Board of Directors (Part 1) - 11/02/2025

Tue 11 February 2025, 09:30 - 13:20

THQ Boardroom

Agenda

09:30 - 09:55
25 min

1. Staff Story

09:55 - 10:00
5 min

2. Formalities

- 1a DRAFT Agenda DCH BoD Part 1 February 2025 - DCS MB.pdf (3 pages)
- 1b Draft Minutes BOD Part 1 10 12 2024 - DCS.pdf (18 pages)
- 1c Action Log BoD PART 1 February 2025.pdf (2 pages)

10:00 - 10:05
5 min

3. Chair's Comments

10:05 - 10:15
10 min

4. CEO Report

- 4. CEO Report Feb 25 Final.pdf (6 pages)

10:15 - 10:25
10 min

5. Board Assurance Framework

- 5a. DCH Board Assurance Framework Q3 Board February 2025.pdf (3 pages)
- 5b. BAF DCH Board Q3 24_25 Final Board February 2025.pdf (13 pages)

10:25 - 10:35
10 min

6. Corporate Risk Register

- 6a. Corporate Risk Front Sheet Trust Board Feb 25.pdf (5 pages)
- 6b. Copy of RISK REGISTER 15 AND ABOVE.pdf (10 pages)

10:35 - 10:45
10 min

7. Quality Committee Assurance

- Assurance Report QC 17 December 2024.pdf (4 pages)
- Assurance Report QC 28 January 2025.pdf (2 pages)

10:45 - 10:55
10 min

8. Maternity Safety Report

- 7.2a front sheet Maternity Neonatal Report Board Jan 2025.pdf (2 pages)
- 7.2b Maternity Board Jan 2025.pdf (20 pages)
- 7.2c front sheet BR plus for QC Dec 2024.pdf (2 pages)
- 7.2d SA5.2 - Dorset County Hospital Final Birthrate Plus report 20.11.2024.pdf (15 pages)
- 7.2e PMRT Q3 cover sheet.pdf (1 pages)

10:55 - 11:05
10 min

9. Update on Learning from the Children and Young People Flagship

- 7.3 CYP flasghip Quality Committee Presentation V3 16.01.25.pdf (6 pages)

11:05 - 11:15
10 min

10. Organ Donation Report

- 7.4a Organ donation report front sheet.pdf (1 pages)
- 7.4b NHSBT DCH Transplant donors Apr-Sep24.pdf (1 pages)

11:15 - 11:25
10 min

11. Finance and Performance Committee Assurance Report

- FPC Jan 25 Assurance Report - DU CH.pdf (4 pages)

11:25 - 11:35
10 min

12. Balance Scorecard

- 8.2 Board Balanced scorecard report Feb meeting.pdf (14 pages)

11:35 - 11:45
10 min

13. Finance Report

- 8.3a. Front Sheet DCH FPC M9.pdf (3 pages)
- 4b. DCH M9 Finance Report.pdf (15 pages)

11:45 - 12:00
15 min

Break

12:00 - 12:10
10 min

14. People and Culture Committee Assurance Report

- PCC Jan 25 Assurance Report - Joint - FW.pdf (4 pages)

12:10 - 12:20
10 min

15. Strategy, Transformation and Partnership Committee Assurance Report

- Strategy Transformation and Partnerships CiC Assurance Report Jan 2025 - DCS.pdf (3 pages)

12:20 - 12:30
10 min

16. Joint Strategy Implementation Update

- 10.2 Joint Strategy Implementation Update Feb 25 Final Draft.pdf (12 pages)

12:30 - 12:40
10 min

17. Audit Committee Assurance Report

- Assurance Report DCH Audit Committee 17 December 2024 - SP.pdf (2 pages)
- Assurance Report DCH Audit Committee 03 February 2025 - SP CH.pdf (2 pages)

12:40 - 12:50
10 min

18. Scheme of Delegation

- 11.2a. AC 17-10-24 - SFIs and Scheme of Delegation update Front Sheet.pdf (4 pages)
- 2b. 1934-1-Standing-financial-instructions.pdf (37 pages)
- 2c. 1933-4-Scheme-of-delegation.pdf (20 pages)

12:50 - 13:00
10 min

19. Service of Enforcement Notice from Information Commissioners Officer re FOI

- 11.4a FOI Compliance Board Report v2 29.01.2025.pdf (4 pages)
- 11.4b Appendix 1 ICO Enforcement Notice.pdf (9 pages)

13:00 - 13:10
10 min

20. Charitable Funds Committee Assurance Report

- 12.1 Assurance Report - DCH Charitable Funds Committee (20.1.25).pdf (2 pages)

13:10 - 13:10
0 min

21. ICB Board Report

- 13.1 ICB Board Report to Partners Part One 071124.pdf (2 pages)

13:10 - 13:15
5 min

22. EDS2

- 13.2a Equality Delivery System EDS2 Report and Action Plan Front Sheet board 2024 (002).pdf (6 pages)
- 13.2b Equality Delivery System EDS2 DCHFT Report and Action Plan 2024 EH approve.pdf (43 pages)

13:15 - 13:20
5 min

23. Questions from the Public

13:20 - 13:20
0 min

24. AOB

Dorset County Hospital
NHS Foundation Trust

Meeting of the Board of Directors (Part 1) of Dorset County Hospital NHS Foundation Trust Tuesday 11th February 2025 at 9.30am to 1.20pm Board Room, Trust Headquarters, Dorset County Hospital, Dorchester and via MS Teams

AGENDA

Ref	Item	Format	Lead	Purpose	Timing
1.	**Staff Story**	Presentation	Nicola Plumb	Information	9.30-9.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Information	9.55-10.00
	a) Apologies for Absence: Matthew Bryant, Dawn Dawson, Rachel Wharton	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 10 December 2024	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Information	10.00-10.05
4.	**CEO Report**	Enclosure	Nick Johnson	Information	10.05-10.15
5.	**Board Assurance Framework** (February Audit Committee)	Enclosure	Jenny Horrabin	Assurance	10.15-10.25
6.	**Corporate Risk Register** (February Audit Committee)	Enclosure	Jo Howarth	Assurance	10.25-10.35
7.	**Quality**				
7.1.	**Quality Committee Assurance Report**	Enclosure	Claire Lehman Eiri Jones	Assurance	10.35-10.45
7.2.	**Maternity Safety Report** (including Birthrate Plus report and PMRT Report) (January QC)	Enclosure	Jo Howarth (Jo Hartley)	Assurance	10.45-10.55
7.3.	**Update on Learning from the Children and Young People Flagship** (January QC)	Presentation	Jo Howarth	Assurance	10.55-11.05
7.4.	**Organ Donation Report** (December QC)	Enclosure	Alastair Hutchison	Information	11.05-11.15
8.	**Finance and Performance**				
8.1.	**Finance and Performance Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	11.15-11.25
8.2.	**Balanced Scorecard (incl. elective tiering)**	Enclosure	Anita Thomas Executives	Assurance	11.25-11.35
8.3.	**Finance Report** (November FPC)	Enclosure	Chris Hearn	Assurance	11.35-11.45

Coffee Break 11.45-12.00					
9.	**People and Culture**				
9.1.	**People and Culture Committee Assurance Report**	Enclosure	Frances West	Assurance	12.00-12.10
10.	**Strategy, Transformation and Partnership**				
10.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Enclosure	David Clayton-Smith	Assurance	12.10-12.20
10.2.	**Joint Strategy Implementation Update**	Enclosure	Nick Johnson	Assurance	12.20-12.30
11.	**Audit Committee**				
11.1.	**Audit Committee Assurance Report**	Enclosure	Stuart Parsons	Assurance	12.30-12.40
11.2.	**Scheme of Delegation** (December Audit Committee)	Enclosure	Chris Hearn	Approval	12.40-12.50
11.3.	**Freedom of Information Requests Compliance and Service of Enforcement Notice from Information Commissioners Officer** (February Audit Committee)	Enclosure	Nick Johnson	Information	12.50-1.00
12.	**Governance**				
12.1.	**Charitable Funds Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	1.00-1.10
13.	**CONSENT SECTION**				All items 1.10-1.15
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
13.1.	**ICB Board Report**	Enclosure	David Clayton-Smith	Information	
13.2.	**Equality Delivery System 2 (EDS2)** (January PCC)	Enclosure	Nicola Plumb	Assurance	
14.	**Questions from the Public**	Verbal	David Clayton-Smith		1.15-1.20
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk				
15.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Information	1.20
16.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of **Dorset County Hospital NHS Foundation Trust** will take place at **9.30am** on **Tuesday 8th April 2025** in **Trust HQ Boardroom and via MS Teams.**				

	Resolution Regarding Press, Public and Others: To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

Quorum:
The quorum of the meeting as set out in the Standing Orders of the Board of Directors is below:
"No business shall be transacted at a meeting unless at least one-half of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present."

Part 2 Items

- Chair's Comments
- CEO Update
- Finance Update and Operational Planning
- External Structural Deficit Review
- Fortuneswell Pharmacy Development and SubCo
- ODPC Board Minutes

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 9am on 10th December 2024 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Margaret Blankson	MB	Non-Executive Director
Matthew Bryant	MBr	Joint Chief Executive
Dawn Dawson	DD	Joint Chief Nursing Officer
Chris Hearn	CH	Joint Chief Finance Officer (via videoconference)
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Alastair Hutchison	AH	Chief Medical Officer (via videoconference)
Nick Johnson	NJ	Deputy Chief Executive and Joint Chief Strategy, Transformation and Partnership Officer
Eiri Jones	EJ	Joint Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non-Executive Director
Stuart Parsons	SP	Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director (via videoconference)
David Underwood	DU	Joint Non-Executive Director
Frances West	FW	Joint Non-Executive Director
In Attendance:		
Jim Bailey	JB	Corporate Governance Manager (DHC) (Observing)
Abi Baker	AB	Corporate Governance Manager (Minutes)
Lindsey Burningham	LB	Deputy Director of Midwifery and Neonatal Services (item BoD24/155)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs
Judy Gillow	JG	Non-Executive Director, University Hospitals Dorset (Observing) (via videoconference)
Jodie Crabb	JC	Divisional Head of Nursing and Quality, Family Services and Surgical Division (item BoD24/147)
David Crabb	DC	Patient Story (item BoD24/147)
Jill McCormick	JM	Guardian of Safe Working (item BoD24/164)
Lynn Patterson	LP	Freedom to Speak Up Lead (item BoD24/165)
Simon Pearson	SPe	Head of Charity and Social Value (item BoD24/169)
Members of the Public:		
Kathryn Harrison	KH	Lead Governor (via videoconference)
Anne Link	AL	Governor (via videoconference)
Apologies:		
Nil		

BoD24/147	**Patient Story**	
	DD introduced the patient story from David Crabb, whose daughter was Jodie Crabb and worked at the trust. David's story would focus on his long-term condition, how he managed this, and his experience as a patient at the trust. DC shared a presentation, providing on outline of his family life on Portland and his work life in the Ministry of Defence and as a coastguard. In 1985	

	DC developed diverticulitis and in 1992 he was medically retired but continued to participate in community life on Portland and remained active. In 2002 he was moved to total parenteral nutrition (TPN) feeding as his body was not able to absorb nutrients through normal feeding. DC described the limitations and restrictions this caused and how he managed his condition at home. Of note, DC highlighted that the TPN allowed him to live his life as best he could, but did not allow for spontaneity or holidays. He stressed how much of his life was dependent on the supplies and equipment he had for his condition. DC's specialist care was provided by The John Radcliffe Hospital in Oxford, three hours away from his home. As such any visit to the hospital had to be carefully planned around his condition. DC underwent regular blood tests with his GP and supplies for the TPN were delivered monthly. Following an acute episode of sepsis, DC required a hip replacement which was undertaken at the trust. Additional support was required due to his condition and DC described the positive experience and care he received from staff at the trust particularly in relation to his long-term condition. He was now more mobile and was able to do things that he could not previously do, such as climbing on the rocks at Portland bill. DC described that most of his admissions to hospital were emergency admissions. The most challenging of which was four months on Abbotsbury ward and the intensive care unit, whilst Covid-19 restrictions were still in place. During this stay DC was in a side-room which he described as being lonely, with minimal entertainment and limited ability to wash himself. Sleeping was particularly challenging due to the level of noise on the ward. Despite this, DC commended the doctors, nurses and dieticians who worked at the trust, who he described as friendly and helpful. He further commended the trust's acute hospital at home (AHAH) service. However, the communication delays between the trust, the John Radcliffe Hospital, and his GP could be difficult and could cause delays with receiving medication. DC described the daily challenges that his condition caused, including the need for a strict routine, the management of supplies, and the ability to access a GP appointment when needed. DC summarised that his long-term condition was a way of life for him, his wife, and his family. He did what he was able to do, but he was not always able to do exactly what he would like to do. Board members thanked DC for his presentation and reflected on the ongoing work to support people with long-term conditions, particularly in relation to remaining out of hospital where appropriate. The importance of communication between primary, secondary and tertiary services was recognised as something that needed improving.	
	Resolved that: the Patient Story be received for information.	
BoD24/148	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting.	

BoD24/149	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD24/150	**Minutes of the Meeting held on the 09 October 2024**	
	The Minutes of the meeting dated 09 October 2024 were approved as an accurate reflection of the meeting, subject to a minor typographical error.	
	Resolved: that the minutes of the meeting held on 09 October 2024 were approved.	
BoD24/151	**Matters Arising: Action Log**	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items. BoD24/117: NP updated that the data in the WRES and WDES was provided by NHS England. Whilst there were some queries about the accuracy of the data, the action would be closed and DU expressed an interest in looking in to this further with the teams, away from the Board meeting. The action was closed. With reference to minute BoD24/114 of the minutes of 09 October, EJ suggested that further detail around the AHAH service be returned to Quality Committee. MBr suggested that this be provided for both trusts. In relation to the matter of evacuation, EJ sought assurance that evacuation in the event of a power surge or outage. AT confirmed that the trust's internal evacuation plan covered this contingency and was being considered more widely within the local resilience forum (LRF).	**QC**
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD24/152	**Chair's Comments**	
	DCS reflected on the responsibilities of the board as leaders to make sure that the care and quality of care patients received remained at a high standard and considered the continued work to implement the joint strategy in support of this effort. DCS characterised his time since the last meeting as being focused on system-working and recognised the hard work going on to support the trust and system financial position. In particular DCS had spent time working with Rob Whiteman (RW), Chair of University Hospitals Dorset (UHD) to ensure the provider collaborative achieved success.	
	Resolved: that the Chair's comments be received for information.	
BoD24/153	**CEO Update**	
	MBr highlighting the following key points for the board. The report would be circulated after the meeting: National:	

- The national launch of the consultation for the ten-year plan. The consultation could be accessed online, but local work to collate views of colleagues was also being undertaken.
- Release the autumn budget which demonstrated constrained public finances. Although there was additional investment for the NHS in revenue, much if not all of this was already committed. There was however a commitment around capital, which was key to the future of digital in the NHS.
- Launch of the national consultation on the regulation of NHS managers. MBr was a member of the national stakeholder group feeding in to this consultation
- Publication of the insightful provider board guidance by NHS England (NHSE), which provided a template for boards to consider their approach to handling and acting on the information they receive. This would be discussed further at a Board Development Session.
- Launch of the NHSE national guidance on sexual safety, which built upon the NHS sexual safety charter. MBr stressed the importance of this in ensuring that the workplace was a safe space and there was a strong focus on this in the trust at present.
- Publication of NHSE guidance relating to the evolution of the operating model, which outlines the role of Integrated Care Boards (ICBs) as strategic commissioners and the move from analogue to digital, treatment to prevention and from hospital to community.
- Mental Health Act reforms continued to progress

System:

- Ongoing discussions with regional colleagues around half-term planning for, quality, performance and finance metrics, as well as those in the medium term.
- A full update on the work of the Our Dorset Provider Collaborative (ODPC) would be provided in part two of the meeting, but the summary was that the outline business case for an electronic health record (EHR) was progressing.

Within the federation with Dorset HealthCare (DHC):

- The work of the Integrated Neighbourhood Team (INT) continued to progress, with the first four areas now up and running (Weymouth and Portland, Boscombe, Poole west, and Purbeck)
- Work was ongoing to develop the enabling plans for the joint strategy
- Focus on completion rates of the staff survey

Within Dorset County Hospital (DCH)

- The Trust had recently been placed in to tier two for elective performance but was making steady progress in this regard with the number of people waiting over a year for care reducing significantly in recent weeks.
- Positive results from the recent survey of urgent and emergency care, with 82% of people rating their experience highly.
- Encouraging scores following the recent Patient Led Assessment of the Care Environment (PLACE) survey, a full report on which would be presented to Quality Committee.

	• Receipt of an 'a' rating in the recent SSNAP audit for stroke. DCS noted the importance of the federation of DCH and DHC working with NHSE and wider system partners. Following a meeting about the ten-year plan DCS believed that there was a determination for it to truly be a long-term plan, as opposed to fixing issues in the short term.	
	Resolved: that the CEO Update be received for information.	
BoD24/154	**Quality Committee Assurance Report**	
	CL spoke to the previously circulated assurance reports from the Quality Committee meetings held on 04 and 26 November. She drew the Board's attention to the below matters: • Further update on the consent action plan would return to the committee in March • Partial assurance around the ophthalmology risk • An anticipated rise in grade two pressure ulcers, due to a great deal of work taking place within the tissue viability team • A move towards the committee having greater strategic focus, rather than operational, supported in part by the development of an executive-led Quality Governance Group. This would help the move to a Quality Committee in Common with DHC • Ongoing work in relation to renal transport concerns • Themes relating to IT and public health in a number of reports received in month • Achievement of the maternity incentive scheme (MIS). CL commended the work of the maternity team and all involved in this work. • Safe staffing report, which would be presented to Board later on SP sought further assurance around the renal transport risk. AT updated that a meeting had been held last week to discuss the matter and progress had been noted, in part due to dedicated transport for renal patients. ICB colleagues, as the service provider, were meeting with patients, listening to their concerns, and reminding them of the option to arrange their own transport and be refunded for it. The risk to patients was now reducing. Noting the theme of IT in a number of areas, MBr suggested that the Strategy, Transformation and Partnership Committee in Common receive an update on the capacity, bandwidth, and priorities for the digital teams. NJ noted for context the development of a joint digital strategy which was due to be completed in March, but that an initial assessment of the digital position would be provided to the committee in January. Some board members had heard about issues with Badgernet from ward staff. NJ would look in to the detail of this as part of the update to the committee.	**STPCIC**
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD24/155	**Maternity Safety Report**	
	LB highlighted the below key points from the report • No third or fourth degree tears or still births in October	

