to known and repeat fallers with an emphasis on reducing the risk of harm. This includes new medication guidelines, Falls Risk Enhancing medications, being highlighted via poster. Shared at Falls Action Group
- Ward dashboards have now gone live to provide information to ward leaders on KPI achievement to drive targeted improvement.
- DCH SHMI has been within the 'expected range' for the past 6 months, against a background of gradual improvement.
- TVN now in post and working through all investigation and reporting processes for pressure damage incidents

People

People

Metrics

	December	January	February
Sickness	4.23%	4.29%	4.46%
Turnover	10.8%	10.8%	10.0%
Vacancy Rate	5.47%	4.56%	3.71%
Appraisal Rate	77%	78%	78%
Mandatory Training Compliance	90%	90%	89%

Progress

- Turnover and Vacancy rates at the lowest level for two years
- Reliance on agency staff has reduced
- Improved Staff Survey results with above average scores in all 9 themes
- Focus on staff health and wellbeing maintained – 150 folders distributed
- New medical leadership programme launched in January
- Apprenticeships continue to grow - 174 staff in a scheme at present
- Over 200 local people attended Careers Day on 2 March

Challenges

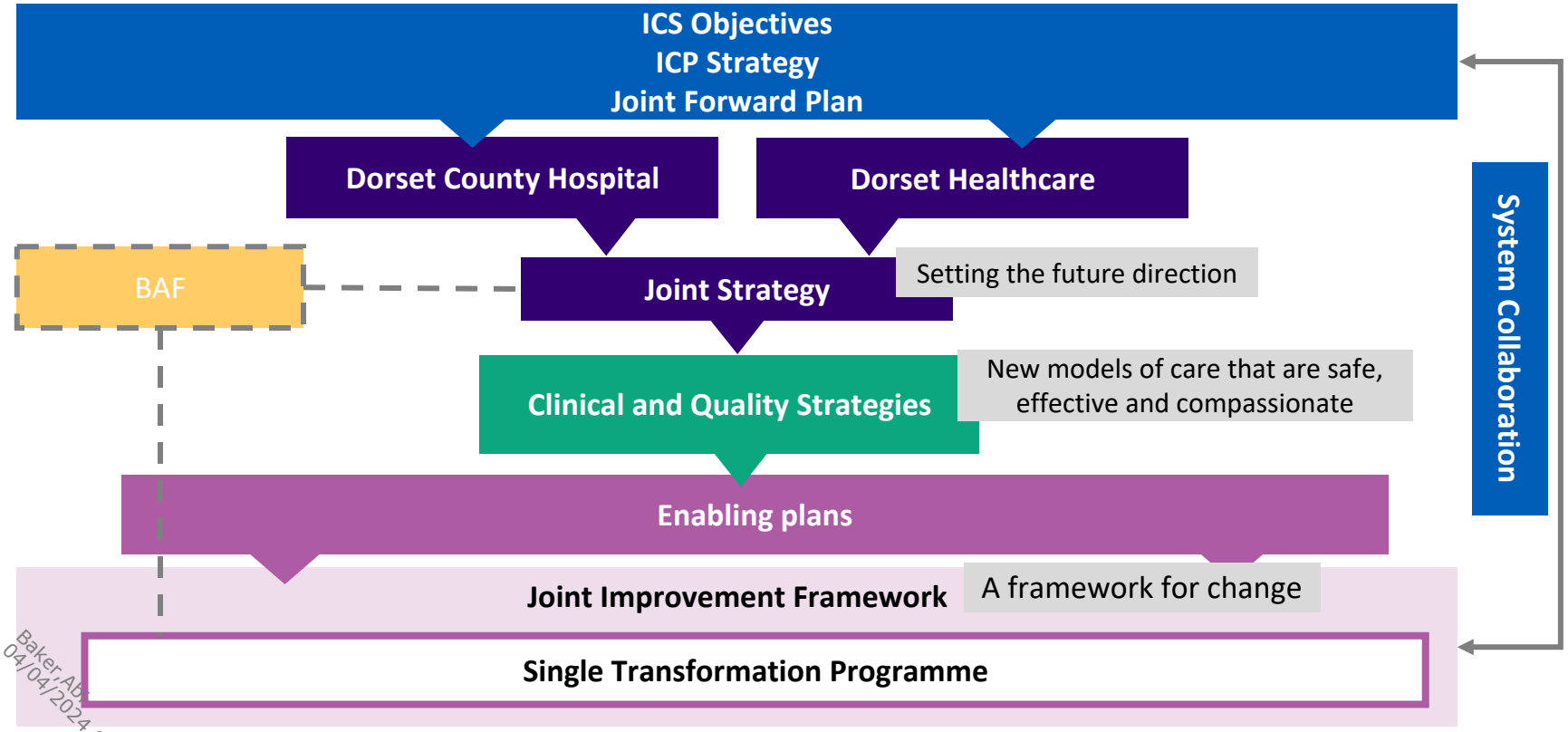
Potential ongoing industrial action, hard to fill roles, staff experience (particularly staff from minority ethnic communities), continued reduction in agency use

Joint Strategy Development

Progress to Date

1. **Why a Joint Strategy – Oct 23**
2. **Framework – Oct 23**
3. **Scope – Oct 23**
4. **Principles – Nov 23**
5. **Broad engagement Nov 23 – early Feb 24**
6. **Analysis – Feb 24**
7. **Vision & Misison development Feb- Mar 24**
8. Objectives and Prioirites - Mar 24
9. Development - Mar 24
10. Approval – May & Jun 24
11. Improvement Framework Apr – Dec 24

Strategic Framework



Working Together programme - Dorset County Hospital and Dorset HealthCare

Summary of Key Themes

Enhanced Partnership Working

- Better joined up care
- Being seen and treated quickly
- Simple patient pathways
- Focus on prevention
- Collaborating with all partners

Supporting our Staff

- Communication
- Involving staff in change
- Strong, supportive leadership
- Wellbeing
- Overcoming challenges
- Opportunities

Future Proofing and Sustainabilit

- Digital enabler
- Financial responsibility
- Sustainability

Delivering the Strateg

- Impact and outcomes
- Design
- Delivery

Baker, Abi
04/04/2024 09:06:49

Place and Partnerships

Developing Integrated Neighbourhoods

Our Dorset

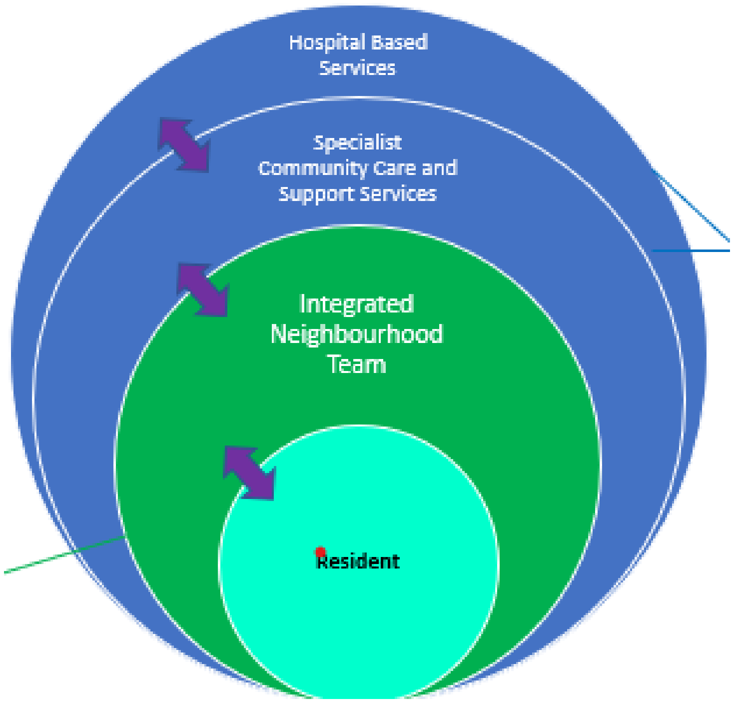
Working Together and Councils Working Together