	• One neonatal death, which was being reviewed through Trust processes, as it did not meet the criteria for external review by the Maternity and Newborn Safety Investigations (MNSI) programme. The results would be detailed in a future report. • A decline in some key quality metrics, all of which pertained to ongoing national or local quality improvement (QI) projects with actions for targeted improvement • Funding for resuscitaires had been received by the DCH Charity DD drew the Board's attention to the neonatal staffing risk, highlighting that the Trust did not currently meet the BAPM standards in terms of the necessary staffing model with a supernumerary coordinator on each shift. The Trust was compliant during working hours, but non-compliant out of hours and at weekends which posed an additional risk. The Maternity Incentive Scheme (MIS) required the Board to endorse the action plan and trajectory towards full compliance. Further to this a business case had been presented to a Joint Executive Management Team (JEMT) meeting which DD, AT and AH were sighted on. The Board endorsed the work required for MIS compliance.	
	Resolved: that the Maternity Safety Report be received for assurance.	
BoD24/156	**Learning from Deaths Report Q2**	
	AH highlighted the following points of note: • Positively, the Summary Hospital-level Mortality Indicator (SHMI) was now at the lowest level for approximately eight years. • Some concerns about the depth of coding which was decreasing each month. This was being reviewed by the coding team. • Total number of spells per 12-month period was now around 34,000, compared to the pre-covid level of 29,500. This increase was placing additional strain on the coding department. • Some concerns about mortality post-hip fracture. Numbers remained small at present and the department were investigating this further. The Quality Committee and Board would be further updated in due course. • The slide relating to the Morecombe Bay report detailed that the Board should be made aware of concerns within departments and that this could be received via an annual or bi-annual report from the responsible officer. Further discussion about the implementation of the Morecombe Bay recommendations would take place in Quality Committee. AH confirmed that deaths included that occurred 30 days after discharge were included in a trust's mortality data, even if that death had no connection to the individuals discharge. AH advised that there were no additional areas of concern, other than those already highlighted. He described that the report was more comprehensive than many other trusts received because the SHMI had previously been of concern and the additional level of detail offered assurance that there were not excess deaths in the Trust. Two key areas that supported this conclusion were intensive care admission and death	

	rates, and the cardiac arrest audit. AH was confident that there were no areas of concern in relation to excess deaths. EJ sought further assurance around the 'potential mis-triage to the ward' indicator detailed on page 67 of the papers. AH would provide further detail to the Quality Committee. DU commended the work done by AH and the coding and clinical teams to bring the SHMI in to the normal range, recalling that it had been a problem for a number of years. During that time structured judgement reviews (SJRs) had been relied on to understand the issue, and it was right that the percentage of SJRs undertaken be reviewed now that the SHMI had improved.	**AH**
	Resolved: that the Learning from Deaths Report Q2 be approved for publication.	
BoD24/157	**Walkarounds Output Report**	
	DD outlined that the report set out the quality walkarounds undertaken between April and September. This included seven in outpatient areas, nine in inpatient areas, and two in non-patient facing areas. The methodology used in the walkarounds included elements of the 15-steps and of the patient safety walkaround toolkit. Thematic findings were detailed under a range of headings. Highlights included staff being welcoming and friendly, good access for mobility scooters, positive interactions between staff and patients, and good processes for infection prevention and control. A number of recommendations were also made, including the need to upgrade the library, improve use of fire doors and publishing cleaning schedules. FW commented that the report offered a real ward to board view and brought to life the influence of the walkarounds. Other Non-Executive Directors described the walkarounds as invaluable, although the administration of them could be smoother. EJ reflected on the benefit that was provided by non-clinical governors joining the walkarounds but felt that the form that was completed after the walkarounds was too quantitative and should include qualitative findings as well. The need for flexibility to ensure that the visits did not impact clinical care was also noted. The Board discussed the recently implemented expanded visiting hours and some concerns that this could make patients more tired. MBr reflected that in his experience of expanding visiting hours, there might be some concerns to begin with, but it ultimately proved to be a positive move. He understood that the change needed to be made thoughtfully and with due consideration for any impacts it might have.	
	Resolved: that the Walkarounds Output Report be received for assurance.	
BoD24/158	**Safe Staffing Report – Annual Review**	

	DD outlined that the report had been presented to November's Quality Committee. The safe staffing review was undertaken in line with the developing workforce standards and utilising the safer nursing care tool. This was an evidence-based tool used alongside professional judgement to consider the dependency and acuity of patients on wards to confirm whether the staffing provision on ward was safe to meet the needs of the patients. The work was supported by twice-daily bed and flow meetings and the introduction of an acuity-based census three times a day. A number of measures had been implemented since last year's report including the introduction of housekeepers to support with nutrition and fluid intake, and the use of ward clerks to help improve electronic discharge summary (EDS) performance. The report went on to detail a number of areas of development in the coming year including increasing headroom allocation, which would be reviewed under the usual business planning processes. Also included in the papers was the maternity Birthrate Plus report, which set out the staffing requirements for maternity. The impact of sickness levels was noted, as well some incidents around medical staffing, but positively there was 100% compliance in a number of metrics. Recognising the financial challenges the trust faced, EJ impressed the need to increase headroom given how important this was to clinical outcomes and preventing deaths, as well as reducing agency costs. She added that it would be helpful to see the skill mix of staff in future reports. The meeting heard that the report was more detailed at DHC, and this would be replicated at DCH in the future. FW reflected on the importance of non-clinical staff, such as housekeepers and ward clerks, to release clinical capability. DD confirmed that the safer staffing process reviewed the cost balance and need for non-clinical and clinical staff in clinical spaces. Discussions noted that the report was completed bi-annually, but MBr provided assurance that any issues of risk identified were acted on immediately. The recommendations presented in the report would be taken forward in to business-as-usual processes, including business planning, with updates provided to the board as required. If a recommendation if not approved, then updates should appropriately describe the risks.	
	Resolved: that the Safe Staffing Report – Annual Review be approved.	
BoD24/159	**Finance and Performance Committee Assurance Report**	
Baker,Abi 04/02/2025 15:47:21	DU highlighted the following matters for the Board's attention: • The increase of strategic risk 6 (finance) from 16 to 20 • Health and Safety (incl. Fire and Water) Compliance Report. Board Assurance Framework score for strategic risk 5 (estates) increased to 16, pending the completion of fire safety work	

	• DU intended to hold a workshop with AT, CH and other Non-Executive Directors to review performance metrics and consider if they were still appropriate or if they could be changed at all. • Cash flow remained a significant risk for the Trust. There had been confirmation of some elective recovery fund (ERF) funding which would support the position but would not solve it. • Focus needed to continue on the cost improvement programme (CIP) and ensuring progress was being made. DU suggested the CIP needed reinvigorating. DU further noted the decisions made at the meeting, as outlined in the report. The approval of the new CAMHS unit was an error as this related to the Dorset HealthCare committee. JH noted that although the committee had approved the modern slavery and trafficking statements, legislative updates were expected which would require them to be reviewed again in less than a year. AT provided clarity around the trust's tiering rating, outlining that this had been set specifically on the concern that the trust might not deliver the 65 week-wait standard by the end of the financial year. The trust had weekly tiering meetings with the region and, given the assurances provided, it was expected that the trust would be removed from tiering shortly. There were no other metrics that had contributed to the tiering position. With regard to the CIP, NJ highlighted that the DCH recovery group was setting up deep dives with each division to ensure focus in the final quarter of the year. The board discussed the need to set realistic targets. MBr noted that targets had been set in good faith and with a view to achieving something that had not been achieved before. He further reflected on the need to balance certainty and ambition. The CIP achieved to date was the highest ever achieved in the trust, with further to go against the target. This should be considered within the context of how hard the agenda for CIP had been pushed.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD24/160	**Balanced Scorecard (incl. elective tiering)**	
	AT referred to the previously circulated report, noting the reduction in indicators that were failing their target, from 16 to eight, between August and October. There were still some indicators that were missing targets to executives were encouraged to review and update these. AT highlighted the following key points from the report: • Fluctuations in cancer performance due to small numbers and within the context of growing demand • Recent visit to theatres by the regional team. A draft report had been received and the action plan would be discussed through Finance and Performance Committee in Common. There were no areas for improvement identified in the report that the trust was not already aware of.	

	• Within theatres the trust was in the top quartile for early starts, the second quartile for late finishes, and the third quartile for turnaround time. The trust was focusing on improving the efficiency of theatres. • Assurance was not yet received over diagnostics as there were not yet enough months demonstrating an improvement, but progress was being made in the cardiac pathway which had now moved to a seven-day service. • There was variation in ambulance handover time due to winter pressures and high acuity, but the trust continued to perform within the 30-minute standard. EJ commended the improvements being made and noted the remaining challenges. A lot had been invested in theatres, but it was recognised that making changes to staffing was difficult. EJ was assured there was a strong focus on the matter and commended the openness from executives on the areas that were difficult to improve. AT noted that the regional team had been complimentary of the theatres team and the activity taking place. The benefit of the opening of the Weymouth theatre was also noted.	
	Resolved: that the Balanced Scorecard (incl. elective tiering) be received for assurance.	
BoD24/161	**Finance Report**	
	CH presented the finance report to the end of month seven. He noted that month seven delivered a deficit of £1.4m against a planned surplus of £0.3m. The year-to-date deficit stood at £8.6m. Key drivers of the deficit included: • Operational pressures including 19 escalation beds and 76 no criteria to reside beds. • The high level of CIP required at £14.4m for the year. £3.3m had been delivered to date, with a significant increase expected over the rest of the financial year. It was expected that the trust would deliver £8 CIP; whilst this fell short of the target it would be the largest CIP deliver in recent years. Work continued to focus on the CIP. • Inflationary pressures, including renewal of three and five-year contracts which were seeing double-digit increase in prices, particularly those linked to energy. • A slight increase in agency usage in month due to sickness, following a reduction in costs and usage over the last 18 months The trust's cash position was monitored on a daily basis. Given the current deficit position the trust had requested additional cash from NHS England in recent months, but this had been rejected. Work was underway to understand the mitigations that could be put in place. This would be further discussed in the confidential part of the meeting. The confidential board meeting would also consider the formal requirement from NHS England for boards to formally approve the capital forecast for the remainder of the year.	

	Asked about the CIP, CH recognised that there was a significant stretch needed to deliver the £8m but this continued to be the ambition, with additional robust governance processes in place to ensure appropriate scrutiny in the delivery of the CIP. SP sought further detail about the quantity of funding expected from the ERF. CH advised that this was not yet confirmed but was being worked through at a local and system level. CH described the ERF position as a positive development and was the result of a number of changes the trust had made over the year, including the opening of the Weymouth theatre and the review of insourcing contracts. The level of ERF funding would be further discussed in Finance and Performance Committee in Common.	
	Resolved: that the Finance Report be received for assurance.	
BoD24/162	**Winter Plan**	
	AT outlined that the trust's winter plan had been presented to the October Board meeting, but that system winter plan had not been available at that time. This was now available and included in the papers. The focus continued to remain focused on the front door and pre-front door of the hospital and to use same-day emergency care (SDEC), virtual wards, and other mechanisms to reduce length of stay or to provide care out of the hospital. The trust's plan was noted as broadly the same as the system plan. CL sought further assurance around the collaborative work with primary care and ambulance trust colleagues to avoid admissions to the hospital. AT outlined that the trust's GP liaison, Martin Longley, worked closely with the primary care network (PCN) for west Dorset in the utilisation of the Acute Hospital at Home (AHAH) service as needed. At a system-level the focus was on the impact of GP collective action, particularly over the winter. The Board discussed vaccination rates amongst staff. The figures remained lower than expected and a working group had been established to oversee the work. It was recognised that some staff were fatigued from needing vaccinations every year. The importance of senior leaders role modelling and supporting staff to have their vaccinations was noted. The Board approved the winter plan.	
	Resolved: that the Winter Plan be approved.	
BoD24/163	**People and Culture Committee Assurance Report**	
	FW highlighted the following key points from the report: • The committee was settling in to working jointly where possible, whilst focussing on trusts individually where relevant. Reports were harmonising and becoming more similar where appropriate. • Informal committee meetings were being used as an opportunity to visit services where key areas of work took place. In October the committee visited the occupational health service. There was an overspend in the this service for the trust but this was understood	

	to be related to the bedding in of a new service and managing a backlog of work. • The committee received a number of additional reports which would be discussed individually later in this meeting, such as the Freedom to Speak Up (FTSU) and the GMC survey report. SP sought clarity about the agenda spend position. NP advised that agency spend had reduced, but that it was still higher than the planned expenditure. Positively, off-framework spend had almost been eliminated. The board discussed the reporting route for the whistleblowing policy and arrangements, recognising that FTSU and whistleblowing information reported to People and Culture Committee in Common. The meeting heard that JH was leading a piece of work to confirm the reporting route for whistleblowing policy as this had also been identified as an action by the DHC Audit Committee. The Board further considered the distinction between FTSU and whistleblowing, the latter being protected disclosures, and that the FTSU guardian would undertake a piece of work to ensure that matters were reported through the correct route.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD24/164	**Guardian of Safe Working Report**	
	JM joined the meeting for this item to present the report covering the period July to September. JM highlighted the following: • 82 exception reports were received; a significant increase compared to the same period last year. • There were seven immediate safety concerns, a reduction from 13 in the previous quarter. The concerns related to an orthopaedic SHO carrying two bleeps, a FY1 doctor who did not feel they were receiving enough support from the FY2 doctor. These were dealt with quickly and additional support continued. • A reduction in vacancy rate from 36.3 to 24.3 whole-time equivalent • Orthopaedics was the area with the highest level of exception reports. A new rota had been developed which made night shifts more manageable and reduce immediate safety concerns. The meeting heard that the data was generated through resident doctors self-reporting. It was understood that there was variation in how individuals reported, with some rarely reporting and other over-reporting, so it was incumbent on the GOSW to consider this in their deliberations and reports. So long as there were a reasonably good number of reports, it was possible to highlight areas of concern. FW asked if there was a way to prevent doctors from undertaking agency work elsewhere if it breached their safe working hours. AH advised there was no foolproof way to prevent it, but if it did happen it was taken seriously and could result in disciplinary action. The board discussed the quality impacts of the escalation reports raised by resident doctors, and whether it was possible to triangulate the GOSW data with risk data to see if there was any adverse impact on patients. DD	

	and AH would look in to this and consider what could be presented to Quality Committee.	**AH, DD**
	Resolved: that the Guardian of Safe Working Report be received for assurance.	
BoD24/165	**Freedom to Speak Up Report**	
	LP joined the meeting for this item. The report was presented for assurance, not approval. LP highlighted the following key points from the report: • 256 cases were received in the reporting period, a significant rise of 156% compared with the same period last year. The rise was partly due to a targeted listening events which accounts for 14% of cases, and regular weekly walkabouts to increase visibility. • The most type of concern raised was staff wellbeing, followed by inappropriate behaviours. This mirrored the picture at DHC and nationally. • Cases were raised by staff in a range of areas, with nursing and midwifery raising the most concerns; this mirrored the national picture and represented their share of the workforce. • Poor communication was a recurring theme, particularly in relation to managers of staff • Next steps included updating FTSU intranet page to include case studies and learning, increasing FTSU training now that it was mandatory, and reviewing workstreams to ensure alignment with DHC. NP highlighted the 95% of cases had actions for resolution agreed within three weeks. Reflecting on concerns about workload across a number of teams, NP considered that if those cases could be resolved within three weeks, then perhaps they did not require the input of the GOSW. LP described that this was a metric she had set herself, described her role in changing how people perceive situations and the need to ensure that managers had time to listen to staff concerns. SP sought clarity around the incivility experienced by staff. LP advised that this was incivility staff experienced from other staff. LP now held dignity and respect workshops which looked at definitions of incivility and mechanisms to deal with challenge courteously. DU commended LPs work over the last two years, noting the increase in FTSU champions from 18 to 39 and LPs efforts to champion and promote the work of the FTSU guardian. The collaborative work with DHC's FTSU guardian was also commended. MBr echoed this thanking LP for the immense amount of work detailed in the report. MBr restated the message that LP had open access to all members of the executive team, including himself.	
	Resolved: that the Freedom to Speak Up Report be received for assurance.	
BoD24/166	**Joint Workforce Wellbeing Plan**	

	NP advised that the joint workforce wellbeing plan was presented today ahead of the joint people plan, which was still in development. It was noted that the trust had not previously had a strategic approach to wellbeing. The plan was broadly aligned to the NHS England Wellbeing Framework, with a number of national documents included in the document for reference. NP described that it was difficult to evaluate the effectiveness of a wellbeing plan, but the plan did offer a guide to how its effectiveness could be reviewed. The trust's wellbeing steering group would implement the plan and would report in to People and Culture Committee in Common. The plan was presented for approval; work to improve wellbeing was already underway but approval of the document would give a clear direction of the strategic intent to improve wellbeing. As chair of People and Culture Committee in Common FW described this a comprehensive piece of work which had been received well by the committee and offered the ability to migrate best practice between the two trusts. The board discussed the requirement for board members to have wellbeing objectives. EJ described that this was implicitly in everything the board did and felt that including an objective could be seen as tokenistic. MBr noted that this was a requirement by 2026 so there was time to consider who to implement it meaningfully. MBr commended the work, noting that the intentions in the plan had to enable an environment in which staff could thrive. Asked about indicative timescales for actions, NP advised that these would be developed in conjunction with the actions arising from joint people plan, later in the year.	
	Resolved: that the Joint Workforce Wellbeing Strategy be approved.	
BoD24/167	**GMC Survey Results and Action Plan**	
	AH outlined that the GMC survey applied only to trainee doctors and that there had been a better than average response rate, with improved scores in 14 of the 19 elements. AH summarised this as a positive report. One concern had been raised regarding local teaching; this had been discussed at the Medical Education Group and action plans developed. Also of note was the below average reporting of burnout. Burnout was reported highest in the emergency department and work was being focused to address the issue. MBr reflected that there were always improvements to be made, but that the staff involved in the training and supervision of trainee doctors should be commended, with the trust being one of the highest-scoring for overall satisfaction in the deanery.	
	Resolved: that the GMC Survey Results and Action Plan be approved.	

BoD24/168	**Strategy, Transformation and Partnership Committee Assurance Report**	
	DCS highlighted the following key points from the report: • Traction was being gained in transformational spaces across the federation • The committee approved the outline business case for a subsidiary company for some back office functions across the system • An update on the electronic health record had been received. The project was described as vitally important to the digital infrastructure of the trust and system partners. • Update on the new hospital programme (NHP) which was reaching agreement on the guaranteed maximum price. • Establishment of the one transformation approach which would provide a methodology to help with decision making • An update on the One Dorset Provider Collaborative which considered horizontal and vertical integration and collaboration.	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD24/169	**Social Value Action Plan**	
	SPe outlined the key points from the bi-annual social value report, including: • Work was underway to consider a joint approach to social value with DHC • An increase in local investment with local suppliers, catering and third sector • An increase in local employment, widening participation and local training • A focus on the green and sustainable agenda. One key target was for the trust to reach net zero by 2045 which posed a significant challenge but was a vital piece of work. SP further outlined a number of other sustainable initiatives detailed in the report. • One paper detailed the work that Tilbury Douglas were undertaking to consider the social value impact and opportunities of the new hospital programme. • 19 patient and public engagement events in the local community within the last financial year MBr commented on the extraordinary and valuable work, noting that it was not only the right thing to do, but that it linked with the joint strategy, our place in the community, and was meaningful for our communities and staff.	
	Resolved: that the Social Value Action Plan be received for assurance.	
BoD24/170	**One Dorset Provider Collaborative Update**	
	NJ took the report as read but highlighted a few key points in relation to the One Dorset Provider Collaborative (ODPC): • Ongoing progress with the Clinical Acute Network Dorset (CANDo) project which was making changes to the way rheumatology and orthopaedic services were delivered.	

	• The final phases of a Dorset procurement service were being worked through and would be presented and would be returned to the ODPC board in January. If approved, it would then progress through trusts specific governance processes. • Benefits of the work of the provider collaborative across the system, particularly in relation to bank and agency staff reduction • A recent oversight meeting of the chairs and non-executive directors (NEDs) of the provider trusts, which many of the trust's NEDs had attended. NJ summarised that the provider collaborative could be a real engine for driving change across the system and for how the provider trusts worked together but noted that there was a risk in relation to resources and attention of work in the ODPC, given the level of activity within the system at present.	
	Resolved: that the One Dorset Provider Collaborative Update be received for assurance.	
BoD24/171	**Timetable and Milestones for Enabling Strategies**	
	NJ outlined that the report sought to provide assurance to the board that the work to implement the joint strategy was ongoing. A number of milestones had been set and detail provided about how to implement and deliver the strategy, including the one transformation approach, the enabling plans (clinical and quality, digital, people, finance, and infrastructure), all of which were underpinned by a culture approach. The enabling plans were in development and on track to be delivered by the end of March. DCS noted the importance of ensuring that managers, including executives, had capacity to undertake the work required of the enabling plans as well as business as usual. DCS further noted the importance of hearing feedback from staff about the delivery and impact of the joint working with DHC. This would support the board to focus on the outcomes, rather than just the processes of the joint working. EJ echoed this noting the importance of hearing how people felt about the work being done to deliver the strategy. Updates would be provided to Strategy, Transformation and Partnership Committee in Common. DD highlighted that clinical and quality was the core business of the trust, and this should be elevated within the enabling plans. She further agreed with DCS about the importance of storytelling and described that some teams were already working together as one naturally. MBr reflected on the ways in which staff within the two trusts had heard the direction that the board had set and were putting that in to practice. Further detail on the enabling plans would be discussed in various forums over the coming months, including a session for the board in March where they can review and discuss the enabling plans, and hear stories and feedback from staff about the delivery and impact of joint working.	
	Resolved: that the Timetable and Milestones for Enabling Strategies be received for assurance.	

BoD24/172	**Charitable Funds Committee Assurance Report**	
	DU highlighted the following key points from the report: • A recommendation to board to approve the charity annual accounts for 2023/24. This would be considered in a separate charitable trustees meeting after the board meeting. • Total income as of end Sep £312,862. Major legacy pending. Unrestricted funds were £279,132 providing a surplus of £39,132 against the reserves target of £240,000. • The charity continued to operate as a going concern • The risk register was reviewed and all risk rating retained • Business planning for 2025/26 had commenced. A draft business plan would be presented to board in February. • The capital appeal total stood at almost £500,000 • A community co-opted member had been added to the committee membership. KH was currently holding this seat and would be able to fully participate in the next meeting as a member.	
	Resolved: that the Charitable Funds Committee Assurance Report be received for assurance.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD24/173	**DCH SubCo Quarterly Performance Report**	
	Resolved: that the DCH SubCo Quarterly Performance Report be received for information.	
BoD24/174	**DCH SubCo Annual Report and Accounts**	
	Resolved: that the DCH SubCo Annual Report and Accounts be received for information.	
BoD24/175	**Wessex Health Partners Annual Review 2023/24**	
	Resolved: that the Wessex Health Partners Annual Review 2023/24 be received for information.	
BoD24/176	**Health and Safety Compliance Report**	
	Resolved: that the Health and Safety Compliance Report be received for information.	
BoD24/177	**Modern Slavery Statement**	
	Resolved: that the Modern Slavery Statement be approved.	
BoD24/178	**Questions from the Public**	
	Two questions had been received from a trust governor ahead of the meeting.	

	The first question related to there being no right of appeal to termination for volunteers. DD answered the question, describing that there was no right of appeal in volunteer policy, volunteer agreement, and there is not a legal requirement to have a right to appeal. Appendix C of this policy details the process by which problems should be resolved, including meetings between the Volunteer Team and the individual concerned, the offer and completion of further training, continued feedback and outcomes of agreed actions. A chronology of concerns, meetings, agreed actions and outcomes is collated to inform the final decision making about termination of role. This will include email correspondence covering the details of previous concerns, discussions, and outcomes at each stage. Termination will only apply as the final action and if previous efforts to address problems have failed to resolve the issues. The second question related to a lack carers lead in the hospital. DD outlined that the trust did have a carer lead who sat within the patent experience team. The carers lead was actively leading on Carers support and reports on activities at the Patient Experience and Public Engagement Committee.	
BoD24/179	**Any Other Business**	
	None raised.	
BoD24/180	**Resolution Regarding Press, Public and Others**	
	To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.	
BoD24/181	**Date and Time of Next Meeting**	
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **9.30am** on **Tuesday 11th February 2025** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**	

Action Log – Board of Directors Part 1

Presented on: 11 February 2025

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting dated: 10 December 2024						
BoD24/164	**Guardian of Safe Working Report**	DD AH to look in to any potential quality impacts of the escalation reports raised by resident doctors, and whether it was possible to triangulate with risk data.	DD AH	April 2025	Not due	**N**
Meeting dated: 09 October 2024						
BoD24/100	**CEO Update**	An investment review of the ridgeway ward redesign to be returned to Board.	CH	February 2025	Post investment appraisal will take place through 2025/26 business planning and reported through to Finance and Performance Committee as part of this process.	**Y**
Meeting dated: 29 May 2024						
BoD24/007	**CEO Update**	An update and learning from the Children and Young People Flagship to be returned to the Board.	DD	Autumn 2024	Scheduled for February's board meeting	**Y**

Actions from Committees…(Include Date)						

Actions to Committees…(Include Date)						
BoD24/151 (10/12/2024)	**Matters Arising: Action Log**	Further detail about the Acute Hospital at Home Service to be returned to Quality Committee.	QC	February 2025	Referred to Quality Committee and on the February agenda.	**N**
BoD24/154 (10/12/2024)	**Quality Committee**	Strategy, Transformation and Partnership Committee in Common to receive an	STPCIC	February 2025	Complete. Item presented to the January	**N**

	Assurance Report	update on the capacity, bandwidth, and priorities for the digital teams			Strategy, Transformation and Partnership Committee in Common	
BoD24/156 (10/12/2024)	**Learning from Deaths Report Q2**	Further assurance around the 'potential mis-triage to the ward' indicator detailed on page 67 of the papers to be provided to the Quality Committee.	AH	March 2025	Update to be included in the next LFD report (due to Quality Committee in March)	**N**
BoD24/100 (09/10/2024)	**CEO Update**	An investment review of the ridgeway ward redesign to be returned to Board.	CH	TBC	The review of ridgeway ward would be returned to Board once it has been reported to Finance and Performance Committee.	**N**

Dorset County Hospital
Dorset HealthCare

Report to	DCH and DHC Board of Directors	
Date of Meeting	DCH – 11 February 2025 / DHC 12 February 2025	
Report Title	Chief Executive Officers Report	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety; SR2 Culture; SR4 Capacity and Demand; SR5 Estates; SR6 Finance; SR7 Collaboration, SR8 Transformation and Improvement	
Financial	No specific implications arising from the report – update on mid-year (H2) position	
Statutory & Regulatory	Update on EDS2 and Public Sector Equality Duty	
Equality, Diversity & Inclusion	Update on EDS2 submissions	
Co-production & Partnership	Update on system working	

Executive Summary

This report provides and overview of key national and local developments:

- 2025/26 priorities and operational planning guidance
- Reforming elective care for patients
- DCH – removed from 'Tiering'
- HSSIB Investigation Report – Mental Health Inpatient Settings
- Independent Commission to Transform Social Care
- Dorset Mid-Year Review Meeting
- New Hospitals Programme
- Local Government Devolution
- One Dorset Provider Collaborative
- National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre
- Integrated Neighbourhood Teams
- Equality Delivery System 2 (EDS2)
- Access Wellbeing Drop in Services
- Shared Vision Tour
- DCH / DHC Executive Team Updates

Recommendation

Members are requested to:

- Receive the report for information.

Chief Executive Officer's Report – February 2025

1 National updates

1.1 2025/26 priorities and operational planning guidance

NHS England (NHSE) published the 2025/26 priorities and operational planning guidance on 30 January 2025. Key priorities include reducing the time people wait for planned care, improving long accident and emergency waiting times and ambulance response times, and improving access to mental health services, particularly for children and young people. In the longer term, the government remains committed to transforming the health service by delivering on its three shifts from hospital to community, sickness to prevention and analogue to digital.

The number of national priorities for 2025/26 has been reduced, with the intention that this will give local systems greater flexibility about how funding is deployed and support a focus on outcomes for patients and communities. There is also recognition that NHS finances continue to be very challenging.

NHSE has asked ICBs to develop plans to meet the national objectives set out in this guidance by March 2025, working with trusts and wider system partners. Plans must be fully owned and signed off by ICB and partner trust boards. Boards will be asked to confirm how these have been used to inform the development and assurance of plans. Full details can be found at: NHS England » 2025/26 priorities and operational planning guidance

1.2 Elective Care

On 6 January 2025 NHS England published a new plan setting out how the NHS will reform elective care services and meet the 18 week referral to treatment standard by March 2029. Under this plan elective care will be increasingly personalised and digital, with a focus on improving experience and convenience, and empowering people with choice and control over when and where they will be treated. The plan can be found at NHS England » Reforming elective care for patients. There is a requirement to have a named existing director responsible for improving the experience of care and experience of waiting for care. For DCH/DHC this Dawn Dawson, Joint Chief Nursing Officer..

At Dorset County Hospital (DCH) the total waiting list size has decreased and has met trajectory for the last two months. The number of patients waiting the longest has reduced during the period. Against the target of zero, 65+ week waits at the end of September, DCH had 28 at the end of December. I am pleased to report that on 3 February 2025 we receive notification that DCH has been removed from NHSE 'tiering for elective' with immediate effect. The letter from Sir James Mackey, National Director, Elective Recovery NHS England, commented that:
'The conscientious work carried out by your teams to improve performance has been impressive and the positive impact on patient care and experience is evident.'.

1.3 HSSIB Investigation Report – Mental Health Inpatient Settings

On 30 January 2025 the Health Services Safety Investigation Branch (HSSIB) published the results of its investigation on the theme of patient safety in mental health inpatient settings. This investigation considered how providers conduct timely and effective investigations into deaths of patients receiving care in inpatient units or within 30 days of discharge. The aim of the investigation was to understand how providers learn from deaths, and how they use that learning to improve. The findings present opportunities to improve systems and practices in mental health services, with potential relevance to other healthcare settings in England. We will consider the recommendations and observation from the report. The full report can be found at HSSIB investigation report - Mental health inpatient settings: Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge (30 January 2025) - HSSIB investigations - Patient Safety Learning - the hub.

1.4 Independent Commission to Transform Social Care

The Government has announced an action plan for social care, including a review of the Better Care Fund and a longer-term commitment to create a National Care Service. Baroness Casey will be leading a commission to develop this work, engaging with colleagues in Trusts, ICBs and primary care. As part of this the review will seek examples of where health and care services work seamlessly together for those who need them, to inform future reform plans. As a system we may have the opportunity to contribute to this. Further details can be found at: New reforms and independent commission to transform social care - GOV.UK

2 Dorset Updates

2.1 Dorset Mid-Year Review Meeting ('H2')

As previously reported, we had our 'H2' meeting with system partners and NHS England on 3 December 2024. A follow-up meeting was held on 17 December 2024. There was recognition that the Dorset system is focussed on reducing costs, improving productivity and delivering a step change in the underlying system position. It has been confirmed that the revised forecast outturn position is an additional £25m deficit against the original planned system deficit of £20m. Further details will be provided as part of the Finance Report.

2.2 New Hospitals Programme (NHP)

There has been much in the media that many of the New Hospital Programme (NHP) projects around the country have been put on hold for extensive periods due to funding restrictions. We are extremely fortunate to have had our projects for Dorset HealthCare and Dorset County Hospital approved before the government announced their review and these are progressing well.

Dorset County Hospital went into contract with Tilbury Douglas in January for their new ED and Critical Care department building. They will start main works this March and the building will open in Summer 2027. Dorset Healthcare will open two new facilities for both child and adult mental health services across the St Anne's campus in Spring 2026, with refurbishment works of vacated spaces continuing for another year. Our colleagues at University Hospitals Dorset have also had NHP schemes approved and will start to move into their new 'BEACH' building from April 2025. The main move of emergency services from Poole to Bournemouth is planned for January 2026.

2.3 Local Government Devolution

The government has announced plans to devolve powers and funding from national to local Government. This will ensure that decisions are made closer to the local people, communities and businesses they affect.

In Dorset the leaders of Dorset, Somerset and Wiltshire Councils had already confirmed their interest in creating a strategic authority for Wessex as part of the Government's Devolution Priority Programme. Bournemouth, Christchurch and Poole (BCP) Council has now decided to join the Wessex bid which would see the region encompass a population of around 1.9 million people. This is not a merger of the councils – each will remain independent serving its local communities.

This development should unlock significant funding to invest in vital infrastructure, skills development, and the green economy. If Wessex is approved to join the Devolution Priority Programme, the Government will carry out public consultation and mayoral elections would take place in May 2026. We will continue to work closely with our local authority partners to maintain these important strategic relationships through and beyond the changes.

2.3 One Dorset Provider Collaborative (ODPC)

An update is provided below on the work of the One Dorset Provider Collaborative (the partnership between DHC, DCH, UHD and the GP Alliance).

Strategic Direction

- The ODPC Board is currently considering its priorities for 2025/26, and how they can align, compliment and add value to the Medium-Term Financial Plan, trusts priorities and the future Long Term plan.

CANDo (Clinical Acute Networks Dorset)

- The clinical networks in place are completing a stock-take of progress to date and successes within the networks for review by the Board. There are 11 networks in operation at present, their scope varies from networking of clinical teams and best practice discussions to changes in service delivery to single-provider led services to support fragile services.
- Shared Oversight of Waiting Times. Good progress is being made with Access Managers developing shared Patient Tracking processes.
- Dermatology. A joint Collaborative and Commissioning event is planned for early January to engage clinical teams in design of new pathways for commissioning to ensure the commissioning arrangements and model of care meet the population needs. A Local Network in place, with 2 network meetings held. There is an emerging (but not full) consensus around a pre-referral A.I. pathway. This could change the scope of PCN triage, but it is likely that roll out beyond the current 2 PCNs would still be required.
- Other Networks. Urology, and orthopaedics functioning well, and the ENT and Gastro networks are currently embedding. Gynaecology leads established a network-likely first date middle of November, and the team has received a request from the ICB to align gynaecology work with their commissioning reviews
- Dorset Acute Networked Services Board has considered deep dives from Orthodontics (in transition to single service), Neurology and Oncology. The Board offers services delivered on an all-Dorset footprint the opportunity to consider issues of fairness and escalate problems and seek Provider Collaborative support for shared solutions.

Procurement and shared services

- The three Trusts agreed to work towards the development of a new Procurement Target Operating Model, and a business case is expected to be considered by the ODPC Leadership Board in January, and subsequently by individual Trust boards.

Governance

- The first Trust Chairs/Non-Executive Directors ODPC Informal steering group was held on 22nd November. This will enhance the ODPC's governance framework and provide additional challenge/scrutiny. Subsequent regular meetings are being scheduled.
- A dedicated ODPC Programme Director has been appointed, and commenced their position in December and is reviewing the strategy and work programmes of the Provider Collaborative in order to set direction for 25/26.

2.5 National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre

Our regional research collaboration, Wessex Research Hubs, of which both DCH and DHC are key partners, has been successful in securing a National Institute for Health and Care Research (NIHR) Commercial Research Delivery Centre (CRDC) award. Commencing in April 2025, the NIHR CRDC will be part of the NIHR CRDC network. This is an important UK Government strategic initiative to increase commercial research in the UK for patient and public benefit and to boost economic growth. Over the 7-year initial term, the NIHR CRDC will further evolve to increase accessibility and address inequalities through embedding work with primary care, increasing the number of partners, and expanding access to cutting edge treatments.

2.6 Integrated Neighbourhood Teams

This month we were part of an engagement event which brought together colleagues from across the Dorset health and care system to work collaboratively on plans for a truly integrated community healthcare service. The Integrated Neighbourhood Teams programme is jointly led by our federation (with many Dorset HealthCare services involved) and the GP Alliance, representing primary care and working closely with both local councils, the voluntary and community sector and UHD.

Around 150 people from a range of sectors participated in the event and there was much energy and enthusiasm in the room. It was clear that there is a strong commitment that this is the right thing to do for our communities to support people's health. The programme is developing at pace, and we will provide further updates at the programme develops.

2.7 DHC Access Wellbeing Programme

The DHC Access Wellbeing programme is continuing to expand with the addition of more drop-in services. Access Wellbeing drop-in spaces, run in partnership with local volunteer/community organisations, are open to anyone over 18, with no appointment needed. They are staffed by trained wellbeing co-ordinators who people to find support on topics including mental and emotional wellbeing, grief and loss, work, money, housing and benefits support, and support for carers and family members.

These are based in existing community settings and will operate on different days of the week, giving people more options to access wellbeing and mental health support. A new drop-in space launched at the Atrium Health Centre in Dorchester in January 2025, and further services will be opening at The Centre Ferndown, Wimborne Community Centre, and Kinson Community Centre (Bournemouth) during February 2025. Additional drop-in services will be launching in west Dorset, north Dorset and Purbeck over the coming months. The new venues will operate as pilot sites, to help understand more about local communities and ensure we are providing support in the right places. Locations and times may change in the future, depending on the needs of each community. More information about all the hubs in Dorset, and what they offer, is available at www.dorsetaccesswellbeing.co.uk/access_wellbeing_hubs.

2.8 Equality Delivery System (EDS) 2 – Dorset County Hospital and Dorset HealthCare

The EDS2 reports for both DCH and DHC were approved at our Committees in January 2025. The EDS2 is a critical improvement tool for NHS commissioning and provider organisations and supports both Trusts in fostering active dialogue with staff, patients, and partners to address health inequalities across the three key domains: Services, Workforce, and Leadership. DCH and DHC remain committed to enhancing equality, diversity, and inclusion (EDI) in every aspect of our operations. The EDS framework has been instrumental in identifying key areas for action, and comprehensive plans are in place to drive progress.

2.9 Shared vision tour

Board members and senior leaders have been visiting our sites during December 2024 and January 2024 to share the joint vision and speak with colleagues about what the vision means to them. It has been great to see people getting involved as the coffee van works its way around our sites.

The events are continuing during February 2024 during which time we will have gathered rich feedback about our shared vision - healthier lives, empowered citizens, thriving communities. This will help inform future activity, including the development of the enabling plans that will support the joint strategy.

2.10 Executive Team

I would like to welcome Rachel Wharton to the DCH Board of Directors as the incoming Chief Medical Officer (CMO). Rachel is a Consultant in the DCH Emergency Department and is currently undertaking a handover with Alistair Hutchison who retires from the DCH CMO post at the end of March 2025. I would also like to take this opportunity to thank Alistair for his contribution over the past seven years at DCH as the CMO and also thank him personally for the support he has given to me as Chief Executive Officer since I joined the Trust in 2023.

At DHC we are about to commence recruitment to substantive Chief Operating Officer position. This process will run during February and March 2025 and is planned to be completed 2025. Rachel Small has been undertaking this role on an interim basis since summer 2024.

Recommendations
The Board is recommended to:

- Receive the report for **information.**

NHS
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Report to	Board of Directors, Part 1	
Date of Meeting	11 February 2025	
Report Title	Board Assurance Framework – Quarter 3	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Assigned risks to be considered by Committees w/c 27 January 2025 and full BAF considered by Audit Committee 3 February 2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	These are the risks from the BAF assigned to this Committee	
Financial	No financial implications arising from the BAF	
Statutory & Regulatory	There is a regulatory requirement to have a BAF in place	
Equality, Diversity & Inclusion	There are no specific EDI implications arising from this report	
Co-production & Partnership	We will consider system risks and alignment to the system BAF as part of the development of the BAF.	

Executive Summary

1. Overview

The Joint Strategy 'Working together, improving lives' was approved at the DCH and DHC Boards on 31 July 2024 and 7 August 2024 respectively. Alongside the development of the Joint Strategy work on developing the Joint Principal Risks to achieving the Joint Strategic Objectives continued and these were approved by the DHC and DCH Boards on the same dates.