Integrated Neighbourhood Teams and the integrated system

Our Dorset
Local NHS and Councils Working Together

Integrated Neighbourhood Team Role:

- Reducing health inequalities and addressing wider determinants of health, adopting a strength-based approach and optimising the use of community assets
- Supporting people with on-going health and care needs to live well , by building their knowledge, skills and confidence
- Proactively identifying, reviewing, and planning care; monitoring and intervening as early as required



Specialist Team Roles

(working across multiple neighbourhoods):

- Offering advice, guidance, education and support to the practice and neighbourhood teams to build knowledge, skills and confidence
- Responding to crisis, escalating or acute care and/or support needs, that require specialist intervention
- Reviewing population health data to proactively identify and address unwarranted variation

Proposed purpose of the Neighbourhood Partnership Group:

- Take responsibility for understanding and developing plans to reduce health inequalities and address the wider determinants of health.
- Develop and implement a communications and engagement plan.
- Engage widely with communities within the neighbourhood to understand what matters to them.
- Triangulate the data insight, local intelligence and community conversations to agree the first phase priorities. (e.g. what, if tackled, will make the greatest difference in improving the health and wellbeing of the neighbourhood?)
- Oversee the successful planning and execution of the project/s.
- Identify, secure and manage specialist skills, enablers and resources required to support delivery.
- Develop appropriate metrics against which to report, providing an evidence base and success measure for change / improvement achieved.
- Monitor and evaluate progress and benefits realisation, providing assurance and insight to the Programme Board.
- Escalate risks and issues to the Programme Board that cannot be mitigated or resolved locally.
- Share learning and opportunities for wider roll-out with the Programme Board.

Neighbourhood Partnership Group - Locally tailored representation which could include:

- Primary Care
- Dorset HealthCare University NHS FT (Mental Health and Community)
- Dorset County Hospital NHS FT or University Hospitals Dorset NHS FT (dependent on Place)
- Adult Social Care Children's Services
- Public Health (Dorset Council or BCP Council, dependent on Place)
- Voluntary Sector
- Community / local population (one from each community if neighbourhood spans areas)
- South Western Ambulance Service
- Local Enterprise Partnership (LEP)
- Parish Councillor/s (one from each community if neighbourhood spans areas)
- Wider community stakeholders: Housing, Education, Police, Fire & Rescue, Transport
- Co-opted Subject Matter Experts (SMEs): Business Intelligence (BI), Business Analysts (BA), Population Health Management (PHM)

The challenge here in agreeing the right representative from organisations is getting the optimal balance between having sufficient connection to the individual neighbourhood and the ability to influence within the organisation

Our Dorset Provider Collaborative

Review. What we think has gone well?

CANDo

- Supported clinicians and managers to come together and form networks. The seven networks are in different stages of development. Three planned networks have not yet been established.
- The existence of networks themselves grows the sense of **"being in it together" with shared learning and review of GIRFT material**. More immediately tangible benefits as below.
  a. **Rheumatology:** Creating a single service under UHD (June 24)
  b. **Orthodontics:** Creating a single service under DCH (June 24)
  c. **Ophthalmology**: GIRFT HVLC workshops Nov 23 and implementation of new models as a result. Business cases prepared for associated trolleys. Developing relationship with Primary Eye Care for potential future community offer
  d. **ENT:** Supporting lead clinicians to developed shared on call rota. Consultant workshops 24th April and 9th May
  e. **Orthopaedics:** Workshop Nov 23 to share challenges and aspirations. Both trusts starting to move "hands" out of main theatres. Aligning patient information to give a single Dorset wide offer. Shared review of procurement data set
  f. **Urology:** Deep dive into GIRFT metrics and beginning work to align pathways
  g. **Gastro:** Initial meetings to establish network taken place. Early discussion on shared bleed rota.

Workforce and Agency

Align Bank Offer

- All Organisations agreed and implementing 3 phase step to achieve CAP for Nursing staff by 01/07/2024
- DCH all HCA now from Bank not agency

Reduction in Agency Use

- Authorisation from Director / Execs prior to booking
- Significant increase in use of Bank and ON Framework agencies
- DHC no use of TNS since June 23 – looking to use ON Framework only by Mar 24
- DCH down to 6% use of TNS
- UHD now at 3.29% off Framework

Sharing Staff

- Significant recruitment ongoing of MHSW available to work across all organisations under MOU
- UHD Development of "Trust Agency" to enable movement of staff

Collaborative Bank

- Options paper in process
- All organisations workshop in March 24 to decide best fit

Financial Impact and reduction in spend

- System wide 70% overspend to Dec 23 on Actual vs planned spend (£53,624 – £31,468) (£000)
- Reduction in OFF framework spend from £1,768 (46%) in Mar 23 to £153 (6%) in Dec 23 (£000)

Infrastructure Development

- Developed our **Purpose, Values, Behaviours and Principles**.
- **Provider Agreement** endorsed at each individual trust board that formed the foundation of how the ODPC will operate.
- Governance arrangements implemented
- Operating framework developed.
- Prioritisation exercise for 2023/24 to ascertain priorities was undertaken.
- **Financial Framework and principles** to support decision making endorsed
- Agreed existing collaboratives are now reporting into the Board
- Initial assessment against Maturity Matrix undertaken

Review of 2023/24. What's gone less well?

- Information and directives from ODPC meetings are **not effectively communicated** into the organisations and relevant teams, leading to challenges in carrying out actions decided upon in ODPC meetings.
- Lack of **adequate resource committed** to the ODPC creating a risk that the ODPC will not have the appropriate infrastructure in place to enable delivery and provide assurance of priorities impacting the ODPCs ability to achieve its strategic goals.
- **Various degrees of appetite** to collaborate, including strong communication of each trust's objectives in this regard, even where there is clinical appetite collaboration will not make progress. E.g. OMF, General surgery and gynaecology
- **Limited support for workarounds** to enable cross organisational access to clinical records, reducing clinical appetite for collaborative working and consequent progress for integrated services will likely reduce.
- **Insufficient appetite** to vary financial arrangements to create aligned approach, and communicate how collaboration is supported financially, even where there is clinical appetite collaboration will not make progress.
- **Speed of decision making** where requirement for decision post OPDC to go through any individual trust governance processes causing delay

Our Dorset

Title of Meeting	**Council of Governors**
Date of Meeting	**08 April 2024**
Report Title	**Finance Report to 29 February 2024**
Author	Claire Abraham, Deputy Chief Financial Officer
Responsible Executive	Chris Hearn, Chief Financial Officer

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

Summary
This report summarises the Trust's financial performance at the end of month eleven of financial year 2023/24, noting at the time of writing this report the month twelve closedown process had just begun and is expected to close after this meeting takes place. A verbal update will be included as appropriate.

Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a surplus position in month eleven being £0.9 million away from plan after technical adjustments and £8.9 million actual deficit away from plan year to date, in line with planned forecast trajectory.

The month eleven and year to date performance is largely driven by:

- Ongoing industrial action, with £3.3 million of national funding supporting the position based on a fair shares contract allocation. Elective recovery baseline targets have been reduced to 100% for Dorset, in recognition of ongoing Industrial Action
- Ongoing use of high cost agency to meet demands, largely driven by an expanded bed base, heightened operational pressures, vacancies and sickness levels
- Above planned levels of inflation, Digital licence costs and Insourcing levels above plan, noting however the latter is expected to recover by year end
- Efficiency delivery challenges

The net costs incurred associated with supporting industrial action amounts to £1.5 million year to date, with a further £1.8 million estimate of lost income opportunity.