Each Trust has a joint set of strategic risks and the template and review process are the same, as described below. However, the BAF is separate for each organisation as the controls and assurances and risk scores are different between DCH and DHC. Appendix One to this report is the DHC BAF for Quarter 3 2024/25.

The Audit Committee is responsible for reviewing the levels and effectiveness of the assurances that the Board receives in respect of the identified strategic risks, ensuring that they are relevant and timely and that this contributes to the effectiveness of then overall system of internal control. Individual Committees have responsibility for oversight of specific risks.

2. Review Process

A standard template is in place. for the Board Assurance Framework, with a consistent framework across both Trusts. This template has been developed to show 'a risk on a page' with an overview of all risks.

- Each risk has an unmitigated, mitigated (as at January 2025) and target score using the 5x5 scoring matrix previously reported. The unmitigated score is the level of risk before any mitigating actions

are taken. The mitigated score is the level of risk with the controls and assurance in place and the implementation of the identified actions.

- Controls and assurances are identified in terms of:
  - Priority Strategies and Plans
  - Risk controls and Plans
  - Oversight Governance and Engagement
- Each assurance has been assessed as Positive / Neutral / Negative. Where there is a gap in control or assurance this has been categorised as 'neutral'.
- Each of the three categories above have an overall assessment based on the controls and assurances in place as Red / Amber / Green. Where there is an assessment of Amber or Red there will be a corresponding action to improve the level of control and/or assurance.
- Each action is marked as:
  - On Plan (Green)
  - Behind Schedule' (Amber)
  - Significantly behind schedule (Red)
  - Complete (Grey)
- Each risk has been assigned to an Executive Lead who has signed off the BAF for their assigned risk.
- The BAF was reviewed and agreed by the Joint Executive Management Team.
- Each risk has also been assigned to a committee and these were reviewed during week commencing 27 January 2025. The BAF was then reviewed by the Audit Committee on 3 February 2025 (including a verbal update on any amendments proposed by Committees).

3. Developments since the last review

- **New field -** The 'rationale for the score' has been added for each risk.
- **Amendments -** All amendments since the last review are shown in red.
- **Board template** - A new template has been developed for all board reporting which includes a requirement to cross reference all reports to specific BAF risks (or to state that there are no implications). This was rolled out during September and October 2024.
- **Strategic Risks cross-referenced into the Corporate / Organisation Risk Register** – All BAF risks have been mapped to the Corporate Risk Registers for DCH and DHC. There is further work being undertaken by the Nursing and Quality Teams to ensure that this appears in the Corporate Risk Registers presented to Committees. In addition, work is underway within the Nursing and Quality Teams to calibrate the scoring of risks (DCH has 97 risks scoring above 15 and DHC has 13).

The developments below were planned for this reporting cycle. A status update is provided below. The delays do not impact on the BAF requirements, and all developments are further enhancements.

- **Key metrics will be assigned to each risk** – delayed to quarter 4 as awaiting approval of metric against strategic objectives, which will then be cross referenced to the BAF. These are being presented to the Strategy, Transformation Committee and Board in January / February 2025.
- **Risk appetite survey** – A Risk Appetite Board Survey was sent out by the Corporate Affairs team during October / November 2024. However, the response rate of low. This coincided with the need to review and align the Risk Management Frameworks / Strategies across DCH and DHC to be completed by end of Quarter 1 2025/26.

4. Quarter Three Board Assurance Framework

Risk Scores

- The highest scoring risk identified within the assurance framework (based on the mitigated risk) score are SR3: Workforce Capacity; SR5: Estates; SR6: Finance and SR9: Digital Infrastructure.
- The risk scores in respect of SR9: Digital Infrastructure was increased in following review by the Strategy, Transformation and Partnerships Committee in January 20205. The likelihood of the risk occurring was increased from 3 to 4 (resulting in an increase in the risk score from 12 to 16) following consideration of the Digital Capability and Capacity Report and the corporate risk register (which included a number of risks related to digital).
- The risk score in respect of SR7: Collaboration has been reduced from 9 to 6 to reflect the increased level of assurance in this area.
- All other risk scores remain unchanged.

Actions

Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified. Where an action has not been achieved by the due date this is marked on the actions plan as 'Behind Schedule' and a revised date has been added. Seven out of ten risks have at least one action that is behind schedule, with revised dates agreed. There are no concerns at this stage as clear rectifications plans are in place.

Recommendation

Members are requested to:

- Receive assurance on the process in place to review the Board Assurance Framework
- Review and scrutinise the risks and identify any areas where further assurance is required

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Dorset County Hospital NHS Foundation Trust
Board Assurance Framework
Quarter 3 - January 2025

Dorset County Hospital NHS Foundation Trust

Board Assurance Framework Overview - January 2025	Strategic Objectives				Responsibility		Score				
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q2 Score	Mitigated Q3 Score	Mitigated Q4 Score	Target Score
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care	X				**Quality Governance**	Chief Nursing Officer	16	12	12		9
SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	X		X		**People and Culture**	Chief People Officer	15	12	12		6
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		**People and Culture**	Chief People Officer	15	15	15		9
SR4: Capacity and Demand If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected	X	X		X	**Finance and Performance**	Chief Operating Officer	16	9	9		6
SR5: Estates If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve	X		X	X	**Finance and Performance**	Chief Finance Officer	16	12	16		9
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	**Finance and Performance**	Chief Finance Officer	20	16	20		12
SR7: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.		X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	12	9	6		6
SR8: Transformation and Improvement If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.	X	X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	16	12	12		6
SR9: Digital Infrastructure If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.		X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	20	12	16		6
SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	15	12	12		9

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care**	Quality Committee

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score
Chief Nursing Officer	Unmitigated	4	x	4	=	16	Increased demand from Emergency attendances and admissions; ED crowding; Use of escalation areas and beds; increased use of agency staff to maintain safe levels; increased acuity and dependency and infection rates.
	Mitigated	4	x	3	=	12	
	Target	3	x	3	=	9	

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities 24/25 (each have a subject matter expert owner)	Board approved 24/25 Quality Priorities incl in the Quality Account 23/24	Positive	
PSIRF Response Plan	Board approved PSIRF Response Plan, updates to Quality Committee (QC)	Positive	Amber
Contractual obligations 24_25	KPI monitoring and Quality Dashboard	Neutral	
Maternity Incentive Scheme (MIS)	Maternity Report, Quality Committee, LMNS oversight and reporting, MIS End Point Review Outcome - Compliance; Internal Audit Report	Positive	
Patient flow Transformation Programme	Programme Board, Monthly reporting and Integrated Corporate Dashboard	Neutral	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities Report to QC (progress against KPIs)	Positive	
Patient Experience Metrics and Improvement Plans	Patient Experience monthly, quarterly and Annual Complaints Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board, 15 Steps Challenge	Neutral	
PSIRF implemented to improve patient safety and Patient Safety Plan	PSIRF Operational and Exec Huddles, Patient Safety Committee oversight of Patient Safety Plan and Quality priorities	Neutral	Amber
Patient Flow Transformation Programme	Programme Board - progress against milestones. Compliance with Winter Planning guidance, Winter Plan approved	Neutral	
Quality Governance Committee Framework	Quality Reports and Dashboards	Neutral	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board	Positive	
Patient Safety Committee	Patient Safety Incidents Report and Assurance Reporting to Quality Committee	Positive	Amber
PSIRF Oversight Group	Patient Safety Incidents oversight to Patient Safety Committee	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
PSIRF Response Plan to refreshed and reviewed for 24/25 - underway with Patient Safety Lead and DDON	Jhow	~~Dec 24~~ Mar 25	Behind Schedule
Establish Quality Assurance Group and annual reporting plan -In place from Nov 24	Jhow	Sep-24	Complete
Implementation of new Complaints and Concerns Policy in line with PHSO standards - Complete ratified October 24	Jhow	Mar-25	Complete
Completion of CQC self assessments and actions plans - under review following recent CQC changes. Target date to be reviewed during Q4	Jhow	Mar-25	On Plan
Completion of MIS -Complete with compliance reported to QGC	Jhow	Feb-25	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: Culture** **If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	4	x	3	=	12
	Target	3	x	2	=	6

Rationale for Score

No change in score - good progress made in key areas. We need the 2024 Staff Survey Results and new Joint People Plan will be a key enabling Plan to set out our priorities for next three years

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan Cultural maturity assessment - internal audit - provided positive assurance	Positive	Amber
Leadership and Management Development Programme	Staff survey - 46% response rate 2024 (increase on previous year) /Pulse Survey / FTSU Quarterly Report / Employment Relations Report in Workforce Dashboard	Neutral	
DCH People Strategy to 2025	WRES & WDES/EDS2/Gender Pay Gap / Staff Survey / Pulse Survey Developing Joint People Plan	Neutral	
EDS in place	EDS 2 developed - reported to PCC and STP CiCs Jan 25	Neutral	
Programme of staff engagement activity	Further assurance required to formalise programme and measure effectiveness	Neutral	
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan to report to PCC	Positive	
People Plan Priorities 2024/25	Workforce report to People and Culture Committee on progress against key metrics / Integrated Corporate Report (ICR)	Positive	
Risk Controls and Plans			
Freedom to Speak Up Policy	Freedom to Speak Up bi-annual and annual reports	Neutral	Amber
Joint Inclusion and Belonging Action Plan	Further assurance required - reprioritisation of priorities and timeframes	Neutral	
EDS2 Action Plan	Action Plan to P&C and STP CiC Jan 25	Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance / Escalation Report to Board	Positive	Amber
Equality and Inclusion Group Sexual Safety Group Health and Wellbeing Steering Group	Assurance Reports to People and Culture Committee	Positive	
Staff Networks, Executives now aligned to networks	Annual EDI Report and Minutes to be reported to PCC from Sept 24	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Re-prioritise Joint Belonging and Inclusion Action plan and timeframe - to PCC Sept 24	NP	Oct-24	Complete
Establishing the Culture and Inclusion Reference Group - not yet established to commence for 25/26	NP	~~Nov 24~~ Apr 25	Behind Schedule
Finalising the governance sub-structure to Joint People and Culture Committee - finalised and reported to PCC Jan 25	JH / NP	Nov-24	Complete
Continue work to support and strengthen FTSU with stronger joint working arrangements - working together ongoing	NP/DD	Dec-25	Complete
Joint People Plan to be developed (aligned to Joint Strategy and ICS People Plan)	NP	Mar-25	On Plan
Strengthen executive involvement in staff networks - Executives now aligned to networks with further work required to embed - built into EDS2 Action Plan	CG	Nov-24	Complete
Complete roll out of system conscious inclusion and inclusive leadership training - roll out complete and training ongoing	EH	Mar-25	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: Workforce Capacity** **If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	5	x	3	=	15
	Target	3	x	3	=	9

Rationale for Score

Score unchanged. Whilst WTE reductions in place WTE controls and QIA mitigate impact on delivery of safe services. Await publication of national planning guidance and results of NHS review which to inform planning.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
DCH People Strategy to 2025 Dorset ICS People Plan and NHS Long Term Workforce Plan	Workforce Metrics in Integrated Performance Report / Staff Survey and Pulse Surveys / Internal Audit Report - Recruitment	Positive	Amber
Workforce Planning framework	Workforce Metrics in IPR - other assurance reporting to be developed	Neutral	
Apprenticeship & Widening Participation Programme	Regular report from Education Team to People and Culture Committee	Positive	
People Promise Retention Exemplar Programme	Progress to NHSE and Board	Neutral	
Risk Controls and Plans			
Annual Workforce Plan and Priorities	Workforce Metrics Report to People and Culture Committee on progress against	Positive	Amber
Learning Needs Analysis	Annual Education Quality Self-Assessment / Learning Needs Analysis	Neutral	
Whole Time Equivalent Reduction Plan	Reporting to DCH Recovery Group and ICB and NHSE - Off plan in year for WTE reductions. Control and QIA provide assurance that safe services not impacts	Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee	Assurance / Escalation Report to Board	Positive	Green
Workforce Programme System Groups (Recruitment, Widening Participation) with recruitment considered at Provider Collaborative	Escalation Report to ICB People Committee (reports to ICB)	Positive	
Safer Staffing Review	Staff Staffing Report to Board, Annual Review approved Dec 24	Positive	
Recruitment Control Panel	Weekly Reporting to Executives (system reporting ceased Jan 25)	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint People Plan to be developed (aligned to Joint Strategy and ICS People Plan)	EH	Jun-25	On Plan
More clarity on system implementation long term workforce plan - will respond in line national and regional direction	NP	~~Dec 24~~ March 25	Behind Schedule
Roll out of recruitment training for managers with focus on diversity and inclusion	EH	Mar-25	On Plan
Develop Talent Management and Succession Planning Approach	EH	Jun-25	On Plan
Finalising the governance sub-structure to Joint People Committee - Complete reported to P&C CiC Jan 25	NP / JH	Nov-24	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: Capacity and Demand** **If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Operating Officer	Unmitigated	4	x	4	=	16
	Mitigated	3	x	3	=	9
	Target	3	x	2	=	6

Rationale for Score

No change in score. We continue to respond to demand and have plans in place to manage this. System challenges remain which impact on our position. In tiering for elective but good progress observed.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*Assessment (See assessment guidance)*
Priority Programmes and Strategies			
Patient Flow Program (Internal to DCH with partners)	Regular updates against key plans and outcomes via F&P reporting	Positive	
UEC Review (Newton) with System partners	Board Development Session Nov 24 and Approved Partnership Agreement Dec 24	Positive	Amber
Operational Plan 24/25 (in accordance with national planning guidance and inc Elective Recovery Fund - ERF)	Reported to F&P and Board (including risks to achievement of plan). Awaiting 25/26 National Planning Guidance	Neutral	
Risk Controls and Plans			
Elective Recovery activities	Work underpinning is within Divisional Performance and F&P reports / regional oversight of recovery - Placed in NHSE Tier 2 for elective (expected to come out in Q4 based on positive performance to date)	Negative	
UEC Improvement Plan	Work underpinning is within Divisional Performance and F&P reports - Deep Dive on UEC to Jan 25 F&P	Neutral	Amber
Performance Management Framework (and resulting deep dive reviews)	Performance Report to F&P and Board and Deep Dives / Internal Audit Reports	Neutral	
Seasonal surge plan	Surge plan reported to F&P with monitoring via Performance Report, Winter Plan approved	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Performance Report to F&P and Assurance Report to Board	Neutral	
System Planned Care Delivery Group /Elective Performance Management Group (EPMG) /Productivity weekly meetings	Performance Report to F&P and Board	Positive	
UEC System meetings - weekly/monthly/Qtrly and Seasonal Surge Planning	Surge plan reported to F&P with monitoring via Performance Report	Positive	Green
Divisional Performance Meetings	Performance Report to F&P and Board and Deep Dives	Positive	
UEC (Newton) Governance framework agreed and in place	Performance Report to F&P and Board and Deep Dives	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Use of Performance Management Framework to increase oversight where performance identified for improvement - year end review of performance	AT	May-25	On Plan
UEC (Newton) diagnostic stage to be completed and next steps clarified - Complete - Partnership Agreement approved	AT	Nov-24	Complete
Cold debrief on seasonal surge plan in Q4	AT	Mar-25	On Plan
Response to planning guidance to be prepared when available and in accordance with national timescales	AT	Mar-25	On Plan
Complete review of Integrated Corporate Dashboard for 25/26 reporting	AT	Apr-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues Sustainability	**SR5: Estates** **If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	4	x	4	=	16
	Mitigated	4	x	4	=	16
	Target	3	x	3	=	9

Rationale for Score

F&P agreed increase in score Nov 24. Work is in progress to identify all gaps in compliance and ensure mitigating plans are in place and can be evidenced. This work is well underway and progressing within clear timescales.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive	
Joint Estates Strategy to be developed - not yet in place	Not yet in place	Neutral	Amber
Capital Programme	Monitoring to Finance and Performance Committee - Internal capital programme over subscribed by £1.5m full year with prioritised schemes ranked across digital, estates and medical devices overseen by CAPSUG - prioritisation monitored to bring within envelope	Neutral	
Risk Controls and Plans			
Estates compliance functions	Compliance reports in estates Function and reported to compliance groups - working to identify gaps and mitigations - reporting in place on progress	Neutral	
Fire safety compliance	Further assurance required on fire safety - review completed to assess gaps and issues and plans in place and ongoing	Neutral	Amber
Backlog maintenance plan	On track and reported to Capital Investment Meeting - impacts on overspend on capital investment	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Transformation (Performance) Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation (from Sept 24)	Assurance Reports to Board	Positive	Amber
Capital Investment Meeting	Gap in assurance - reporting to Committee to be strengthened re QIA of capital schemes	Neutral	
Estates related compliance groups in place (water, fire, health and safety)	Compliance reports on estates and health and safety from Nov 24 to F&P	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP & NHSE	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy	CH	Jul-25	On Plan
Strengthen assurance reporting on estates planning and compliance - Complete reporting in place	CH	Dec-24	Complete
Review of compliance functions by newly appoint Joint Director of Estates and Facilities - Review completed and actions required	DM	Dec-24	Complete
Review of fire safety compliance and governance by newly appoint Joint Director of Estates and Facilities - Review completed and actions required	DM	Nov-24	Complete
Implement mitigating actions on fire and develop a five year plan for fire compartmentalisation - to F&P May 25	DM	May-25	On Plan
Estates compliance - End of Q4 expect to be assured that fully understand level of compliance and gaps that require mitigation - April 25	DM	Apr-25	On Plan
QIA process for capital investments to be strengthened	DM	Mar-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: Finance** **If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score
Chief Finance Officer	Unmitigated	4	x	5	=	20	Risk score increased following F&P Discussion Nov 24. We remain off plan with focussed action in place to address and progress is being made with improved CIP delivery M9. Consider if cash risk required
	Mitigated	4	x	5	=	20	
	Target	4	x	3	=	12	

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
5% efficiency delivery required of which recurrent delivery at min 60% and <20% classed as high risk by end of Aug 24	Oversight via Value Delivery Board, Divisional Performance meetings and Finance & Performance Committee and Recovery Group (established Oct 24) - CIP behind YTD but improved since M8	Neutral	
Operational plan 2024/25 break even delivery (in year risk adjusted forecast outrun with agreed trajectory at system level)	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board	Negative	Red
Medium Term Financial Plan - underlying position recovery and improve future sustainability inc cash focus	Medium Term Financial Plan to Finance and Performance Committee. Revenue request rejected by NHSE / DHSC Dec 24 & Jan 25 and exploring system collaboration. Daily cash report to CEO from Dec 24	Negative	
Risk Controls and Plans			
Operational workbook completion supported by Transformation & Finance with EQIA process updates - Trust CIP Tracker master for recording, CFO led support review meetings with all areas	Value Delivery Board Executive SRO oversight and Recovery Group from Oct 24 , reporting to Finance & Performance Committee accountability frameworks, internal audit assurance review conducted, efficiency deep dive session F&P Oct 24 and follow up Jan/ Feb 25	Neutral	
Regular budget meetings, enhanced budget manager training, recovery plans required for all overspending areas	Finance Reporting to Divisional Performance Meetings, Finance and Performance Committee & Trust Board	Neutral	Amber
System wide working & development - System Investment Group & System Recovery Group	Reports to System Investment Group & System Recovery Group, plus regular NHSE regional engagement / Oversight Framework rating	Negative	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Escalation Reports to Board, Finance Report to Committee and Board	Positive	
Recovery Group in place to respond to deterioration in financial position and workforce controls	Governance review underway to clarify governance	Neutral	
Value Delivery Board (VDB) - CFO Chair & Executive SROs in place per identified themed area, EQIA process being enhanced	Internal audit report HFMA checklist assessment and CIP process audit conducted	Positive	Amber
System wide working - System Recovery Group, CEO Escalation meeting	Financial oversight reports internally and System ICB	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Efficiency deep dive to be presented to FPC Sept 2024 - completed Oct 24	CH / CA	Sep-24	Complete
Review of prior year non recurrent efficiency delivery for recurrent potential, challenge non recurrent status for agency and productivity schemes - changed to ongoing because under continual review and iterative process	CA	01/09/2024 Ongoing	On Plan
Daily cash monitoring and appropriate mitigations including income maximisation, timely debt collection etc - In place	CA	Sep-24	Complete
Recovery plans in place for all overspending areas - target areas include non clinical bank review, NCTR patients, theatre utilisation, escalation beds, external security usage and medical agency usage - In place and reported to Recovery Group from Oct 24	CH	Sep-24	Complete
Enhanced of EQIA Process - undertaken by Transformation Team - not yet in place TBC	NJ	~~Nov 24~~ Apr 25	Behind Schedule
system mitigation re medium term cash sustainability - through planning 25/26 - in development	CH	Mar-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR7: Collaboration** **If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	4	x	3	=	12
	Mitigated	3	x	2	=	6
	Target	3	x	2	=	6

Rationale for Score

Improved score due to strengthened governance arrangements developed and implemented in Q3 including JTIB, NED Oversight Group and clear reporting on priorities to Committees and Board. This now need to be embedded and form part of BAU.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Forward Plan, supports NHS system focus on the same priorities	ICB-led Provider Relationship meetings, ICB Membership	Positive	Green
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board / PC Report to Board / NED PC Oversight Group in place from Nov 24	Positive	
One Transformation Approach (including Integrated Neighbourhood Teams and Flagships Programmes)	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and Finance and Transformation to Aug 24. To STP Committee from Sept 24	Positive	
Risk Controls and Plans			
Compliance with NHS Provider Licence and Code of Governance re duty to collaborate	Provider Licence and Code of Governance Compliance Report to Audit Committee annually	Positive	Amber
Five pillars from Joint forward plan - aligned of all programmes	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, further work required to understand ICB monitoring of ICB pillars and our role in that	Neutral	
Portfolios of change - INT / MH / Sustainable services / working together / operational redesign	Reporting to JTIB and to STP Committee from September 2024	Positive	
Oversight Arrangements for Governance & Engagement			
ICB and ICP Membership	Chair member of ICP, CEO member of ICB - updates and minutes to Board bi-monthly	Positive	Green
Finance and Transformation Committee to Aug 24 and Strategy, Transformation and Partnership Committee - from Sept 2024	Escalation Reports to Board	Positive	
Working Together Portfolio Board and Working Together Committee in Common then replaced by STP CiC from Sept 24	Escalation Reports from Working Together CIC to Board - to Aug 24 and STP from Sept 24	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Framework for ensuring all proposals demonstrate alignment to the ICS Objectives / Joint Forward Plan - Complete - prioritisation process via JTIB	PL	Jan-25	Complete
Strengthen reporting to Board in respect of provider collaboratives and partnership working	PL	Nov-24	Complete
Capital planning investment to be aligned to strategic objectives	PL	May-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR8: Transformation and Improvement** **If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	4	x	4	=	16
	Mitigated	4	x	3	=	12
	Target	3	x	2	=	6

Rationale for Score

Score unchanged, progress continues, some complexities to developing meaningful plans identified impacting delivery timeframes. Approaches between DCH/DHC different and further engagement required to align.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy	Approved Strategy - metrics to be developed	Neutral	Amber
One Transformation Approach (including Integrated Neighbourhood Teams and Flagships Programmes)	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and Finance and Transformation to Aug 24. To STP Committee from Sept 24	Positive	
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	
Electronic Health Record (EHR) Programme (Outline Business Case - OBC)	DCH Board approved OBC (updated Dec 24). Further approvals by NHSE / Cabinet Office	Neutral	
Risk Controls and Plans			
Strategy Implementation Plan	Approved plan in place - assurance to be via bi-annual delivery reports, strategy dashboard to STP Committee- not yet in place	Neutral	Amber
Five pillars from Joint forward plan - aligned of all programmes	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, further work required to understand ICB monitoring of ICB pillars and our role in that	Neutral	
Enabling plans; Clinical & Quality, People, Digital, Finance and Infrastructure	Plans to be developed - timetable in place with plans by April 25, with some risks to achieving this timetable due to need to allow sufficient time for meaningful engagement	Neutral	
Joint Improvement Framework approach	Approved Joint Improvement Framework approach - to be implemented. Continued momentum and celebration of improvement taking place alongside programme	Neutral	
Oversight Arrangements for Governance & Engagement			
Portfolio Boards - Flagships, Integrated Neighbourhood Teams and Working Together Portfolio Boards	Transformation Reports	Positive	Green
Joint Transformation Improvement Board	One Transformation Highlight Reports	Positive	
Working Together Committee in Common (to Aug 24) and STP Committee from Sept 24	Escalation Reports to Board	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint Strategy - Develop the Strategy Dashboard (including metrics to measure reduction in health inequalities) - measures approved but further work to align metrics to strategic objectives and agree form of reporting - executive engagement during Jan 25 to progress	PL	~~Nov 24~~ Mar 25	Behind Schedule
Joint Improvement Framework. Develop the outline plan until Mar 25. 'Discover' stage 1/4 complete. Next stage (2) is 'Define' - Learning is longer timeline required for meaningful engagement. Define to be completed by June 25. Stages 3+4 dependent on outcome of 'Define' stage	PL	~~Oct 24~~ June 25	Behind Schedule
Joint Strategy. Produce and get approval for the Enabling Plans - Timeline to be reviewed as some risks to achieving this timetable due to need to allow sufficient time for meaningful engagement	PL	Mar-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR9: Digital Infrastructure** **If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	3	x	2	=	6

Rationale for Score

Score increased following Jan 25 Committee review - reflects number of underlying risks in this area. Strategy and roadmap will determine future state which will seek to mitigate risks with legacy infrastructure

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*Assessment (See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL)	Neutral	
EHR Programme (OBC)	DCH Board approved OBC - Further approval Dec 24. Further approvals required by NHSE / Cabinet Office - affordability gap closed	Neutral	Amber
Risk Controls and Plans			
Digital risks monitored and reported	Monthly Report to Digital Transformation and Assurance Group (DTAG)	Neutral	Amber
Data Security & Protection Toolkit	Submission via Finance and Performance Committee and audited by BDO, reviewed by SIRO	Positive	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee - From Sept 2024	TOR approved - Reporting to Board commenced October 2024	Positive	
EHR Programme Board and EHR Advisory Group	EHR Report into Board	Positive	
DCH Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects	Positive	Green
Joint Digital Services Leadership Group DCH & DHC	Governance and reporting to be developed	Positive	
Information Governance Group (also covers cyber)	Bi-monthly report to Finance and Performance Committee, STP from Sept 24	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint digital strategy to be developed and submitted for Board approval	SD	Mar-25	On Plan
NHSE Review of outline business case (OBC) followed by EPR Investment Board/Cabinet Office - Target date now Jan 25	SD	~~Oct 24~~ Jan 25	Behind Schedule
Implementation of Federated Data Platform (NHSE Mandate)	SD	Mar-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy	SD	Mar-25	On Plan
Implement DCH/DHC EHR Advisory Group - In place	SD	Sep-24	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR10 Cyber security** **If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	3	x	5	=	15
	Mitigated	3	x	4	=	12
	Target	3	x	3	=	9

Rationale for Score

No change in score - continue to understand and mitigate threat landscape

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	NHSE Digital Maturity Assessment & NHSE What Good Looks Like (WGLL)	Positive	
Secure email accreditation	ISO 27001 compliance linked to secure email accreditation (DCB1596)	Positive	Green
Risk Controls and Plans			
Data Security & Protection Toolkit	Submission is via Finance and Performance Committee (FPC) and audited by Internal Audit BDO, reviewed by SIRO	Positive	
Regular phishing campaigns conducted, monitoring of alerts, patching and maintenance, password controls	Cyber security audit conducted by BDO (Aug 23), reported to IGG & FPC	Neutral	Amber
Cyber Security monitoring arrangements and system controls	Quarterly cyber security report to FPC	Neutral	
Oversight Arrangements for Governance & Engagement			
Information Governance Group (also covers cyber)	Bi-monthly report to Finance and Performance Committee, STP from Sept 24	Positive	
Monthly Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects	Neutral	Amber
Digital Services Leadership Group (recently implemented - with only digital team representation)	Governance and reporting to be developed	Neutral	
Finance and Performance Committee (Strategy Transformation and Partnerships from Sept 24)	Escalation Report to Board (from Sept 24) Cyber Report to Board Dec 24	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint ICB-led cyber security strategy being developed - in progress and scheduled to complete Jan 25	SB	~~Nov 24~~ Jan 25	Behind Schedule
Implement multifactor authentication (MFA) for all staff (in progress) - in progress and scheduled to complete Feb 25	SB	~~Nov 24~~ Feb 25	Behind Schedule
Development of Infrastructure roadmap to support joint digital strategy	SB	Mar-25	On Plan
Joint digital strategy (includes cyber) to be developed and submitted for Board approval	SD	Mar-25	On Plan

ASSURANCE ASSESSMENT

GREEN	AMBER	RED
Well functioning controls in place to manage risks and deliver objective	Some key controls in place, but may not cover all risks or elements of objective	Clear gaps in controls for management of risks and delivery of objective
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**
	Clear actions to address gaps in controls and/or assurances	Plan not sufficient to address gaps in controls and/or assurances

RISK SCORING MATRIX

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

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

0 - 3	Very low risk
4 - 6	Low risk
8 -12	Moderate risk
15 - 25	High risk

Report to	Board of Directors, Part 1	
Date of Meeting	11th February 2025	
Report Title	Corporate Risk Report – Quarter 3	
Prepared By	Laura Sellick, Risk team	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	All sub board committees have received a quarterly risk register report relevant to their areas of focus. On 3rd February the Audit Committee has received the full Corporate Risk Report	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	All strategic risks are included in the corporate risk register	
Financial	Risks associated with requirements for financial investment	
Statutory & Regulatory	Performance against a number of local and national metrics and KPIs and linked to legal and regulatory requirements Integral to CQC quality standards	
Equality, Diversity & Inclusion	No implications	
Co-production & Partnership	No implications	

Executive Summary

The Board are ultimately responsible and accountable for the comprehensive management of risks faced by the Trust.

In line with the Trust's Risk Management Framework, the Board will receive and review the Committee relevant Risk Registers via the Board Assurance Committees and the Board Assurance Framework quarterly, and which identify the principal risks and any gaps in assurance regarding those risks.

The Board Assurance Framework (BAF) forms part of the Trust's Risk Management Framework and is the framework for identification and management of strategic risks. All operational risks on the Risk Register will be linked to the Trust's strategic objectives, regardless of risk score at time of addition or review.

Following the implementation of the revised Risk Management Framework (2023), each Board Assurance Committee received the Corporate Risk Register report with the specific risks assigned to them.

The Committees formally review and scrutinise the risks within their remit. These reports will be received at least once a quarter together with the Board Assurance Framework.

As defined in the Framework, any risk register items scored 15 or above will be reported in totality to the Risk and Audit Committee, with the sub-committees receiving reports relevant to their area of responsibility. Any risk register item scoring 15 or above will automatically be escalated to the Corporate Risk register.

In February's reporting cycle, the People and Culture Committee escalated the risk around the capacity of the digital team to the Strategy, Transformation and Partnerships Committee in Common. The Quality Committee also escalated the clinical digital risk and stagnation of movement in high-risk scores. The Risk and Audit Committee were appraised regarding the Digital Capacity and Capability review that was taken to Strategy Transformation and Partnerships Committee in Common which identified long and medium-term solutions. A short term DCH Digital Recovery Plan is also being developed. The Strategy, Transformation and Partnerships Committee in Common also agreed that the BAF risk score should be increased to 16 (4x4).

Recommendation

The Committee is recommended to:

- Receive the report for **assurance**
- review the current Risk and Audit Risk Register; and
- note the High-risk areas.
- consider overall risks to strategic objectives and BAF.
- request any further assurances.

Trust Board

1 Executive Summary- Overview of Risks

1.1. **4 new opened risks scoring 20 and above, added during the last quarter**.

1.2. Failure to comply with the Regulatory Reform (Fire Safety) Order 2005
Risk 1985 opened 4/10/25, agreement at FPC to consolidate and revisit fire risks in light of mitigations and progress with actions.

1.3. Fire Alarm system constantly in fault
Risk 2023 opened 9/12/25. As above.

1.4. Lack of DEXA Reporting capacity
Risk 2011 opened 22/11/25, actions to recruit have been approved and will inform risk scores accordingly.

1.5. Occupational Therapy Staffing gaps mean the team will need to run in Business Continuity, unable to fulfil all work
Risk 2004 opened 8/11/25, due for review on 24/2/25

1.6. **8 new risks scoring 15-19 added during the last quarter.**

1.7. Bladder Scanner on Lulworth is Unrepairable - Replacement Required
Risk 1987 opened 9/10/25, mitigations underway to consider equipment sharing and downgrade.

1.8. Consultant rota gaps
Risk 2001 opened 7/11/24, under review by CMO.

1.9. Histopathology Biomedical Scientist Workload Capacity
Risk 2003 opened 8/11/24, review is overdue, due on 9/12/24. Work underway with One Dorset Pathology to align risk management arrangements and oversight.

1.10. Lack of Adequate Support for Digital Systems in a 24/7 Acute Trust
Risk 2007 opened 19/11/24, review due on 22/2/25.

1.11. Lack of Emergency & Trauma Bookings System in Theatres
Risk 1994 opened on 17/10/24, review due on 24/2/25

1.12. Pre-Assessment Room Availability
Risk 1996 opened 25/10/25, review due on 13/1/25

1.13. Risk of unknown incorrect maternity records in Badgernet as a result of memory leak incident

Risk 2025 opened on 11/12/24, review due on 22/2/25. Incident Oversight Group established. No evidence of incomplete records or associated risks to patient care. Work with digital supplier remains ongoing and mitigations are in place.

1.14. Server Room Air Conditioning Unit checks after Power Outages

Risk 2014 opened on 25/11/24, review is overdue, due on 29/11/24

2. Main narrative

2.1. The Trust Corporate Risk Register is the central repository for the most significant operational risks scoring 15+ arising from individual services, Care Groups or Divisional risk registers that are not currently fully mitigated, or controlled, or where risks have significant impact on the whole organisation and require oversight and assurance on their management. These risks represent the most significant risks impacting the Trusts' ability to execute its' strategic objectives and therefore align with the principal strategic risks overseen by the Board.

2.2. The Board sub-committees receive quarterly Corporate Risk Register reports to ensure that the risks that are relevant to those Committees are being managed effectively, and that the risks are being shared across the organisation.

2.3. Risks on the risk register are aligned and linked to the Board Assurance Framework. Not every high scoring risk on the Trust Risk Register will appear on the BAF, and not all BAF entries will appear on the Trust Risk Register, which is the tool for the management of operational risk.

2.4. Through the Board sub-committees, the Board will receive assurance that the BAF and Corporate Risk Register has been used to:

- inform the planning of audit activity (Risk and Audit Committee)
- inform financial decision making and budget setting (Finance and Performance Committee)
- inform quality and governance decisions (Quality Committee)
- inform workforce; human resources; training and development decisions (People and Culture Committee)

2.5. Risk and Audit Committee Corporate Risk Register detail (excel document open and active risks as at 27/01/25). Note summary report relates to Quarter 3.

2.6. Managed and closed risks aligned to RAC for last quarter (excel document closed)

3. Conclusion

3.1. Risks continue to be regularly reviewed and have been aligned with the revised Risk Management Framework and are linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place. The Risk team will continue to support the Divisions, enabling and educating them to update and manage their risks accordingly.

4. Recommendations

4.1. The Board / Committee is recommended to:

- Receive the report for **assurance**
- review the current Corporate Risk Register; and
- note the High-risk areas.
- consider overall risks to strategic objectives and BAF.
- request any further assurances.

Name and Title of Author: Laura Sellick
Date 28/01/2025

5. Appendices

5.1. Active and Open Risks 15+ (including Closed Risks)

Opened	ID	Division of responsibility	Service of responsibility	Local Manager	Title	Rating (initial)	Rating (current)	Rating (Target)	Mitigations/Controls	Review date	Type of Risk	Strategic objectives
01/11/2023	1752	Chief Information Officer	Digital Services (formerly IT)	Brown, Simon	2003 Servers Out of Support Since 2010	16	16	4	Systems will be migrated to supported platforms when commitment from projects and other digital staff become available.	26/01/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
25/09/2023	1735	Chief Information Officer	Digital Services (formerly IT)	Brown, Simon	2008 Servers Out of Support Since January 2020	16	16	4	Plans are ongoing to reduce the no of legacy systems within the Trust, these are evidences in the Trusts quarterly cyber report, which is discussed at both DTAG and IGG (summary is as below) Reducing the presence of systems that no longer receive vendor patches or support considerably improves the Trusts cyber posture. Legacy systems contain known vulnerabilities and backdoors which are frequently abused by online crooks in large scale malicious campaigns. In retaining these known susceptible systems inevitably opens the Trust to unacceptable levels of risk. Through the snapshots below it is clear to see the departments commitment to reducing legacy systems wherever possible. 07/01/22 EoL Endpoint estate – 30.30% 27/03/23 EoL Endpoint estate – 10.62% 21/06/23 EoL Endpoint estate – 7.5% Note: A portion of the remaining 7.5% requires additional hardware to replace the EoL kit that does not support software upgrades to the latest iterations of Windows OS. The department continued to make progress with the server estate following a similar trend as the endpoints above. This typically takes longer due to the associated resources required (financial, operational & staffing) to successfully plan and implement system level upgrades. This process is also frequently held up due to contractual reasons – with suppliers not being liable for replacing/upgrading systems. As of the close of Q1, DCH has reduced the percentage of legacy servers down from 18.2% to 6.8% at the start of January. In addition, the department has been proactively upgrading the Server 2012 estate which is due go EoL in October, halving the number of these devices from 86 to 50.	26/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
16/10/2023	1745	Chief Information Officer	Digital Services (formerly IT)	Brown, Simon	2012 Servers Out of Support Since October 2023	16	16	3	list of servers is regularly reviewed with Technical support teams and cyber, risks are shared at IGG and through quarterly cyber reporting	26/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
06/06/2024	1903	Family Services and Surgical Division	Decontamination Service	Sallows, Fiona	Age of Washers in EDU	16	16	2	EDU Washer 13H100255 EDU Washer 33H100257 Still in working order but department now have reduced capacity for normal activity. Senior management informed and awaiting updates from TDOC support.	14/02/2025	Finance and Performance Committee	Sustainability
17/11/2022	1550	Urgent & Integrated Care Division	Emergency (ED) Services	Hartley, Samantha	ambulance delays and hospital flow	20	20	6		01/04/2025		
20/01/2022	1196	Family Services and Surgical Division	Orthoptist Service	Fox, Jon	Backlog of Paediatric & Ocular Motility Appointments	16	15	6	Prioritise urgent patient by booking them as a priority. Extra Clinics being run where possible, which run alongside the usual clinics. Extra clinics to run throughout the year. Waiting list constantly being reviewed.	20/02/2025	Finance and Performance Committee	Care, Communities, Sustainability
09/10/2024	1987	Family Services and Surgical Division	General Surgery Service	Foot, Laura	Bladder Scanner on Lulworth is Unrepairable - Replacement Required	15	15	2	We are currently borrowing a scanner from Ridgeway Ward as mitigation, however this scanner is a lesser quality that what we require as an acute surgical ward. This also takes nursing time to leave the ward and return it.	01/01/2025	Finance and Performance Committee	Sustainability
13/02/2023	1611	Urgent & Integrated Care Division	Renal Service	Ncube, Dumiso	Blood results for Renal Patients from Somerset Foundation Trust are not added to eMed (Renal System) as there is no interface	9	15	1	4 June 2024 Somerset have plans to enable access, DCH meeting with Somerset on 12 June 2024 for update.	17/02/2025		
10/08/2024	1938	Urgent & Integrated Care Division	Across all specialties	Johnston, Neil	Care Group has a large Projected Overspend at the end of the year which risks financial position for care group and division	16	16	9	Trust wide recruitment of nursing gaps has supported general reduction in agency spend in Qtr 1. High risk areas remain (Moreton and Fortuneswell with agency cover of unfunded posts in regular use. Director of Nursing working on plan with Headroom funds to support risk mitigation. Drugs budget overspend may be mitigated partially by central income recovery, but this is not able to be quantified and has been escalated as a concern with management accounts team. Care group is working on new models of care for Frail older patients that it is hoped will deliver efficiencies and reduced bed base costs to contribute towards savings target. Recognition of reduced agency spend is contributing to CIP target delivery, but is not able to be adjusted in budget.	24/02/2025	Finance and Performance Committee	Place Objective
24/12/2019	874	Family Services and Surgical Division	Children's therapy service	Sandells, Warren	Cerebral Palsy Integrated Pathway (CPIP)	9	16	6	X-Ray clinic with paed physio and radiographer- identifying highest risk children. Previously not routinely monitored by paediatrician. Children then recorded as green, amber, red with specific pathway. This has been achieved within existing resouces, reduced risk and freed up consultant time. We have set up a local database to ensure X-rays for all children known to DCH are carried out in a timely manner. The next steps require addition physiotherapy time for measurement and 24-hour postural management. Business case submitted.	24/02/2025	Finance and Performance Committee, Clinical Effectiveness Group	Care, Communities, Sustainability