Agency currently stands at £3.4 million overspent against plan, with £1.5 million of this incurred with highest Off Framework agencies, and within this £0.3 million has been incurred year to date providing support to mental health patients. February continues to see significant decrease in agency costs from previous months following a combination of system applied agency rate reduction, positive internal substantive recruitment increases and reduced medical locum usage.

The Trust has supported circa 19 escalated beds which continues to drive demand. The number of patients at the end of February with no criteria to reside was 70.

Continuation of increased cover for medical rota gaps in Unscheduled Care, Medicine for the Elderly, General Medicine and Urology contribute to the medical agency overspend, however less locum usage was seen in February due to availability.

Above planned levels of inflation have been incurred year to date with gas over by 25% and electricity over by 65%. Drugs, catering supplies, blood product contract and other contract increases are between 8% and 13.5% above planned levels.

The Trust continues to actively review its sustainable energy options including strategy refresh and exploring all contract management opportunities with both cost and volume focus, for ways to mitigate inflationary pressures being incurred.

As previously reported to the Council, forecast analysis demonstrates the risk to delivering a break even position to be in the region of £14 million. Following review with the Executives, further stretch targets linked to efficiency, productivity and agency have been put in place for the remainder of the financial year to reach £10 million forecast outturn, however with national funding offsetting the costs incurred relating to industrial action, this forecast outturn position reduces to £7.5 million.

It has been agreed across the Dorset system that acute providers will then be supported to a break even position by financial year end.

The Trust's year to date deficit as at month eleven stands at £8.9 million. A reduction of £1.4 million is required to reach £7.5 million. This will be achieved by non recurrent measures linked to service level agreement review, expected VAT rebate, balance sheet review and timing of revenue funding expected linked to external capital programmes.

The Trust has delivered £4 million of efficiencies for the year against a year to date plan of £9.5 million.

The cash position is £10.8 million as at February, impacted by heightened expenditure and timing of recent payments which is being closely monitored. Without intervention worst case modelling indicates the Trust would need to mitigate a shortfall of cash in the region of £5.6 million in the last quarter of this financial year, however a number of implemented mitigations have been actioned with H2 trajectories reducing this shortfall level.

The capital spend in month is away from plan by £0.6 million. The year to date position stands at £2.2 million behind plan reflective of timings in expenditure payments including externally funded schemes such as Digital electronic patient record (EPR) and the New Hospitals Programme (NHP).

Paper Previously Reviewed By
Chris Hearn, Chief Financial Officer

Strategic Impact
Trusts are expected to achieve a break-even financial position by the end of the financial year 2023/24, with the exception of costs associated with supporting further Industrial Action impact for December and January as advised by NHSE England.

Risk Evaluation
The Risk and Audit Committee can confirm there has been no non-audit work undertaken by the External Auditors during the current financial year to date.

Impact on Care Quality Commission Registration and/or Clinical Quality
As above

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

As above	
Financial Implications Failure to deliver a balanced financial position could result in the Trust being put into special measures by NHSE. Efficiency delivery remains challenging for the Trust.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	To review and note the 2023/24 position to 29 February 2024

Council of Governors Finance Report for 11 Months ended 29 February 2024

	Plan 2023/24 £m	Actual 2023/24 £m	Variance £m
Income	250	264.9	14.9
Expenditure	(250)	(274.7)	(24.7)
Surplus / (Deficit)	**0**	**(9.8)**	**(9.8)**
Technical Adjustment – Capital Donations/Depreciation	0	0.9	0.9
Adjusted Surplus/(Deficit)	**0**	**(8.9)**	**(8.9)**

Variance to Month Eleven

1.1 The income and expenditure position at the end of February is a deficit of £8.9 million and is largely driven by:

- Ongoing industrial action
- Ongoing use of high cost agency to meet demands, driven in part by an expanded bed base
- Above planned levels of inflation, Digital licence costs and Insourcing levels above plan
- Efficiency delivery challenges

1.2 Pay costs pressures are driven by ongoing high cost agency usage providing safe cover for vacancies, sickness, heightened operational pressures and the impact of industrial action, however agency expenditure has reduced significantly from prior months following key actions delivered by the High Cost Agency Reduction programme supported by all Dorset organisations applying a Nursing agency rate reduction of 15% since January 2024.

1.3 Non Pay costs were above plan largely due to the impact of ongoing inflationary pressures, in particular gas, electricity, catering supplies (milk, bread, other dairy and oil), blood products, catering and laundry. Above plan expenditure relating to the timing of insourcing activity supporting elective recovery also contributes to the adverse position.

1.4 The Trust wide efficiency target stands at £10.9 million for the year, circa 4% of expenditure budgets in line with peers and national planning expectations. Full year efficiency delivery noted at month eleven stands at £4 million, with active Executive led oversight being supported by the Trusts Value Delivery Board.

CASH

2.1 At the end of February, the Trust held a cash balance of £10.8 million. Active monitoring and key mitigations have been identified to help manage this cash position.

CAPITAL

3.1 Capital expenditure for the period to 29 February 2024 amounted to £20.8 million against a plan of £23 million, being behind plan by £2.2 million largely due to the timing of planned levels of spend related to externally funded schemes for the Digital Electronic Patient Record programme and the New Hospitals Programme. This position is expected to recover with forecast levels of spend anticipated by the end of the financial year.

Joint Executive Director of Corporate Affairs
Jenny Horrabin

Jenny was appointed Joint Executive Director of Corporate Affairs for Dorset HealthCare and Dorset County Hospital on 11 March 2024.

She is a qualified accountant and chartered company secretary. She worked in audit and assurance for over 20 years in the public and private sector, before moving into a Company Secretary role in the NHS in 2012.

She joined the trusts from Coventry and Warwickshire Partnership Trust, having previously worked in senior governance and corporate affairs roles in two clinical commissioning groups.

Jenny has a passion for continuous improvement and excellence in practice and is an active member of the NHS Company Secretaries Network and a member of the HFMA Audit and Governance Committee. She is also a trustee of a charity.

Report Front Sheet

1. Report Details			
Meeting Title:	Council of Governors		
Date of Meeting:	08 April 2024		
Document Title:	Quality Priorities 2024/25		
Responsible Director:	Jo Howarth, Interim CNO	Date of Executive Approval 12/03/20204	March 2024
Author:	Kerry Little , Quality Assurance Manager		
Confidentiality:	No		
Publishable under FOI?	Yes		
Predetermined Report Format?	Yes		

2. Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	19/03/2024	

Purpose of the Paper	*Note (✓)*	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
3. Executive Summary	In line with regulation and national guidance, DCHFT developed new Quality Priorities for 2023/24. To ensure that improvement is monitored, and change can be observed over time, the Trust is requesting approval carry over these priorities into 2024/25. The end of year report on Quality Priorities will be reported as part of the Trust Quality Account The Quality Account 2023/24 is currently being compiled and will be presented for approval at this committee in May, prior to publication in June 2024. The Council of Governors is asked to discuss the Quality Priorities as outlined in the following report							
4. Action recommended	The Council is recommended to: 1. **NOTE** the report							

5. Governance and Compliance Obligations			
Legal / Regulatory Link	**Yes**		Performance against a number of local and national metrics and KPIs and linked to legal and regulatory requirements
Impact on CQC Standards	**Yes**		Integral to CQC quality standards

Risk Link		**Yes**		Links to Board Assurance Framework and Corporate Risk Register
Impact on Social Value		**Yes**		Patient experience and confidence of local community in services provided. Improving the health of the local community and opportunities for wider engagement
Trust Strategy Link		The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives		
Strategic Objectives	People	Ability to recruit and retain staff; credibility and confidence of the Trust in the local community		
	Place	Serving the population of Dorset		
	Partnership	System working to achieve high standards of care		
Dorset Integrated Care System (ICS) Objectives		**Which Dorset ICS Objective does this report link to / support?**		
Improving population health and healthcare		**Yes**		
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**	

Council of Governors
April 2024

Quality Priorities 2024/25

Executive Summary
In line with regulation and national guidance, the Trust has developed new Quality Priorities for 2023/24.