17/05/2019	641	Chief Information Officer	Clinical Coding	Slough, Jane	Clinical Coding	20	15	3	Clinical Coding Manager in post. 3 Accredited Clinical Coders are out to advert and 3 apprentices are due for recruitment in September 2023. The other mitigation that may have a small opportunity is the impact of changes being implemented in 2024 for outpatients to move, for some limited specialities, to paperless clinics which may reduce the workload for the Health Records team to allow more scanning, however this is unlikely to have any significant impact in 2024. We have also recruited 2 trainee coders who start soon but whereas this will provide some local resource, it will be some months before this impacts productivity and in the short term will need support from existing coders. We are looking at some smaller opportunities to support coding productivity with improvements to the coding software but this requires testing, we are aiming to have this in place early in the new year.	23/04/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
29/04/2024	1877	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	Clinical digital Safety - DCB0160 assurance debt	12	20	8	Trust CNIO collecting baseline data and will author an options paper for discussion at DTAG. CNIO prioritising go lives for new HIT or upgrades to existing systems to mitigate new risks with CSO embedded in digital services. CSO training booked in June and September to train new CSO's.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
22/01/2024	1799	Chief Finance Officer	Catering Services	Cooper, Thomas	Cold Room Food Storage	16	16	16	A plan to upgrade the temperature monitoring system has been worked up and at time of writing was awaiting approval from IT about integration of the system with our own before we go ahead with procurement process. Non digital thermometers have been placed in the cold rooms as a back up for the data on digital thermos. All stock in the cold rooms affected the worst have been placed on trollies so it can be quickly moved in to a functioning cold room. The leadership team within catering have all been made aware and are carrying out extra checks.	30/09/2024	Finance and Performance Committee, Patient Safety Group, Health, Safety, Fire and Security Group	Care, Colleagues, Sustainability
24/12/2019	868	Family Services and Surgical Division	Gynaecology Service	Male, James	Colposcopy Service	16	16	2	- Consultants and Nurse Colposcopists doing additional colposcopy lists where possible - Trainee Colposcopy Nurse currently undergoing supervised training lists - Business case for equiptment to support more nurse led activity	14/02/2025	Finance and Performance Committee	Care, Communities, Sustainability
07/11/2024	2001	Family Services and Surgical Division	Paediatrics Service	Newman, Ruth	Consultant rota gaps	16	16	2	Locums offered to existing SPRs, locums nest and agency. Existing consultant group met and have covered additional shifts as much as possible.	20/01/2025	Finance and Performance Committee	
10/08/2024	1932	Urgent & Integrated Care Division	Respiratory Service	Johnston, Neil	CPAP Service Space at Vespasian House to be pulled, no permanent location identified, meaning inability to deliver from Mar-25	12	16	4	Current risk is mitigated by being able to operate out of Vespasian house, but no permanent space identified for the service next year, therefore risk is unmitigated.	10/02/2025	Finance and Performance Committee	Care, Communities, Sustainability
13/05/2021	1097	Chief Nursing Officer	Safeguarding Children Service	Cake, Sarah	CPIS child protection information sharing	15	15	10	Safeguarding team continue to have to review all ED records and pass the hospital number through Pas to check status of the child .	05/03/2025	Quality Committee, Digital Systems Risk	
11/09/2019	725	Family Services and Surgical Division	Critical Care Service (CRC)	Sidey, Emma	CRCU Currently Breaches the Building Regulations HBN-04	15	15	1	NHP confirmed to go ahead, planned opening 2027. Isolation of infected patients is managed in accordance with policy and with IPC team support. Mixed sex breaches are avoided where possible and escalated to executives when not.	03/03/2025	Finance and Performance Committee, Estates and Facilities Governance and Compliance	Care, Colleagues, Sustainability
30/08/2022	1495	Family Services and Surgical Division	Critical Care Service (CRC)	Sidey, Emma	CRCU Nursing Workforce and Education Gap	16	16	4	Use of high-cost agency is relied upon to fulfil staffing gaps, this ensures adequate skill mix/ safe staffing. Last year, this was in part funded by a TVWCCN targeted investment, however this funding is not re-occurring. Mandatory training is often covered by CPEs and SV band 7's- impacting massively upon their workload. Training is limited and delayed where service pressures do not permit release of staff.	27/02/2025	People and Culture Committee	Care, Colleagues
03/11/2018	635	Family Services and Surgical Division	Critical Care Service (CRC)	Sidey, Emma	Critical Care Discharge Delays Over 24hrs and Lack of Flow for Ward Level Patients	15	15	9	Critical Care dashboard supports exception reporting to care group 3 with monitoring of delayed discharges. CRCU Matron, Matron of the Day and Flow cell working to expedite discharges in as timely a fashion as possible, taking Trust wide flow pressures into account (high number NRTR). CRCU nursing team undergo supportive discharge planning training regularly and utilise discharge team.	03/03/2025	Finance and Performance Committee	Care, Communities, Sustainability
11/09/2019	730	Family Services and Surgical Division	Critical Care Outreach/Hospital at Night	Sidey, Emma	Critical Care Outreach Team Under Resourced	16	16	6	Overtime offered within the team, locums nest (at cost) and clinical lead working extra.	06/01/2025	People and Culture Committee	Care, Colleagues
14/09/2021	1152	Chief Information Officer	Digital Services (formerly IT)	Gardiner, Ruth	Current Digital Staffing levels present risk to both operational and strategic activities	16	20	9	The management of risk and developing a joint digital strategy with DHC will determine how the organisation evolves/grows. Discussions with the ICB are also underway for staffing opportunities.	22/02/2025	People and Culture Committee, Digital Systems Risk	Care, Colleagues
18/05/2023	1650	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	DCH Patients who have access to their GP records can now see documents for DCH before they have been contacted/seen by theTrust	12	16	12	Results and clinic letters are uploaded as mandated nationally. Awareness needs to be raised with GPs and clinicians to make them aware of the immediate access for patients.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
10/01/2025	2040	Workforce and Human Resources	Human Resorces	Youers, Catherine	Disabled Car Parking at Dorset Council-Owned Facilities	16	16	9	Escalation to workforce 7/1 due to meet with staff who are imminently relocating to SWH to understand current arrangement. Legal advice being sought by HR	16/01/2025		

29/05/2019	677	Chief Finance Officer	Estates Department	Millis, Michael	Electrical Installation Condition Report - East Wing	16	16	6		18/10/2024	Finance and Performance Committee, Estates and Facilities Governance and Compliance	Care, Colleagues, Sustainability
29/05/2019	676	Chief Finance Officer	Estates Department	Millis, Michael	Electrical Installation Condition Report - South Wing	16	16	6	06.09.24 Reviewed taking account of current financial position and adjusted risk accordingly	18/10/2024	Finance and Performance Committee	Care, Colleagues, Sustainability
09/01/2019	481	Chief Finance Officer	Estates Department	Millis, Michael	Electrical Installation Condition Report North Wing	16	16	9	Planned to be completed by end of 2019 06.09.24 Reviewed taking account of current financial position and adjusted risk accoridngly	18/10/2024		
12/07/2024	1919	Chief Information Officer	Digital Services (formerly IT)	Gardiner, Ruth	Electronic Health Record - Insufficient Digital Resource to support EHR readiness and implementation	16	16	12	Trust Board approval of the OBC is subject to further assurance on readiness and resourcing. Resources may need to be diverted from other strategic or BAU work with consequential risks to other projects or to operational provision	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
02/02/2024	1815	Chief Information Officer	Digital Services (formerly IT)	Gardiner, Ruth	Electronic Health Record, risk of not receiving FD Funding	16	16	12	Currently working at pace to develop an outline business case with Somerset that includes options that could be affordable and which work jointly for Dorset and Somerset based on pre-market engagement. Earliest indication of whether an affordable option can be considered in mid February 2024	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
20/09/2024	1980	Family Services and Surgical Division	Maternity Service	Hartley, Jo	EPAC restricted service	12	15	6	ED is the only option available out of hours	04/02/2025	Quality Committee	Care
11/05/2021	1094	Chief Finance Officer	Facilities Department	Clarke, Lee	ESTATES: Lack of staff accommodation	16	16	4	•Use of B&B's, Hotels and Caravan parks is not an option, as all have advised they are fully booked from June/July 2021, due to a demand in staycations! •Some potential properties have been identified to purchase, however, funding is required to initiate, and the buying and legal elements of the process will not likely complete in time for the shortfall in rooms required. •Discussions with Housing Associations have not been as fruitful as anticipated, although we are still exploring one line of enquiry. •Some success has been achieved in acquiring additional leases, which seems to be the most favorable option, especially as they are mainly cost neutral, with exception to upfront costs of set up and furnishing. We have started to seek new leases directly with potential landlords, by; advertising via the Trusts social media sites and local press. Along the lines of; the Trust is looking to increase its current private lease arrangements to provide additional accommodation for its Clinical/Medical staff and is interested in hearing from landlords who wish to lease their properties the Trust. •Early discussions have taken place with Dorset County Council who has identified a number of their property portfolio for disposal and redevelopment. These are being pursued further that may provide some accommodation opportunities in the longer term, but not in time for our pinch points.	18/10/2024	Finance and Performance Committee, Estates and Facilities Governance and Compliance	Care, Colleagues, Sustainability
08/02/2023	1606	Family Services and Surgical Division	Paediatrics Service	Newman, Ruth	Facing the Future standards for acute paediatric cover	10	15	3	Need to explore possibility of resident consultant cover in evenings (17:00-21:00) as PAU peak time. This will require additional consultant time as currently not all of the 10 consultants are doing resident cover. Will allow for patients to be reviewed in 14 hour window as per the standards. This work will need to tie in with job-planning a per risk number 1608.	20/01/2025	People and Culture Committee	Care, Colleagues
12/07/2021	1122	Chief Executive	Corporate Services	Gravett, Diane	Failure to comply with Freedom of Information Legislation	15	16	4	Software solutions are being trialled, although capacity to complete the trial is insufficient. There are currently no other mitigations in place.	30/11/2024	Strategy, Transformation and Partnerships	Care, Communities, Sustainability
04/10/2024	1985	Chief Finance Officer	Fire Safety	Nairn, Angus	Failure to comply with the Regulatory Reform (Fire Safety) Order 2005	20	20	6	1.Evacuation training provision to staff in patient facing areas 2.Reviews of Risk assessments and evacuation plans 3.Records of maintenance for statutory compliance 4.Compartmentation prioritisation methodology 5.Processes for keeping hospital streets / evacuation routes free from clutter 6.SoP for the transportation and storage of portable medical gas cylinders	04/11/2024	Finance and Performance Committee, Health, Safety, Fire and Security Group	Care, Colleagues, Sustainability
28/07/2022	1463	Family Services and Surgical Division	Radiology Service (DCH)	Morris, Julia	Failure to Replace Mammography Equipment	12	16	3	Regular Maintenance in place.	21/02/2025	Finance and Performance Committee, Medical Devices Group	Sustainability
09/05/2024	1886	Chief Finance Officer	Finance	Hearn, Chris	financial sustainability 24/25	16	16	6	Budget meetings, monitored at FPC	30/09/2024	Finance and Performance Committee	Sustainability
09/12/2024	2023	Chief Finance Officer	Estates Department	May, Terence	Fire Alarm system constantly in fault	20	20	6	Specialist Contractor required, daily/weekly.	10/01/2025	Risk and Audit Committee	
05/06/2021	1105	Chief Finance Officer	Estates Department	Nairn, Angus	Fire Doors in accommodation do not meet the requirements of current legislation.	15	15	6	This is a historic risk the origins of which or why it was raised I am unaware of, it is difficult therefore to provide any historic mitigations or control measures. risk however remains HIGH. Current situation, please refer to new recent Datix DCH90892 which identifies that there are defective doors that are yet to be identified. There are no mitigations in place for defective doors that are yet to be identified. Control measures will be put into effect once defective doors are identified that may include additional localised detection, staff awareness etc. Moving staff into alternative accommodation once high risk defects are identified and rectified is not an available control measure as there is no spare staff accommodation to utilise, this leaves some staff at a high level of risk. Door defects are being found during spot checks of staff accommodation and are being prioritised for repair according to the risks they pose.	18/10/2024	Finance and Performance Committee, Health, Safety, Fire and Security Group, Estates and Facilities Governance and Compliance	Care, Colleagues, Sustainability

24/05/2024	1896	Chief Finance Officer	Fire Safety	Nairn, Angus	Fire Team Response to emergencies	16	16	2	Email sent to Kevin Loader to advise the fire teams of the correct procedures to follow as an interim measure and cc'd to Jason Chambers for information. A formal training package is now being developed for the fire teams for delivery over the next 2 weeks. A further door opening training package will be developed for all staff in departments who carry out the initial alarm investigation prior to the arrival of the fire team.	17/09/2024	Finance and Performance Committee, Health, Safety, Fire and Security Group	Care, Colleagues, Sustainability
21/09/2021	1175	Chief Finance Officer	Estates Department	Daniell, Paul	Fortuneswell Pharmacy footprint not fit for purpose	12	16	4	Risk is currently being mitigated as far as possible by the vigilance of the staff. Funding has been agreed - awaiting Estates to have capacity to complete the reconfiguration work.	13/02/2025	Finance and Performance Committee, Estates and Facilities Governance and Compliance, Medicine Safety Committee	Care, Colleagues, Sustainability
01/02/2024	1605	Family Services and Surgical Division	Paediatrics Service	Male, James	General Paediatric Outpatient Waiting Lists	15	15	6	Moved to partial booking to highlight issues.	23/12/2024	Finance and Performance Committee, Clinical Effectiveness Group	Care, Communities, Sustainability
04/01/2024	1781	Family Services and Surgical Division	Ophthalmology Service	Fox, Jon	Glaucoma FOWL Long Waiters	20	16	6	Additional (in-house) activity is being put on as and when staffing allows. B4 technicians running assessment clinics to release clinicians time needed for F2F appointments Additional virtual reviews being put on as and when staffing allows.	10/02/2025	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group	Care, Communities, Sustainability
13/08/2024	1940	Family Services and Surgical Division	Across all specialties	Coalwood, Stuart	Head & Neck Management Office	20	15	12	Offer to work in alternative locations to staff where possible (hot desking) Offer to work from home where/ when possible Purchase of personal fans Windows fully open (not correctly from H&S point of view) Winter - Purchase of bottled water to avoid having no water in building Headphones are regularly used by members of the teams to have music playing to manage with the increased background noise. Plans to discuss WFH with team to support with working environment and additional noise in larger office	27/02/2025	Finance and Performance Committee, Health, Safety, Fire and Security Group, Estates and Facilities Governance and Compliance	Care, Colleagues, Sustainability
08/11/2024	2003	Urgent & Integrated Care Division	Histopathology Service	Hansford, Samantha	Histopathology Biomedical Scientist Workload Capcity	16	16	6	Locum Associate Practitioner (Band 4) in post, working 4 days per week: contract in place until end March 2025 As & When BMS contract in place for Band 6 BMS working 2+ days per week to support.	09/12/2024		
03/07/2024	1912	Chief Information Officer	Clinical IT Systems	Armstrong, Lee	ICE - unsent EDS (Electronic Discharge Summary) issues	20	15	12	Reports currently being generated by ICE. These notify each ward of incomplete EDS's that need to be actioned and are displayed in date order with alerts as the EDS's get older. We understand there are escalation routes to Divisions for outstanding summaries. Some EDS's aren't sent timely as they may have been created in a outpatient spell instead of an inpatient spell on ICE. CSST receive a daily report and move any incorrect spells and to the correct spell.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
07/02/2022	1207	Urgent & Integrated Care Division	Renal Service	O'Neill, Kathleen	Insufficient HD capacity across all sites - increase in demand does not meet our capacity	16	16			13/02/2025		
02/08/2022	1467	Chief Finance Officer	Strategic Estates	Richey, Fiona	Insufficient revenue funding available to achieve the required staffing levels	12	16	12	Phased completion should reduce level of risk. As we progress to FBC we need to review the workforce plan and assumptions and articulate a confident position in relation to revenue funding. 07/03/24 - FBC submitted with updated workforce plan. Underlying stem financial position may have an impact. 5/8/24 - This will form part of 25/26 business planning round. Limited funding available.	30/12/2024	Finance and Performance Committee	Sustainability
19/11/2024	2007	Chief Information Officer	Digital Services (formerly IT)	Gardiner, Ruth	Lack of Adequate Support for Digital Systems in a 24/7 Acute Trust	12	16	8	Clinical systems support provided for out of hours. Greater number of on-call analysts to cover all areas of DTI.	22/02/2025		
23/09/2024	1981	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	Lack of Assurance from Fortrus to meet clinical safety processes	16	16	6	Review of the contractual commitments between Fortrus and DCH at an executive level as previous meeting shave not resolved the issues. Resetting the contractual milestones. Should the Trust and Fortrus be unable to provide us with some stability in the system, the Trust would have to revert back to paper records within ED environment.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability

07/11/2022	1542	Urgent & Integrated Care Division	Microbiology Service	Rees, Gareth	Lack of compliance to the Pathology QMS system in Microbiology	12	16	4	HSE work and routine business as usual to provide a clinical service. Plans put in place to attempt to address all the issues raised are already falling behind. Staffing pressures have been raised to the division. The executive team are also aware of the increased pressure on the team with regards to the loss of UKAS accreditation and the work required to recover this. UPDATED 04/03/2024 - following withdrawal of accreditation the department provides quarterly updates to the Quality Committee which includes some workload figures, TAT metrics and training competencies. - a business case was written to support the request for 2 band 6 BMS staff which would enable the department to progress with improvements in the quality work to work towards ISO 2022 compliance. This business case was rejected, therefore no progress can be made on quality work. - IDPS work continues to be set outside the department at additional cost and additional pressure to the team whilst the department remains without UKAS accreditation. - There has been further slippage with quality work with increased number of overdue documents which do not match current work processes, increased number of overdue NCs, increased number of overdue audits.	08/01/2024	Quality Committee, Clinical Effectiveness Group	Care
22/11/2024	2011	Family Services and Surgical Division	Across all specialties	Morris, Julia	Lack of DEXA Reporting capacity	20	20	2	Seeking additional reporting capacity Exploring option of outsourcing - despite cost implication although need confirmation that their reports will conform to NOGG 21, and VFA's will be assessed.	10/02/2025	Finance and Performance Committee	
17/10/2024	1994	Family Services and Surgical Division	Theatre Service	Barkshire, Jane	Lack of Emergency & Trauma Bookings System in Theatres	15	15	4	Nil - escalated to Digital team regarding solution.	24/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
24/01/2025	2052	Urgent & Integrated Care Division	Renal Service	Ncube, Dumiso	Lack of identified location or continuity plan dialysis patients needing isolation at DCH	15	15	2	Current mitigation would be to use the Prince of Wales side rooms or to take over one of the ward bays. The lost beds would need to be provided elsewhere. As a plan this would be ad hoc.	25/02/2025		
02/05/2023	1635	Urgent & Integrated Care Division	Renal Service	O'Neill, Kathleen	Lack of Isolation Facilities on Prince of Wales ward	16	16	4	Use of rooms is managed on daily basis by juggling the patients who need to be transferred over POW ward. Patients can also be admitted onto other ward side rooms when appropriate and the nephrology team will manage the patient as an outlier. 3 Jan 2024 - Work to make the 2 side rooms useable begins on week commencing 8 January. This will provide 5 side rooms with dialysis capacity. 10 May 2024 - Urgent proposal for future development to cover the shortfall in outpatient isolation & haemodialysis capacity. Once this is resolved the ward will then have 5 siderooms as planned & required.	13/02/2025		
26/09/2024	1983	Family Services and Surgical Division	Paediatrics Service	Fry, Zoey	Lack of Office Space - Children's Centre	9	16	1	A SUG Form has been presented and we are awaiting an outcome on whether some teams can be moved to other areas of the trust with their teams.	10/02/2025		
24/05/2023	1655	Family Services and Surgical Division	Paediatrics Service	Rookes, Raphaella	Lack of Service Provision for Avoidant/Restrictive Food Intake Disorder	12	15	4	Currently Paediatricians are caring for these CYP within their acute and/or community workloads. There may occasionally be support from SALT with assessment but ongoing management which can be timely and labour intensive sits with the paediatrician. Advise sought as required from regional network but this is a voluntary rather than established network.	03/01/2025	Quality Committee	Partnership Objective, Place Objective
04/01/2024	1780	Family Services and Surgical Division	Ophthalmology Service	Fox, Jon	Macular FOWL Long Waiters	20	16	6	Additional (in week) activity is being created when staffing allows. Failsafe Officer monitoring waiting list and escalating any clinical concerns to Macular Lead Consultant.	29/01/2025	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group	Care, Communities, Sustainability
21/09/2021	876	Family Services and Surgical Division	Maternity Service	Hartley, Jo	Maternity Staffing	12	15	4	Staffing is reviewed very regularly, several times a day. Staff are asked to work different shifts, to stay longer and to work extra. However, they are also supported to know they can decline these requests. Community midwives re-allocated to LW as required - this is on a daily basis and of course impacts workload in community. Staff called in oncall - also impacts staffing the next day. Specialist midwives & matrons regularly work clinically. Escalation policy utilised as required with escalation to divert occurring regularly during July, Aug and Sept. Good system working across the ICS with women diverted to other services.	03/02/2025	People and Culture Committee	Care, Colleagues
11/12/2019	839	Family Services and Surgical Division	Paediatrics Service	Fry, Zoey	MDT representation in Specialist Paediatric Epilepsy Service	2	16	2	New post holder in place for Paediatric Epilepsy service since November 2021 covering 1.0wte in a job share to caseload over 150 epilepsy patients. This is however not sufficient staffing to meet NICE guidance and recommended standards. Additional 12.5 hours given to Epilepsy from core CCN hours to support and maintain a local epilepsy service.	03/02/2025	People and Culture Committee	Care, Colleagues
20/11/2018	659	Urgent & Integrated Care Division	Pharmacy Service	Jones, Nicholas	Medicines Supply Challenges	20	16	6	Supply issues are being monitored bi-monthly by the Medicines Committee. This is in relation to COVID 19 and Brexit.	02/04/2025	Quality Committee	Care, Communities, Sustainability
13/06/2023	1675	Family Services and Surgical Division	Theatre Service	Lythe, Joe	Medtronic Valleylab FX Diathermy Machines	12	16	16	Currently not a risk - will flag with capital planning to ensure suitable alternative sourced. Note review of capital replacement plan in place. These machines are failing when being checked. They are 23 years old and medical electronics are doing their best to keep them in use. High risk of patient cancellations due to a shortage of these machines .	17/03/2025	Finance and Performance Committee	Care, Communities, Sustainability
13/01/2025	2042	Urgent & Integrated Care Division	Microbiology Service	Miller, Andrew	Microbiology Biomedical Scientist Workload Capacity	16	16	6	Workflow improvements are piecemeal when new equipment is provided, so far the coverage has been limited due to the scope of managed service tenders. There is currently (Jan 2025) a business case proposal to introduce MALDI-TOF identification to improve bacteriology workflow, speed of results and reduce costs. Divisional management have supported the Microbiology team by not requiring UKAS accreditation until it can be resourced.	31/01/2025		
21/04/2023	1629	Chief Operating Officer		Rowe, Ian	Move of Hampshire Trust to a Sectra PACS	16	16	9	October 2023 - guidance to be provided to DCH clinicians in the specialities most effected (colorectal and liver cancers) they will have a change of process to request access to imaging if they believe it has been done by Hampshire hospitals.	10/02/2025	Finance and Performance Committee	Care, Communities, Sustainability

23/11/2022	1554	Family Services and Surgical Division	Theatre Service	Lythe, Joe	National Shortage of Stock - Supply Chain Problems	15	16	3	Procurement will alert to supply chain issues and try to obtain replacement. Clinicians are informed of shortages and included in checking that alternative is appropriate.	10/02/2025	Finance and Performance Committee, Clinical Effectiveness Group	Sustainability
01/05/2024	1881	Family Services and Surgical Division	Special Care Baby Unit (SCBU)	Pascoal Horta, Debora	Neonatal Nursing staffing	16	16	6	Business planning request sent to Divisional director and chief nursing officer back in November 2023. Ward manager covering some clinical shifts when cover is not possible. Other members of staff on quality roles, also covering clinical shifts instead. Agency still being used and very often bank and overtime hours done by permanent members of staff.	03/02/2025	People and Culture Committee	Care, Colleagues
27/03/2024	1852	Family Services and Surgical Division	Neurophysiology Service	Morris, Julia	Neurophysiology Staffing	15	15	3	Job planning will be reviewed to address the balance of work to support clinical and quality of service. We are going to review how urgent and IP are covered. There are times when we struggle to meet the IP demand We have created protected time for reporting ambulatories and will review if that is on track For a small team we also need to reflect on impact of this on health and well being for small team This situation is developing the DM01 is currently in a poor position and urgent and IP has doubled for escalation. 03012025 Demand for service continues to increase and exceeds capacity. IP and Urgent work has increased over 2024, DM01 there is a waiting list of 12-13 for NCS and CTS which is new, non clinical work is being impacted. Cases are becoming more complex and there is often pressure to obtain reports faster than the TAT. Increasing pressure on staff to deliver service on an urgent basis. The clinics are operating at 100% and pressure on both both clinical and non clinical work. Currently additional demands on service lead times (management activities) adding further pressure to team.	28/03/2025	People and Culture Committee	People Objective
04/01/2023	1571	Chief Finance Officer	Strategic Estates	Richey, Fiona	NHP - Design Programme Slippage	12	16	6	EWN - with PSCP and Supply Chain Meetings and regular communication managed collaboratively Agreed schedule for design sign off Agree design caveats and PSCP to cost ahead of GMP (most changes are not significant or high risk) 5/8/24 - Clinical design completed. Technical drawings to be finalised. Contract due to complete end of September.	30/09/2024		
05/12/2023	1770	Chief Information Officer	Clinical IT Systems	Godber, Louise	No electronic capture and referral process for treating tobacco dependency in the acute sector	15	15	6	Discussion around the use of ICE for reporting procedures.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
02/06/2023	1663	Family Services and Surgical Division	Paediatrics Service	Fry, Zoey	No Height and Weight Room - Children Centre	15	15	5	Adapted a small section of the waiting area for patients height and weight measurements to be taken with temporary screens in place.	10/02/2025	Finance and Performance Committee	Care, Colleagues, Sustainability
10/01/2024	1788	Family Services and Surgical Division	Radiology Service (DCH)	Morris, Julia	Obstetric reporting system - Viewpoint is at end of life	20	16	2	Continue to use system until no longer supported	14/02/2025	Finance and Performance Committee	Place Objective
08/11/2024	2004	Urgent & Integrated Care Division	Adult Occupational Therapy Service	Gamblen, Sonia	Occupational Therapy Staffing gaps mean the team will need to run in Business Continuity, unable to fulfil all work	20	20	12	Working on referral criteria , referral process and prioritisation. This will need to include a waiting list for Occupational Therapy intervention. Meeting with Home First team 12/11/2024 to discuss allocation of case load. Discharge team to have PIN numbers to access NRS equipment to order equipment for home where appropriate for those patients not requiring OT involvement.	24/02/2025	People and Culture Committee	
10/08/2024	1934	Urgent & Integrated Care Division	Dietetics and Nutrition Service	Johnston, Neil	Ongoing Malnutrition Risk to Patients through MUST action plan not being met after initial assessment.	12	16	6	Sufficient numbers of suitable weighing devices in place within the division / trust. Will need to establish ongoing training for staff in correct use and recording of weights.	10/03/2025		
04/09/2024	1957	Family Services and Surgical Division	Ophthalmology Service	Fox, Jon	Ophthalmology Lost to Follow Up Patients	20	16	4	Review of clinics for the last 3 years needs to be undertaken.	10/02/2025	Quality Committee	
09/01/2025	2039	Family Services and Surgical Division	Orthoptist Service	Cole, Kayleigh	Orthoptist service stroke capacity	15	15	6	We have converted all new and follow up patients not needing a visual field onto an orthoptist only clinic. However this is putting huge pressure on the orthoptic only clinics. I have asked for the stroke clinics to be added to the rolling rota, however ophthalmology want to run a glaucoma clinic on a friday so this is not possible. I have emailed the stroke team to say we will not be accepting patients that are referred for reduced vision only, these patients should be advised to see their own optician	06/02/2025		
21/01/2025	2048	Family Services and Surgical Division	Theatre Service	Kapoor, Gaurika	Otology drill replacement	16	16	4	We are using drills on temporary loan whilst awaiting Capital committee.	10/02/2025		
08/02/2023	1608	Family Services and Surgical Division	Paediatrics Service	Newman, Ruth	Paediatric consultant job planning and rota cover	15	15	1	Current exploration of job plans underway including resident on-call commitments. This will then enable job plans to be updated. Action being undertaken by consultant group themselves.	20/01/2025	People and Culture Committee	Care, Colleagues

10/09/2018	472	Family Services and Surgical Division	Paediatrics Service	Ekerold, Anna	Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics	15	20	10	May 2024 – DCH Transformation of Community Services (ASD / ADHD) commenced which is exploring; Waiting list – full validation in progress (commenced June 2024) Process – review of referral routes, and administrative process in referral, triage, and management of the waiting list. To commence PTL meetings once WL validation is completed Workforce – current clinical and administrative models under review. Exploration of job descriptions, roles and remits. Alternative workforce models for consideration. To combine Risk 1529 into risk 472, specifically around nursing workforce and capacity. Addressing training and development needs. Risk – to ensure that all complaints / FFT are linked to this risk, and community paediatrics team reminded to Datix all incidents that occur in relation to this risk (e.g, delay in receiving new referrals, increased waiting times, patients coming to harm on WL, incorrect referral method used, YP turning 18 whilst on WL – this list is not exhaustive) Systems development – Continue t work with the ICB on reviewing and amending the referral, triage and assessment processes for ASD / ADHD across Dorset. Patient Experience – better understanding of how CYP and families are waiting, and learning about their own experiences. Weekly meetings with project team – AE & RD Monthly meetings/ workshops with the wider clinical, management and admin team to progress actions and workstream New Ways of working: Piloting preschool one stop MDT clinics to provide assessment and diagnosis / onward referral in one clinic appointment. Long standing mitigations in place: General Paediatrics already sharing the workload of ADHD / Safeguarding. These functions should sit within the Community Paediatric remit, but there is no capacity. This is also not a long term solution. ASD diagnostics process is completed as a single clinical diagnosis, rather than MDT diagnosis.	14/02/2024	Finance and Performance Committee	Care, Communities, Sustainability
14/04/2021	1080	Urgent & Integrated Care Division	Dietetics and Nutrition Service	Johnston, Neil	Patients admitted with an adult eating disorder may not receive the specialist care they need.	15	20	6	New policy has been drafted and has completed final review. It is now to be submitted to clinical guidelines. This new guidance will provide a structure for the management of these complex patients. Once approved by clinical guidelines dietetics will work with gastro docs and wards to consider best way to raise awareness of the guideline to relevant professionals. New policy on the management of patients with eating disorders has been ratified by the Nutrition Steering Group (NSG), we are planning some training sessions in the new year once we have passed through the current COVID Omicron crisis and are back to BAU. In the meantime we will continue to work closely with all professionals involved in these cases using our new policy to guide our decision making and escalations. Discussions with Sonia Gamblen and Andy Miller to discuss management of this patient group with CCG/DHC. Currently there is a gap in service provision for these patients which needs addressing. DCH is only one part of a larger care pathway for appropriate management.	10/03/2025	Quality Committee	Partnership Objective, Place Objective
09/09/2024	1972	Chief Finance Officer	Estates Department	Carver, Colin	Patients and staff cannot rely on the call bells summoning assistance as they are not working effectively	20	16	4	Three ward areas have had replacement call bells installed (Stroke, Moreton & PoW). Maternity is currently having a system installed, followed by radiology and Kingfisher. There is no assurance that Ilchester and the remaining areas have a plan or any associated timescale.	25/11/2024	Finance and Performance Committee	Care, Colleagues, Sustainability
08/09/2022	1502	Urgent & Integrated Care Division	Pharmacy Service	Jones, Nicholas	Pharmacy Aseptic Unit - High risk to patient safety	20	16	8	- Action plan being addressed - 48 hour turnaround time - cap on numbers - improved scheduling on unit - ICS task and finish group being set up to look at medium to long term - Monthly review of action plan progress - business case	05/02/2025	Quality Committee, Medicine Safety Committee	Care
25/10/2024	1996	Family Services and Surgical Division	Pre-assessment Service (SAL)	Carless, Ms Alison	Pre Assessment Room Availability	12	15	4	The staff are making do with the rooms that are available to them and doing their best given the situation they are in.	13/01/2025	Finance and Performance Committee	
22/07/2024	1922	Family Services and Surgical Division	Theatre Service	Lythe, Joe	Provision of Vascular Access Service	20	16	6	Presently utilising gaps in the emergency list where an appropriately trained person can carry out the access. Not all Anaesthetists are trained to do this. Using the 2 trained theatre staff is not always possible due to it not being part of theatres establishment.	10/02/2025	Finance and Performance Committee	Care, Communities, Sustainability
26/09/2022	1516	Family Services and Surgical Division	Radiology Service (DCH)	Morris, Julia	Radiology Reports not being reviewed	20	16	4	Medical director informed. All Radiology staff aware to phone or speak directly to clinicians in event of a critical/life threatening finding but not all potential life changing conditions will be covered under the icomm alerts Task and Finish Group Established action plan in place	14/02/2025	Clinical Effectiveness Group, Quality Committee	Care
18/07/2023	1703	Family Services and Surgical Division	Paediatrics Service	Fry, Zoey	Re-designation of Local POSCU & Oncology Workforce	9	16	2	NHSE Service Specification followed locally except unable to meet the 10 new patients a year to remain an Enhance Level 2A POSCO.	10/02/2025	People and Culture Committee	Care, Colleagues
06/09/2024	1963	Chief Finance Officer	Estates Department	Carver, Colin	Replacement of Cat 3 Autoclaves & associated RO pipework	15	15	6	Components are being replaced to keep the equipment running.	18/10/2024	Finance and Performance Committee	Care, Colleagues, Sustainability
01/10/2021	1162	Family Services and Surgical Division	Theatre Service	Ismaili, Lisa	Risk of 'on the day' Cancellations with Over Night Opening of Day Surgery	15	15	6	Review of available capacity for in-patients agreed at 11.00 bed meeting. Staffing (agency) requested daily following decision to open. Site risk assessment to be carried out prior to opening. SOP going to TMG.	24/02/2025	Quality Committee	Place Objective