To ensure that improvement is monitored, and change can be observed over time, the Trust is requesting approval to carry over these priorities into 2024/25.

The end of year report on Quality Priorities will be reported as part of the Trust Quality Account

The Quality Account 2023/24 is currently being compiled and will be presented for approval at this committee in May, prior to publication in June 2024.

1. Introduction

In line with national guidance, DCH developed priorities following engagement with DCH clinical staff, partners, the executive team, local community representatives and, of course, patients and their families.

Dorset County Hospital NHS Foundation Trust (DCH) continued to work to deliver changes to improve both the effectiveness and the quality of its services throughout 2023/24.

Below are listed the quality improvement priorities requested to be carried over for 2024/25. Quality Priorities will be reported on regularly through the Quality Report into Quality Committee with and end of year update.

Patient Safety

1. Reducing avoidable harm – including a continuous reduction in the overall number of patients in hospital with no criteria to reside and harms as a consequence of delays and deconditioning.
    a. As measured by incidents of harm and numbers of patients in hospital with no criteria to reside by length of stay.
2. Implement the Patient Safety Incident Response Framework (PSIRF) to deliver and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
    a. As measured by the delivery of national programme milestones (PSIRF) and improvements against PSIRP priorities
3. Improve and sustain compliance with national guidance and local policy on consent, through the delivery of training and the implementation and use of a digital consent system.
    a. As measured by training numbers, audit of policy compliance, delivery of the e-consent implementation programme, related complaints, adverse incidents, litigation, and claims

Patient Experience

1. In collaboration with system partners, increase staff capacity through a Train the Trainer Programme and capture the patient voice to inform service delivery and quality improvement.
    a. As measured by training numbers, captured feedback and direct participation of people with lived experience to targeted programmes and QI projects.
2. Deliver purposeful, therapeutic activity to patients through a planned programme of work developed by the Active Hospital Group and through the recruitment and delivery of a volunteer Activity Squad.
    a. As measured by progress against agreed action plan, training numbers, delivery of targeted activities and calendar of events, patient experience survey and overall incidence of violence and aggression against staff by patients who lack capacity (via Staff Survey)
3. Improve the experience of Children and Young People attending and admitted with emotional, psychological, and mental health needs.

Clinical Effectiveness

1. Deliver continuous improvement in the Standardised Hospital Mortality Indicator (SHMI) to within expected limits.
2. Deliver the national target for Electronic Discharge Summaries of issue within 24hours of discharge.
3. Deliver full compliance with the Maternity Incentive Scheme (MIS), with emphasis on delivering full compliance with the Safety Actions and Saving Babies Lives.

2. Recommendation

The Council is recommended to:

1. **NOTE** the report

Name and Title of Author: Kerry Little, Quality Assurance Manager
Date: 14/03/24

Leadership Competency Framework
April 2024
Council of Governors

Author	Emma Hallett, Deputy Chief People Officer
Purpose of Report	The paper is for information and details of the Leadership Competency Framework for Board members which is aligned to NHS England's People Promise.

A review of the fit and proper persons requirements for Board members was undertaken in 2019 following the Kark review and recommended the development and implementation of key areas of competence for Board Directors. The Leadership Competency Framework responds to this recommendation and aims to promote diversity and high-quality care provision and is based on wider industry best practice.

The framework outlines six competency domain requirements against which all Board members are required to assess themselves against which will inform appraisal and development discussions. Achievement against the competency domains supports the fit and proper persons assessment for Board members.

The six competency domains take account of NHS England's Operating Framework, patient safety strategy, workforce plan, diversity and inclusion and the Well Led Framework and include:

- Driving high quality and sustainable outcomes
- Setting strategy and delivering long term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance
- Creating a compassionate, just and positive culture
- Building trusted relationships with partners and communities.

The requirements of the framework will be incorporated into trust recruitment processes for Board members and, in the autumn of 2024, into the annual Board member appraisal process (following publication of the Board Member Appraisal Framework) as part of the fit and proper persons requirements. These processes will be aligned across DCH and DHC and will be shared with the Governors via the Nominations and Remuneration Committee.

The full framework is enclosed.

Recommendation	The governors are asked to note the report.

Date published: 28 February, 2024
Date last updated: 28 February, 2024

NHS leadership competency framework for board members

Publication (/publication)

Content

1. Introduction

1.1 Context

Leaders in the NHS help deliver better health and care for patients by setting the tone for their organisation, team culture and performance.

We have worked with a wide range of leaders from across the NHS to help describe what we do when we operate at our best. We have engaged with stakeholders including NHS Providers, NHS Employers and NHS Confederation, and built in best practice from other industries. We have used the feedback to design the 6 competency domains in the Leadership Competency Framework (the framework) to support board members to perform at their best.

The competency domains reflect the NHS values (https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#nhs-values) and the following diagram shows how they are aligned:

Working together for patients*	**Compassion**
Building a trusted relationship with partners and communities	Creating a compassionate, just and positive culture
Respect and dignity	**Improving lives**
Promoting equality and inclusion and reducing health and workforce inequalities	Setting strategy and delivering long term transformation Driving high quality sustainable outcomes
Commitment to quality of care	**Everyone counts**
Driving high quality and sustainable outcomes Setting strategy and delivering long term transformation	Promoting equality and inclusion and reducing health and workforce inequalities Creating a compassionate, just and positive culture
Providing robust governance and assurance	

*Wherever the word “patient” is used in this document, this refers to patients, service users and carers.

The competency domains are aligned to Our NHS People Promise (https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/), Our Leadership Way (https://www.leadershipacademy.nhs.uk/organisational-resources/our-leadership-way/) and the Seven Principles of Public Life (https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2) (Nolan Principles). A high-level summary of the values and concepts from these documents is in Appendix 1.

(https://www.england.nhs.uk/wp-content/uploads/2024/02/leadership-competency-framework.png)

1.2 Background

In 2019, the Tom Kark KC review of the fit and proper person test was published. This included a recommendation for 'the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed'. This framework responds to that recommendation and forms part of the NHS England Fit and Proper Person Test Framework (https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/) for board members (FPPT).

The framework takes account of other NHS England frameworks and strategies including:

- NHS England Operating Framework (https://www.england.nhs.uk/publication/operating-framework/)
- NHS National Patient Safety Strategy (https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)
- NHS Long Term Workforce Plan (https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/)
- NHS Equality, Diversity and Inclusion Improvement Plan (https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/#high-impact-action-1)
- National Quality Board Shared Commitment to Quality (https://www.england.nhs.uk/publication/national-quality-board-shared-commitment-to-quality/)
- NHS Well Led Framework (https://www.england.nhs.uk/well-led-framework/)
- The statutory framework of the Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted)

1.3 Purpose

Being an NHS board member means holding an extremely demanding yet rewarding leadership responsibility. NHS board members have both an individual and collective role in shaping the vision, strategy and culture of a system or organisation, and supporting high-quality, personalised and equitable care for all now and into the future.

This framework is for chairs, chief executives and all board members in NHS systems and providers, as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members
- support individual board members to self-assess against the six competency domains and identify development needs.

People taking on first-time director roles, in particular, are unlikely to be able to demonstrate all the competency examples. However, this framework should provide a guide by which, over time, directors can measure themselves and develop

proficiency in all areas. Where development areas are identified, commitment to working on these will be important.

As non-executive directors have different roles and responsibilities to those of executive directors, and there are differences between executive director roles, the framework supports the assessment of board members in their role as part of a unitary board. All six competency domains should be considered for all board members, taking account of any specific role related responsibilities and nuances.

Achievement against the competency domains supports the Fit and Proper Person assessment for individual board members.

2 The six leadership competency domains

2.1 Driving high-quality and sustainable outcomes

The skills, knowledge and behaviours needed to deliver and bring about high quality and safe care and lasting change and improvement – from ensuring all staff are trained and well led, to fostering improvement and innovation which leads to better health and care outcomes.

2.2 Setting strategy and delivering long-term transformation

The skills that need to be employed in strategy development and planning, and ensuring a system wide view, along with using intelligence from quality, performance, finance and workforce measures to feed into strategy development.

2.3 Promoting equality and inclusion, and reducing health and workforce inequalities

The importance of continually reviewing plans and strategies to ensure their delivery leads to improved services and outcomes for all communities, narrows health and workforce inequalities, and promotes inclusion.

2.4 Providing robust governance and assurance

The system of leadership accountability and the behaviours, values and standards that underpin our work as leaders. This domain also covers the principles of evaluation, the significance of evidence and assurance in decision making and ensuring patient safety, and the vital importance of collaboration on the board to drive delivery and improvement.

2.5 Creating a compassionate, just and positive culture

The skills and behaviours needed to develop great team and organisation cultures. This includes ensuring all staff and service users are listened to and heard, being respectful and challenging inappropriate behaviours.

2.6 Building a trusted relationship with partners and communities

The need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities, and our workforce. Strengthening relationships and developing collaborative behaviours are key to the integrated care environment.

3 Using the framework

3.1 Recruitment

The competency domains should be incorporated into all NHS board member* job/role descriptions and recruitment processes. They can be used to help evaluate applications and design questions to explore skills and behaviours in interviews, presentations and other aspects of the recruitment and assessment process.

* ‘Board member’ refers to all board members – executive and non-executive.

3.2 Appraisal

The competency domains in section 5 should form a core part of board member appraisals and the ongoing development of individuals and the board as a whole. The framework should be applied as follows – a new Board Member Appraisal Framework incorporating the competencies will be published to support this:

Chairs should:

- Carry out individual appraisals for the chief executive and non-executive directors, based on the framework and other objectives
- Assure themselves that individual board members can demonstrate broad competence across all 6 domains and that they have the requisite skills, knowledge and behaviours to undertake their roles
- Assure themselves there is strong, in-depth evidence of achievement against the competency domains collectively across the board, and ensure that appropriate development takes place where this is not the case

- Ensure the findings feed into the personal development plans of non-executive directors
- As and when required, include relevant information in the Board Member Reference (https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2023%2F08%2FPRN00238-ii-appendix-2-the-board-member-reference-template.docx&wdOrigin=BROWSELINK) when a board member leaves

Chief executives should:

- Carry out individual appraisals for the executive directors based on the framework and other objectives
- Ensure the findings feed into the personal development plans of the executive directors

The senior independent director (or deputy chair) should:

- Carry out the appraisal for the chair based on the framework and other objectives
- Ensure the findings feed into the personal development plan of the chair

Board members should:

- Self-assess against the six competency domains as preparation for annual appraisal
- Identify and plan development activity as part of ongoing continuous professional development (CPD), taking into account any professional standards that are also applicable for specific board member roles
- Review the self-assessment with their line manager and obtain feedback

All board members will have more detailed individual, team and organisational objectives. The 6 domains identify competency areas and provide examples of leadership practice and behaviours which will support delivery against objectives.

3.3 Development

Even the most talented and experienced individuals are unlikely to be able to demonstrate how they meet all the competencies in this framework all of the time. However, it should provide a means by which, over time, individuals can measure themselves and develop proficiency in all areas.

The competency domains will be built into national leadership programmes and support offers for board directors and aspiring board directors. All board members should actively engage in ongoing development to enable continued and greater achievement across the competency domains over time, and should be supported to do so.

Board members should refer to the directory of board level learning and development opportunities (https://www.england.nhs.uk/long-read/directory-of-board-level-learning-and-development-opportunities/) for existing development offers.

3.4 Scoring guide

Appendix 2 is an optional scoring guide for individual board members to use when self-assessing against the competency domains.

4 Next steps

The Board Member Appraisal Framework will be published by autumn 2024. It will reflect the competency domains in this framework, as well as other performance objectives. It will also provide guidance on how to assess performance against the 6 competency domains, including for experienced board members and those who have been in post less than 12 months.

The LCF will continue to be kept under review, and may be updated periodically to reflect changes in the NHS operating environment, as well as feedback received from users. Feedback can be sent to england.karkimplementationteam@nhs.net (mailto:england.karkimplementationteam@nhs.net).

5 Detailed leadership competency domains

The individual competencies are expressed as ‘I’ statements. This is to indicate personal actions and behaviours that board members will demonstrate in undertaking their roles. However, it is recognised that, including in the context of a unitary board, high performance and delivery against objectives is also achieved through effective team working and collaboration.

1. Driving high-quality and sustainable outcomes

What does good look like?

I am a member of a unitary board which is committed to ensuring excellence in the delivery (and / or the commissioning) of high quality and safe care within our limited resources, including our workforce. I seek to ensure that my organisation* demonstrates continual improvement and that we strive to meet the standards expected by our patients and communities, as well as by our commissioners and regulators, by increasing productivity and bringing about better health and care outcomes with lasting change and improvement.

* All references to “organisation” also refer to systems for board members of integrated care boards.

Competencies

1. I contribute as a leader:

a. to ensure that my organisation delivers the best possible care for patients

b. to ensure that my organisation creates the culture, capability and approach for continuous improvement, applied systematically across the organisation

2. I assess and understand:

a. the performance of my organisation and ensure that, where required, actions are taken to improve
b. the importance of efficient use of limited resources and seek to maximise:

i. productivity and value for money

ii. delivery of high quality and safe services at population level

c. the need for a balanced and evidence-based approach in the context of the board’s risk appetite when considering innovative solutions and improvements

3. I recognise and champion the importance of:

a. attracting, developing and retaining an excellent and motivated workforce
b. building diverse talent pipelines and ensuring appropriate succession

plans are in place for critical roles
c. retaining staff with key skills and experience in the NHS, supporting flexible working options as appropriate

4. I personally:

a. seek out and act on performance feedback and review, and continually build my own skills and capability
b. model behaviours that demonstrate my willingness to learn and improve, including undertaking relevant training

2. Setting strategy and delivering long-term transformation

What does good look like?

I am a member of a unitary board leading the development of strategies which deliver against the needs of people using our services, as well as statutory duties and national and local system priorities. We set strategies for long term transformation that benefits the whole system and reflects best practice, including maximising the opportunities offered by digital technology. We use relevant data and take quality, performance, finance, workforce intelligence and proven innovation and improvement processes into account when setting strategy.

Competencies

1. I contribute as a leader to:

a. the development of strategy that meets the needs of patients and communities, as well as statutory duties, national and local system priorities
b. ensure there is a long-term strategic focus while delivering short-term objectives
c. ensure that our strategies are informed by the political, economic, social and technological environment in which the organisation operates
d. ensure effective prioritisation within the resources available when setting strategy and help others to do the same

2. I assess and understand:

a. the importance of continually understanding the impact of the delivery of strategic plans, including through quality and inequalities impact assessments
b. the need to include evaluation and monitoring arrangements for key financial, quality and performance indicators as part of developing strategy
c. clinical best practice, regulation, legislation, national and local priorities, risk and financial implications when developing strategies and delivery plans

3. I recognise and champion the importance of long-term transformation that:

a. benefits the whole system
b. promotes workforce reform
c. incorporates the adoption of proven improvement and safety approaches
d. takes data and digital innovation and other technology developments into account

4. I personally:

a. listen with care to the views of the public, staff and people who use services, and support the organisation to develop the appropriate engagement skills to do the same
b. seek out and use new insights on current and future trends and use evidence, research and innovation to help inform strategies

3. Promoting equality and inclusion, and reducing health and workforce inequalities

What does good look like?

I am a member of a unitary board which identifies, understands and addresses variation and inequalities in the quality of care and outcomes to ensure there are improved services and outcomes for all patients and

communities, including our workforce, and continued improvements to health and workforce inequalities.

Competencies

1. I contribute as a leader to:

a. improve population health outcomes and reduce health inequalities by improving access, experience and the quality of care
b. ensure that resource deployment takes account of the need to improve equity of health outcomes with measurable impact and identifiable outcomes
c. reduce workforce inequalities and promote inclusive and compassionate leadership across all staff groups

2. I assess and understand:

a. the need to work in partnership with other boards and organisations across the system to improve population health and reduce health inequalities (linked to Domain 6)

3. I recognise and champion:

a. the need for the board to consider population health risks as well as organisational and system risks

4. I personally:

a. demonstrate social and cultural awareness and work professionally and thoughtfully with people from all backgrounds
b. encourage challenge to the way I lead and use this to continually improve my approaches to equality, diversity and inclusion and reducing health and workforce inequalities.

4. Providing robust governance and assurance

What does good look like?

I understand my responsibilities as a board member and how we work together as a unitary board to reach collective agreement on our approach and decisions. We use a variety of information sources and data to assure our financial performance, quality and safety frameworks, workforce arrangements and operational delivery. We are visible throughout the organisation and our leadership is underpinned by the organisation's behaviours, values and standards. We are seen as a Well Led organisation and we understand the vital importance of working collaboratively.

Competencies

1. I contribute as a leader by:

a. working collaboratively on the implementation of agreed strategies
b. participating in robust and respectful debate and constructive challenge to other board members
c. being bound by collective decisions based on objective evaluation of research, evidence, risks and options
d. contributing to effective governance and risk management arrangements
e. contributing to evaluation and development of board effectiveness

2. I understand board member responsibilities and my individual contribution in relation to:

a. financial performance
b. establishing and maintaining arrangements to meet statutory duties, national and local system priorities
c. delivery of high quality and safe care
d. continuous, measurable improvement

3. I assess and understand:

a. the level and quality of assurance from the board's committees and other sources
b. where I need to challenge other board members to provide evidence and assurance on risks and how they impact decision making
c. how to proactively monitor my organisation's risks through the use of the Board Assurance Framework, the risk management strategy and risk appetite statements
d. the use of intelligence and data from a variety of sources to recognise

and identify early warning signals and risks – including, for example, incident data; surveys; external reviews; regulatory intelligence; understanding variation and inequalities.

4. I recognise and champion:

a. the need to triangulate observations from direct engagement with staff, patients and service users, and engagement with stakeholders
b. working across systems, particularly in responding to patient safety incidents, and an understanding of how this links with continuous quality improvement

5. I personally:

a. understand the individual and collective strengths of the board, and I use my personal and professional knowledge and experience to contribute at the board and support others to do the same

5. Creating a compassionate, just and positive culture

What does good look like?

As a board member I contribute to the development and ongoing maintenance of a compassionate and just learning culture, where staff are empowered to be involved in decision making and work effectively for their patients, communities and colleagues. As a member of the board, we are each committed to continually improving our approach to quality improvement, including taking a proactive approach and culture.

Competencies

1. I contribute as a leader:

a. to develop a supportive, just and positive culture across the organisation (and system) to enable all staff to work effectively for the benefit of patients, communities and colleagues
b. to ensure that all staff can take ownership of their work and contribute to

meaningful decision making and improvement
c. to improve staff engagement, experience and wellbeing in line with our NHS People Promise (for example, with reference to equality, diversity and inclusion; freedom to speak up; personal and professional development; holding difficult conversations respectfully and addressing conflict)
d. to ensure there is a safe culture of speaking up for our workforce

2. I assess and understand:

a. my role in leading the organisation's approach to improving quality, from immediate safety responses to creating a proactive and improvement-focused culture

3. I recognise and champion:

a. being respectful and I promote diversity and inclusion in my work
b. the ability to respond effectively in times of crisis or uncertainty

4. I personally:

a. demonstrate visible, compassionate and inclusive leadership
b. speak up against any form of racism, discrimination, bullying, aggression, sexual misconduct or violence, even when I might be the only voice
c. challenge constructively, speaking up when I see actions and behaviours which are inappropriate and lead to staff or people using services feeling unsafe, or staff or people being excluded in any way or treated unfairly
d. promote flexible working where possible and use data at board level to monitor impact on staff wellbeing and retention

6. Building trusted relationships with partners and communities

What does good look like?

I am part of a board that recognises the need to collaborate, consult and co-produce with colleagues in neighbouring teams, providers and systems, people using services, our communities and our workforce. We are seen as leading an organisation that proactively works to strengthen relationships and develop collaborative behaviours to support working together effectively in an integrated care environment.

Competencies

1. I contribute as a leader by:

a. fostering productive partnerships and harnessing opportunities to build and strengthen collaborative working, including with regulators and external partners
b. identifying and communicating the priorities for financial, access and quality improvement, working with system partners to align our efforts where the need for improvement is greatest

2. I assess and understand:

a. the need to demonstrate continued curiosity and develop knowledge to understand and learn about the different parts of my own and other systems
b. the need to seek insight from patient, carer, staff and public groups across different parts of the system, including Patient Safety Partners

3. I recognise and champion:

a. management, and transparent sharing, of organisational and system level information about financial and other risks, concerns and issues
b. open and constructive communication with all system partners to share a common purpose, vision and strategy

Appendix 1: Values and concepts from key documents which form an anchor for this framework

Our people promise

- We are compassionate and inclusive

- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

NHS values

- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

Our leadership way

We are compassionate

- We are inclusive, promote equality and diversity, and challenge discrimination
- We are kind and treat people with compassion, courtesy and respect.

We are curious

- We aim for the highest standards and seek to continually improve, harnessing our ingenuity
- We can be trusted to do what we promise

We are collaborative

- We collaborate, forming effective partnerships to achieve our common goals
- We celebrate success and support our people to be the best they can be

Health and Care Act 2022

- Collaborate with partners to address our shared priorities and have the core aim and duty to improve the health and wellbeing of the people of England.
- Improve the quality, including safety, of services provided.
- Ensure the sustainable, efficient use of resources for the wider system and communities

Seven principles of public life

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

Appendix 2: Optional scoring guide for individual self-assessment against the competencies

Download a word copy of this scoring guide (https://www.england.nhs.uk/wp-content/uploads/2024/02/B0496i-app-2-optional-scoring-guide-for-individual-self-assessment-against-the-competencies.docx).

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Appendix 1

Council of Governors Information Pack

Contents:

Board Sub-Committee Escalation Reports (February and March 2024):

- Quality Committee
- Finance and Performance Committee
- People and Culture Committee
- Risk and Audit Committee
- Charitable Funds Committee
- Working Together Committee in Common

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NHS
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Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 19th February 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• Concern with regard to the OMF position and timeline for the service across DCH and UHD. • Increase in waiting lists and times, in particular Gynaecology.
Key issues / matters discussed at the Committee	The meeting considered the following: • Divisional Reports from **Family Services and Surgical Division** ○ Noted an improvement in theatre utilisation but concern in DM01 deteriorating. ○ CIP delivery was raised as a concern **Urgent and Integrated Care Division and Somerset Stroke Services Update** ○ Concern with regard to cardiology and the potential risk of significant harm to patients. **Somerset Stroke Services update** ○ Committee was updated that Somerset have agreed the change in the provision of stroke services. HASU at Yeovil will close, date yet to be decided. • **Performance Report noting:** ○ Data illustrating non-elective demand in the system was presented and similar work underway for elective demand. ○ Theatre utilisation has improved to 73% however still off target from the national target of 85%. ○ Impact on elective recovery by industrial action was illustrated and it was noted that the Trust will not be providing in-sourcing for elective activity above tariff. • **Finance Report noting:** ○ Year to date deficit of £9.8m. ○ There is an efficiency shortfall partly due to under collection and impact of industrial action. ○ Agency spend is £30k off plan, there has been improvements in spend since the change of cap in January. ○ Positive cash position of £3.5m • **Draft Budget and Operational Plan 2024/25** ○ Interim planning assumptions received which are linking to internal processes. Final guidance yet to be published. ○ Committee delegated authority for the high level flash submission. ○ Assumption of no further industrial action and assume covid demands remain at similar levels. ○ Will start 2425 at a breakeven position. • Patient Flow Board Quarterly Review ○ Collaboration opportunities with Dorset Healthcare and the Working Together programme

	○ Dorset Council have funded positions which are working alongside the Trust in the Discharge lounge. ○ Need to ensure partners are committed to supporting long term following MADE events. • Escalation reports from: **CPSUG** ○ Noted that all capital schemes are prioritised and the committee and board will be sighted on capital programme for next year. **Value Delivery Board** ○ Noted to improve the escalation report to highlight the risk associated with delivered CIP.
Decisions made by the Committee	• Draft Budget and Operational Plan 2024/25 recommended for approval
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• Escalation of cardiology patient safety risk to Quality committee

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NHS
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Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 18th March 2024

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• The achievability of 2024/25 financial plan and risk associated with CIP target raised as a concern
Key issues / matters discussed at the Committee	**Performance report** • Long waits are performing better than trajectory with reduction in 65 and 78 week waits, 0 planned for 78 week by end of May. Faster to diagnosis standards 77% against 75% target. It was noted DCH are a positive outlier in Wessex. • 62 day backlog has come down due to a validation of letters. • Improved diagnostic performance and this has been noted at tiering meeting. • ED performance remains static but still above 76%. • PIFU and Theatre Utilisation remain static, and it was noted both areas performing better than peers. • Areas of concern noted. Demand for non-elective activity has been consistent all year and continues to increase. • Elective demand increase analysis (completed by the ICB) confirms post code drift and most of the increase comes from the East. 54% elective growth has come from Bournemouth and Poole primary care network. • NCTR has increased and seen a 3-month increase. All 3 areas of concern impact elective and non-elective activity and performance outputs and main drivers for what is holding performance back. **Finance update** • M11 ended month £8.9m deficit. • On going improvements in agency, vacancy percentage has improved as well as the system agency rate reduction which has seen in month spend just over £800k, it was noted for first time below plan. • Cost improvement has achieved just over £4m. • The trust final proposed position is to end with a £7.5m deficit, which if achieved will be bridged by the Dorset ICB to break even. The risk associated was noted and raised as a concern by the committee. **Operational Planning 2024/25** • Following the £76m flash submission there has been system and regional work to reduce and this has bought the target to a £44m deficit submission with DCH submitting £8.5m deficit. Cost improvement is a particular challenging area and CIP target is set at 4% which is £11.3m. • All systems (nationally) pushed to review CIP targets, Dorset ICB submitting 5% with the additional 1% risk sitting in ICB pending iterations moving through planning process. • A risk of a shortfall of cash in Q1 and in line with timescales the trust has requested for Q1 draw down.

Decisions made by the Committee	• Draft Budget and Operational Plan 2024/25 recommended for approval at Extra-ordinary board on 18th March 2024 • Cash request from NHSE recommended for approval by the board. • DCH estates strategy recommended for approval by the board. • Pathology Services (Lot 5) Managed service for Molecular Diagnostics for Southern Counties Pathology (SCP) recommended for approval by the board. • Electronic Health record case note scanning contract extension recommended for approval by the board.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Finance risk to be reviewed in light of current position.
Items / issues for referral to other Committees	• Impact of pausing digital programmes on patient safety to be raised at Quality committee.

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 19th February 2024

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• Reduction in agency spend, vacancy rates and sickness absence. Increase in apprenticeships and appraisals. • Guardian of Safe Working Report to be shared at Board

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting broadly positive metrics.
	• Divisional Reports from
	  ○ Urgent and Integrated Care Division including a pharmacy deep dive. This was seen to be a good model for divisional reports.
	  ○ Family Services and Surgical Division
	• Bank and Agency Usage and Expenditure Report noting positive improvements and a period of stability owing to the work of the People Directorate and across the Trust. Work still to be done to look at the structural causes of bank and agency usage.
	• Update on Locally Employed Doctors
	• Guardian of Safe Working Report
	• There were no subgroup Escalation Reports
	• Helpful questions from governors relating to engaging with local housing developments and noting transport issues.

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

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Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: Monday 18th March 2024

Presented by: Margaret Blankson (Chair)

Significant risks / issues for escalation to Board for action	• The Gender Pay Report was approved and is recommended to the Board for national submission and publication. • The Board Assurance Framework was noted and would be discussed at the Board. • The Staff Survey results were discussed and would be further discussed at the Board. Of note were some positive, statistically significant results, and some results that indicated further work was needed by the Trust.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• People and Performance Report and Dashboard noting:
	  ○ Reduction in agency spend, vacancy rate, and turnover.
	  ○ Successful Healthcare Support Worker recruitment event with more than 20 full time equivalent workers recruited.
	  ○ Increasing waiting time for staff accessing onsite and phone counselling, now a four week-wait. This was being closely monitored.
	• Divisional Reports from
	  ○ Family and Surgical Services Divisional report was deferred.
	  ○ Informatics / Business Intelligence (including Coding update) noting the increasing requirements of the services which support with the functioning of clinical systems.
	  ○ Estates and Facilities noting positive trajectory with a number of key performance indicators. Shortage of and difficulty attracting trade professionals to the Trust, which was similarly experienced by other trusts.
	• There were no Escalation Reports from working groups reporting to the committee.
	• The committee effectiveness review process was noted.
	• The ICB people and Culture Committee Minutes were noted.

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

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Escalation Report

Committee: Quality Committee

Date of Meeting: 20th February 2024

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• Ongoing review of an optometrist who is no longer employed by the Trust • Work underway to resolve the dialysis transport issues; some improvement already seen • Positive transformation workstreams and partnership approach

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting:
	  ○ Various core metrics remain under trajectory, including healthcare acquired infections.
	  ○ Increase in falls; 50% of incidents were patients who fell more than once. Good discussion around this topic.
	  ○ Plans to show the quality dashboard live in future meetings
	• Divisional Update from Trauma and Orthopaedics noting a query from the CQC regarding national joint registry mortality data. The data had been reviewed and corrected with the national joint registry confirming that the Trust is not an outlier.
	• Maternity Safety Report noting
	  ○ Key metrics shared at the meeting by showing the live dashboard
	  ○ Assurance sought around training compliance
	  ○ Further assurance awaited in response to a Thirlwall inquiry action
	  ○ A meeting to be arranged between the maternity safety champions, and system and regional maternity teams.
	• Learning from Deaths Report noting the SHMI had been in range for eight of the last nine months.
	• Managing External Inspections Standard Operating Procedure
	• Transformation Update and QI Progress Report
	• Escalation Reports from the following subgroups, generating assurance questions from committee members
	  ○ Clinical Effectiveness Committee
	  ○ Patient Safety Committee
	  ○ Infection Prevention and Control Committee
	  ○ Research Steering Group
	  ○ Patient Experience and Public Engagement Committee

Decisions made by the Committee	• Learning from Deaths Report
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new noted.

Items / issues for referral to other Committees	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 19th March 2024

Presented by: Eiri Jones

Significant risks / issues for escalation to Board for action	• A steady or improving state in relation to quality metrics. Where there were areas of concern the committee was provided with assurance that actions to improve the position were underway. • Broadly positive CQC Maternity Survey results • MBRRACE data for 2022 published in March 2024 indicated that the Trust's stabilised and adjusted neonatal mortality rate excluding deaths due to congenital abnormalities was more than 5% higher than the average for similar Trusts. Work was underway to review this including a five-year review of neonatal mortality.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality Report noting a thorough discussion and presentation of the live dashboard. This was noted to be particularly useful in showing the link from ward to board.
	• Maternity Reports generating good discussion and specific questions where further assurance was required. Reports presented were:
	  ○ Maternity Safety Report
	  ○ MBRRACE data for 2022, published March 2024
	  ○ ATAIN quarter 3 report – noting a positive position below the national target
	  ○ CQC Maternity Survey Results
	• The Trust Equity and Equality Quality Impact Assessment policy and use of the Dorset system tool was noted.
	• The National Audit Programme Update was noted.
	• Quality Priorities 2024/25 were reviewed and the continuation of the current priorities was supported.
	• The following Escalation reports were received and noted:
	  ○ Medicines Committee
	  ○ Safeguarding Committee
	  ○ Clinical Effectiveness Committee work plan.
	• The committee effectiveness review process was noted.
	• The ICB Quality committee minutes were noted.

Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework and Corporate Risk Register were noted and felt to be reflective of the current risks. • An increasing risk to the Corporate Risk Register was noted relating to renal transport. This has been escalated to the ICB via Performance and Quality routes. Continued monitoring of patient safety incidents via the Quality Report will remain

Items / issues for referral to other Committees	• Nil

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 19th March 2023

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The Board Assurance Framework and Corporate Risk register were approved. • There were no material changes or significant impact arising from changes to Accounting Policies and Areas of Estimation within the Annual Accounts. • The Annual Accounts will be prepared on a going concern basis. • The Annual Internal Audit Work Plan was approved and is recommended to the Board. • The External Audit Plan and fees were approved. • The Managing External Inspections Standard Operating Procedure was approved.

Key issues / other matters discussed by the Committee	The committee considered the following items:
	• Review of accounting policies and areas of estimation.
	• Going Concern Report
	• Internal Audit Progress Report noting:
	  ○ The Cost Improvement Audit returned **moderate** assurance on process design and **moderate** assurance for effectiveness.
	  ○ The Recruitment audit returned **significant** assurance for process design and **moderate** assurance for effectiveness.
	• The Anticrime Report and self-assessment were received, noting all areas were on track to deliver compliance with the standards.
	• The External Audit Progress report was received.
	• The Gifts and Hospitality Register report was noted.
	• The committee effectiveness review process was noted.
	• The ICB Audit Committee Minutes were noted.

Decisions made by the Committee	• The Board Assurance Framework and Corporate Risk register were approved. • The Annual Internal Audit Work Plan was approved. • The Anticrime Work Plan was approved. • The External Audit Plan and fees were approved. • The Managing External Inspections Standard Operating Procedure was approved. • The Charitable Funds Consolidation review was noted and the committee approved the non-consolidated status within the Trust Annual Report.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework and Corporate Risk register were approved. Committees were asked to place review of risks higher on their respective agendas. Further discussions were to be had regarding system level risks, not owned by the trust, that impacted other partners within the system

Items / issues for referral to other Committees	• Other committees to prioritise the BAF and Corporate Risk Register on their agendas and to review mitigations.

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 20 March 2024

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• **Chemotherapy Appeal major donor request for refund of donation (£30K+ £7.5K Gift Aid)** due to significant delays to Fortuneswell Unit redevelopment. Charitable Funds Committee decision 'in principle' to refund donation if required. Head of Charity is liaising with donor who has agreed to receive the latest Chemotherapy Unit project progress update and will then consider if they still wish their donation to be returned. Head of Charity will inform Charity Chair of final decision accordingly.
Key issues / matters discussed at the Committee	**DCHC Charitable Funds Committee (20.3.24)** • **DCH Charity Finance/Income 23/24** reports (M11 Feb 2024) received. Total income to date as of end Feb £491,910. Unrestricted funds were £347,420, providing a surplus of £127,420 against the reserves target of £220,000. Income to date for March is £57,615. Year-end income total forecast to be around £550,000. • **Capital Appeal (ED/CrCU)** report received. £394K income/pledges to date as of Feb 2024. Kate Adie CBE DL has agreed to be Appeal Patron. Major donor engagement event to be held at Athelhampton House on 2nd May 2024. Promotion ongoing for DCH100 Jurassic Coast Challenge (May 2024) targeted to raise £100K. Corporate engagement ongoing. Grants funding and donor engagement programme ongoing.
Decisions made by the Committee	• **Chemotherapy Appeal major donor request for refund of donation (£30K+ £7.5K Gift Aid)** due to significant delays to Fortuneswell Unit redevelopment. Charitable Funds Committee decision 'in principle' to refund donation if required. Head of Charity is liaising with donor who has agreed to receive the latest Chemotherapy Unit project progress update and will then consider if they still wish their donation to be returned. Head of Charity will inform Charity Chair of final decision accordingly.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil

Items / issues for referral to other Committees	• Nil

Working Together

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Escalation Report

Executive / Committee: Working Together Committee

Date of Meeting: Monday 5th February 2024

Presented by: David Clayton-Smith (Joint Chair)

Significant risks / issues for escalation to Committee / Board for action	• The Benefits Realisation: Metrics and Outcome Measures was approved by the committee. • The Prioritisation Framework was approved by the committee. • Discussions around the evolution of the committee to encompass a broader transformational remit. • A full discussion regarding the Joint Chief Nursing Officer proposal, with the committee endorsing the recommendation.

Key issues / matters discussed at the Committee	The committee in common considered the following items:
	• Working Together Monthly Highlight Report noting:
	  ○ Consideration being given to moving flagship four (admission avoidance) to the Integrated Neighbourhood Team Programme, pending assurance that the programme was robust enough to support the flagship.
	  ○ Limited capacity in the digital workstream due to the significant focus on EPR implementation
	• Benefits Realisation: Metrics and Outcome Measures
	• Prioritisation Framework: to support decision making for areas of focus for 2024/25
	• Governance review progress
	• Evolution of the committee in common
	• Strategy: updated position

Decisions made by the Committee	• The Benefits Realisation: Metrics and Outcome Measures was approved by the committee. • The Prioritisation Framework was approved by the committee. • The Joint Chief Nursing Officer proposal was endorsed by the committee
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	•
Items / issues for referral to other committees	• Nil