11/12/2024	2025	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	Risk of unknown incorrect maternity records in Badgernet as a result of memory leak incident	20	16	12	The incident oversight group will meet on 19th December to conclude all outstanding actions including how to mitigate the remaining risks associated with unknown incorrect records	22/02/2025		
25/11/2024	2014	Chief Finance Officer	Estates Department	Daniell, Paul	Server Room Air Conditioning Unit checks after Power Outages	15	15	4	Estates to check every server room air conditioning units are running after a power cut.	29/11/2024	Finance and Performance Committee	
05/06/2023	1664	Family Services and Surgical Division	Paediatrics Service	Fry, Zoey	Skill Mix within -Paediatric Outpatient Department - No Registered or Lead Nurse	12	15	6	Rely on Kingfisher staffing and available Bank staff to support the children's centre with staffing gaps for sickness and training. 4 additional HCAs have been recruited - currently going through recruitment checks.	10/02/2025	People and Culture Committee	Care, Colleagues
23/05/2024	1895	Chief Finance Officer	Estates Department	Nairn, Angus	South Walks Fire segregation	9	16	2	Currently at maximum capacity as it stands until DCC undertake, 1. Separation of SWH DCH side and DCC Library fire alarm. 2. Fire compartmentation requirement to separate Library from SWH and DCH side. Mitigations are currently the whole building operates as one fire strategy, any event we result in simultaneous evacuation.	11/10/2024		
05/04/2022	1236	Urgent & Integrated Care Division	Medical Physics Service	Thurston, Jim	Space for Clinical Engineering & Medical Physics	8	15	5	Update September 2024: Two new posts in Medical Physics starting in Q3 2024/25 mean there is no office space left for any further expansion to meet the current business case. It will also be difficult to find office space for any further new posts in Clinical Engineering. The risk score remains 3 x 5 = 15 High, and will move higher (4 x 5 = 20 High), depending on recruitment to new posts over the next 6 months. However, space may become available on site once the new off-site store/commissioning facilty is established at Higher Bockhampton.	02/12/2024		
06/09/2024	1960	Family Services and Surgical Division	Decontamination Service	May, Terence	SSD - Failure of Equipment	16	16	6	Weekly engineers visits, increased maintenance costs and equipment failure	04/10/2024	Finance and Performance Committee	Care, Colleagues, Sustainability
06/09/2024	1964	Family Services and Surgical Division	Decontamination Service	May, Terence	SSD & Endoscopy RO/Water softener Replacement	16	16	4	New units would be more cost effective and initial period covered under warranty	13/01/2025	Finance and Performance Committee	Care, Colleagues, Sustainability
06/09/2024	1962	Chief Finance Officer	Estates Department	Carver, Colin	Steam Generator Replacement	16	16	6	Machinery is being maintained as well as possible	03/01/2025	Finance and Performance Committee	Care, Colleagues, Sustainability
11/11/2021	1168	Chief Finance Officer	Strategic Estates	Horton, Matt	System revenue affordability pressures	16	16	8	Updated risk title 07/03/24 Continued review of revenue requirements for NHP project Dorset Healthcare are leading the system wide discussions with DoFs and we will keep them appraised on the timetable for the DCH OBC to ensure we can minimise any potential delay. Revenue Affordability -proposal of baseline assumptions went to OFRG last Friday 03/12, a team is being put together to look at the strategy and use those baseline assumptions to hit OBC timings Early indications are that timetables will correlate. OBC submitted 10.06.22 OBC on schedule for submission at end of May. 5/8/24 FBC submitted January 2024. Trust submitted a balanced plan for 24/25 fy.	16/12/2024	Finance and Performance Committee	Sustainability
21/05/2022	1289	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	SystemC - Supplier	16	16	12	Planned replacement of VitalFLO included in Clinical Systems Strategy but this will be subject to business case. Current plan is to replace VitalFlo with the bed management module of Agyle, however, this is currently delayed due to the digital transformation programmes being paused until a decision on EHR in early May 2024.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
09/03/2022	1221	Chief Operating Officer	Central Appointments	Savin, Adam	Tackling the backlog of elective care	20	16	8	The trust in on track to deliver against the revised trajectory of zero, 65+ week waits and has made good progress in reducing the number of patients waiting over 52 weeks. Mitigations that remain in place including: 1) Comprehensive insourcing plan, with all activity insourced below the tariff rate 2) 12-week validation programme, which means all patients on the waiting list are contacted every 12 weeks to ensure they still want to be on the waiting list and their condition has not changed 3) PTL management process, which includes clinical oversight to ensure patients clinical priority is regularly reviewed 4) The trust remains in tiering, with weekly review meetings with the ICB and NHSE. The trust values this process as an opportunity to keep stakeholders engaged	31/03/2025	Finance and Performance Committee, Clinical Effectiveness Group	Care, Communities, Sustainability
22/01/2024	1800	Chief Finance Officer	Catering Services	Cooper, Thomas	Temperature Holding Equipment Inadequate	16	16	16	There are no mitigations we can put in place to increase the food safety standards without the equipment mentioned. I would like to see the missing bowl warmer and thawing cupboard ordered and the RTS unit we need a back up in case of failure to mitigate risk. Potential mitigations include moving away from frozen food and reducing service to areas outside of our remit that we currently serve. We may also have to reduce the availability of high risk items. It should be noted these will incur significant cost pressures to the trust and have an impact on patient experience and nutrition.	29/01/2024	Finance and Performance Committee, Patient Safety Group	Sustainability

21/01/2025	2047	Chief Operating Officer	Central Appointments	Savin, Adam	The management of and the booking of follow up appointment	20	20	4	Specifically for ophthalmology, an oversight group has been established, which is executively led and is leading on the development of a plan to identify and contact patients who may have been lost to follow up. The group is also leading on the development of the plan to prevent further recurrence. A further audit is underway, to determine if the findings are unique to the year audited (2019/20) or if the issues have continued post the COVID recovery. More widely, the Access team will lead a review of all services, this will include harm audits, the introduction of standardised booking and PTL management practices for follow up booking, a return to partial booking and an options appraisal to centralise all follow up booking (it is currently done within the Care Groups). This commences in April, when a team will be seconded to complete the work. A governance structure is being developed for the programme.	31/03/2025		
27/09/2024	1984	Urgent & Integrated Care Division	Dietetics and Nutrition Service	Rookes, Raphaella	The trust is unable to offer robust Oncology dietitian input for patients due to single postholder / established post	15	15	6	Wider cancer services away of current staffing provision and signposted appropriately. Upskilling of acute dietitians to be able to support more basic oncology patients.	24/02/2025	People and Culture Committee	Care, Colleagues
30/11/2022	1556	Family Services and Surgical Division	Theatre Service	Lythe, Joe	Theatre Staffing Sustainability	16	16	6	Workforce planning in progress, alternative pipeline for staffing being considered. Review of roles and posts, potential for ?SFA roles, or other clinical roles. The could be lowered with business planning support	10/02/2025	People and Culture Committee, Clinical Effectiveness Group	Care, Colleagues
26/10/2023	1749	Family Services and Surgical Division	Across all specialties	Lythe, Joe	Theatre Utilisation Below 85%	20	20	6	Updated action plan being drafted in response to external visit in late 2024. Previous utilisation plan was shared with services in June 2024 to give actions in order to improve utilisation. Actions appear to be having an impact, but performance remains inconsistent. Plans in place with Divisional director and performance director to keep focus on theatre utilisation.	14/02/2025	Finance and Performance Committee	Care, Communities, Sustainability
14/06/2023	1678	Urgent & Integrated Care Division	Acute Oncology	Johnston, Neil	There are insufficient Oncologists to meet the demands on the service for outpatient appointments.	15	15	6	Linked with managed risk of Acute Oncology Staffing (Nursing). Increased ACP presence to support Acute oncology ward, and provision of outpatient clinics to support Oncology teams. Working with University Hospital teams to ensure risk is both highlighted and mitigations / action plan in place to support. Apr-24 Macmillan funding for 2 years has been identified to support ACP role which will support Lung cancer pathway.	24/02/2025	Finance and Performance Committee	Care, Communities, Sustainability
06/03/2024	1843	Urgent & Integrated Care Division	Haematology Service (blood sciences)	Johnston, Neil	There is insufficient capacity for consultant led clinics in Haematology for current demand levels	16	16	2	Additional clinics have been put on to try and manage the backlog, but this is putting additional strain on the consultant team. Jason M is increasing capacity - once a month clinic mixed with Audrey Ryan - Gynae pts. Using slots on bone marrow clinics and fast track slots (overbooks) to accommodate for these patients.	24/02/2025	Finance and Performance Committee, Patient Safety Group	Care, Communities, Sustainability
11/06/2024	1906	Family Services and Surgical Division	Theatre Service	Lythe, Joe	Total Intravenous Anaesthetic Pumps Required	12	20	4	We will continue to use the available pumps with a view to purchase additional TIVA pumps at the earliest opportunity.	10/02/2025	Quality Committee	
03/07/2024	1913	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	TPP SystmOne - EPR core unit	15	20	4	Regular meetings have been set up with the Interim CIO, Interim Head of Systems, Development, and Digital Transformation, Chief Nursing Information Officer, Data Quality Lead and the NHS Dorset digital team. From these meetings an action plan has been formulated to gain further information on the risk and to explore how best to resolve it, including finding suitable resource to manage open tasks.	22/02/2025	Strategy, Transformation and Partnerships	Communities, Sustainability
09/02/2021	1037	Family Services and Surgical Division	Paediatric Transition Service	Tuckett, Charlotte	Transition Service for Young People to Improve Health Outcomes	20	16	4	The Transition Stakeholder group has a diverse, multi-agency attendance that is improving understanding of services working with young people and exploring how we may work together more effectively. Transition Steering Group for now formed that sits under the Health Inequalities Board and gives the Transition Stakeholder Group a place to report to and escalate concerns to. RSG and TCYP PAS Flags to identify young people in the transition process. Alastair Hutchinson is Executive lead for transition. Strong National and Regional links established for sharing knowledge, ideas and best practice.	03/03/2025	Quality Committee, System Risk - sits with ICB or other	Care
20/05/2024	1893	Urgent & Integrated Care Division	Haemodialysis Service	Miller, Andrew	Transport for Renal patients	16	16	9	Escalated to ICB as the commissioners of the service and the contract holders Regular meetings between provider and ICB - continue as problems continue. manager appointed to dialysis for direct contact which does help but a lot more risks when she is on leave.	13/12/2024	Finance and Performance Committee, System Risk - sits with ICB or other	Care, Communities, Sustainability
20/05/2022	1272	Chief Information Officer	Clinical IT Systems	Gardiner, Ruth	Trust Integration Engine	20	16	9	This is a known risk which has been escalated to the Digital Transformation and Assurance Group chaired by Nick Johnson and attended by Executive team. Digital Services are meeting suppliers to mitigate risk. Updated 20/02/2024: Whilst the supplier is now on the procurement framework making re-procurement easier, the risk remains high as our integration engine is still run by a micro-company. Updated 04/04/2024: As part of EHR alternative systems integration approach will be included.	22/02/2025	People and Culture Committee, Patient Safety Group, Digital Systems Risk, Clinical Effectiveness Group	Care, Colleagues
19/08/2024	1948	Urgent & Integrated Care Division	Emergency (ED) Services	Hartley, Samantha	UHD reconfiguration due to CSR and NHP	16	16	2	There are plans that Poole will remain ED consultant lead for 1 year after reconfiguration but there are risks that the UTC model will migrate patients to DCH. system UTC transformation Clinical dependency group UTC onsite at DCH	19/09/2024		
18/06/2024	1909	Chief Finance Officer	Fire Safety	May, Terence	Unauthorised Battery Disposal	9	16	3	The batteries were removed and disposed of via Darren Hallett with immediate effect following their discovery. The current risk rating below reflect the risk prior to discovery.	18/09/2024	Finance and Performance Committee, Estates and Facilities Governance and Compliance	Care, Colleagues, Sustainability

17/05/2024	1891	Chief Information Officer	Digital Services (formerly IT)	Brown, Simon	Windows 11 upgrade at risk due to lack of hardware resource	6	16	16	Early investment in hardware and resource (including staffing which is currently only funded until June 2025).	01/02/2025		

Dorset County Hospital
NHS Foundation Trust

Quality Committee Assurance Report
for the meeting held on Tuesday 17 December 2024

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer
Quoracy met?	Not Quorate at commencement of the meeting but Quoracy met part wat through the meeting.
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Patients lost to follow up is an issue in regard to ophthalmology • Acknowledge issues relating to operational pressures that all services are under and that a risk to quality might happen. • Taken assurance things happening in regard to the winter plan to mitigate risks. Quality impact and reporting will be coming back to Feb 2025 • Successful SSNAP stroke audit achieved for the first time in 4 years. • Success SHMI now 1.06 positive. Spells increase annually. • Opportunity for having some focus on Board Assurance Framework for a board development day and how this triangulates with different Committees to ensure it is being used and understood consistently

Key issues / matters discussed at the meeting	The Committee received, discussed and noted the following reports:
	• Chief Nursing Officer Update
	  • Busiest winter so far as per the numbers attending ED
	  • Acute respiratory infections and flu numbers had doubled over the last 10 days and were expected to double again. We also have Covid patients and a significant number of patients with RSV.
	  • New strain of Norovirus which was also having an impact on services, which had quadrupled the infection risk.
	  • National webinar had taken place about pressure on services over next 2 to 3 weeks coinciding with the holiday season. Request from National team to focus on flow, joint working with social care in Mental Health.
	  • Invited to regional webinar talking about quality of IPC escalation of data. Information to be added to national regional templates and that will help shape the picture of what was happening and what needed to be done on a broader level and that event was well attended.
	  • Vaccination rates are not as we would have wanted for Covid and flu. There is a real focus on getting staff vaccinated and we will be putting out more communications to staff to make

sure that they are taking advantage of the scheme and promoting that keeping staff well led to good patient care.
    - Positive news about MIS audit. Thanks given to the team. The Trust had not had MIS compliance forth last two years so to achieve what the team had this year was a significant step forward and a lot of work had been put in to achieving that by the team.
    - Real pressure on services over last week/weekend and this week with flu/Covid/RSV across some units and that had created real pressure on the front door. Patients were cohorted in corridors and additional beds had to be opened on the Mary Anning Unit. We had to use day surgery unit too and had an outbreak of Norovirus on the renal unit which impacted capacity.
- Chief Medical Officer update
    - Wards remain under immense pressure due to respiratory infections, Covid, flu, Norovirus and RSV. Flu numbers have doubled and were expected to increase further over the seasonal period.
    - JEMT raised the importance of staff being vaccinated and historically pre Covid, flu vaccine uptake was in the mid 80% and we were one of the best performing Trusts. Unfortunately flu and Covid vaccinations this year are running at under 30%. It is not unique to DCH, that is the national pattern at the moment.
    - GP collective action. Detailed discussion happening between ICB and the general practice community in Dorset which resulted in resolution of some issues regarding shared care for patients. There are 9 other issues on the list of collective action that GPs are pushing ahead with.
    - NHP has got to very important stage, plans are now settled and we about to get a final maximum price from contractor. We are hoping building will commence in early spring.
    - CMO Replacement should be announced shortly with a view to that person starting in January, which would give a three-month handover period and hopefully enable a seamless transition.
    - The SHMI dropped substantially this month, and we expect it to stay at this level for 3 months. It's close to 1.05 and that a real testament to the Coding Department and others. Regarding how busy the hospital is by number of spells, the pre Covid mean was 30,023 over 2014-2019, which them dropped during Covid we are now at 34500 spells, which is nearly a 15% increase compared to pre-Covid average.
- Quality report including:
    - Continuing to take a PSIRF approach to IPC and there is an ongoing quality improvement project running to help reduce infections related to urinary catheter associated blood stream

infections. Operationally the IPC team were very busy with managing infections due to flu/Covid/RSV and Norovirus

- TVN service are continuing to roll out the new risk assessment and are focusing on the front door to make sure patients are being risk assessed for pressure damage and placed on the right patient pathway. Referral levels remain high. Team capacity has been increased by combining some work with IPC and moving the audit work to a lower banded post to give additional capacity.
- Good progress has been made in regard to mixed sex accommodation, there has been a drop in the number of incidents reported. It remains an area of focus and there are areas where we are cohorting respiratory illnesses where there are clinical justifications to do so.
- Achievement of score A in the SSNAP stroke sentinel audit results. This is the first time this standard has been achieved in four years so felt that it was important to raise this at Committee as a significant achievement in quality of service offered by the stroke team. There is detail in report about areas for further improvement.

- Maternity and Neonatal Quality and Safety Report, noting achievement of the Maternity Incentive Scheme for this year.
  - Discussed risk relating to blood spot testing and weekend services. This issue has been around for a number of years, and we don't get all blood tests on the correct day, the key issue is that the results arrive in time. No babies have been harmed because of this and we are not the only service not to have community service on both days.
- Winter plan
  - Progress to date noted. This the DCH and system plan and a lot of the plan is underpinned by the longer-term Newton work. This is about improving services we do well and not trying new things over winter. There is no promise of any winter funding which has led to different conversations about sustainability and improving what we already have.
  - Noted ongoing risks and issues in relation to no criteria to reside patients.
- Organ Donation Report
  - We had 3 consented donors in the period from April to September 2024 and from that we had two solid organ donors. We had no missed donor referrals and no occasions when a specialist nurse was not available for the donation discussion, which was all really positive.

- Escalation reports from below sub-groups of the Quality Governance Group were also received for assurance.

	• Quality Governance Group Escalation Report • Patient Safety Committee • IPCC Assurance Report • Safeguarding Escalation Report • End of Life Committee
Decisions made at the meeting	•
Issues / actions referred to other committees / groups	•

Dorset County Hospital
NHS Foundation Trust

Quality Committee Assurance Report
for the meeting held on Tuesday 28 January 2025

Chair	Eiri Jones, NED
Executive Lead	Dawn Dawson, Chief Nursing Officer Alastair Hutchison, Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Full compliance with the Maternity Incentive Scheme. An audit by the trust's internal auditors has confirmed this position. • Concerns remain about the number of risks that relate to digital.

Key issues / matters discussed at the meeting	The Committee received, discussed and noted the following reports:
	• Chief Nursing and Chief Medical Officer Update, noting
	  ○ Recruitment of a tenth consultant in obstetrics and gynaecology, meeting the requirement from the Ockenden Report. This will allow the trust to implement other actions from the report.
	  ○ Stable Summary Hospital-level Mortality Indicator (SHMI)
	• Quality report including:
	  ○ Evidence of good infection prevention and control practice, within a context of increased flu cases and a norovirus incident.
	  ○ An increase in mixed-sex accommodation
	  ○ Good practice and improvements being seen in renal transport
	• Maternity and Neonatal Quality and Safety Report, noting
	  ○ Receipt of the Birthrate plus report. This would form part of future safer staffing reports.
	• Board Assurance Framework
	• Corporate Risk Register
	• Children and Young People Update on Neurodiversity Deep Dive, and Update on Learning from the Children and Young People Flagship with a further, focused update to be provided at a future Board Development Session.
	• Quality Committee in Common Proposal, which was supported by the committee
	• Escalation reports from below sub-groups of the Quality Governance Group were also received for assurance.
	  ○ Medicines Committee

	○ Mental Health Steering Group ○ Clinical Effectiveness Committee ○ Patient Safety Committee
Decisions made at the meeting	• Nil
Issues / actions referred to other committees / groups	• Nil

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, Part 1	
Date of Meeting	Tuesday 11 February 2025	
Report Title	Maternity and Neonatal Quality and Safety Report	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, CNO	
Previously Considered By	Quality Committee 28 January 2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 – Safety and quality	
Financial	Achieving the Maternity Incentive Scheme (MIS) provides approx. £250k rebate to maternity services	
Statutory & Regulatory	Elements in this report relate directly to Maternity Incentive Scheme	
Equality, Diversity & Inclusion	Not specifically	
Co-production & Partnership	Nil	

Executive Summary

This report sets out the quality and safety activity covering the month of December 2024 (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

- One 4th degree tear following a spontaneous birth
- National Maternity Dashboard data provided alongside Trust data to demonstrate sustained improvement in PPH rates >1500mls.
- Total number of incidents reported 79. Only one datix for delayed IOL
- Two inutero transfers. One to UHD and one to Portsmouth – both appropriate
- Only one term admission to the neonatal service

- Risk register updated.
  1. **1980** A risk has been updated to include the reduction in EPAC hours from February 2025.
  2. **2031** A new risk has been opened relating to the cover provided in Maternity Reception. The current position is that the roster has ben redesigned following consultation with the team. A member of the team has returned following the end of her secondment, so the next rota has only a small number of shifts not covered (prior to bank staff being offered).

- Three complaints received with themes of
  1. Communication and compassion particularly for families with babies requiring neonatal care
  2. Ther management of patient information, specifically email addresses

- Workforce data - sickness rates until 31/10

1. Midwives – 6.83%
2. Maternity Support Workers – 7.37%
3. Special Care Baby Unit – 11.44%
4. 8.5% midwifery shifts remained unfilled

- One incident of babyloss identified during a routine appointment for a glucose tolerance test at approximately 18 weeks of pregnancy.

- Documentation audit for Q2 included. Incidents of errors being identified are increasing but this may be indicative of better reporting. Key themes are

1. Birth notifications not sent
2. Failure to record time of completion of triage

Recommendation

Members are requested to:

- **Receive the report for assurance**

NHS
Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

January 2025

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

Executive Summary

This report sets out the quality and safety activity covering the month of December 2024 (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

- One 4th degree tear following a spontaneous birth
- National Maternity Dashboard data provided alongside Trust data to demonstrate sustained improvement in PPH rates >1500mls.
- Total number of incidents reported 79. Only one datix for delayed IOL
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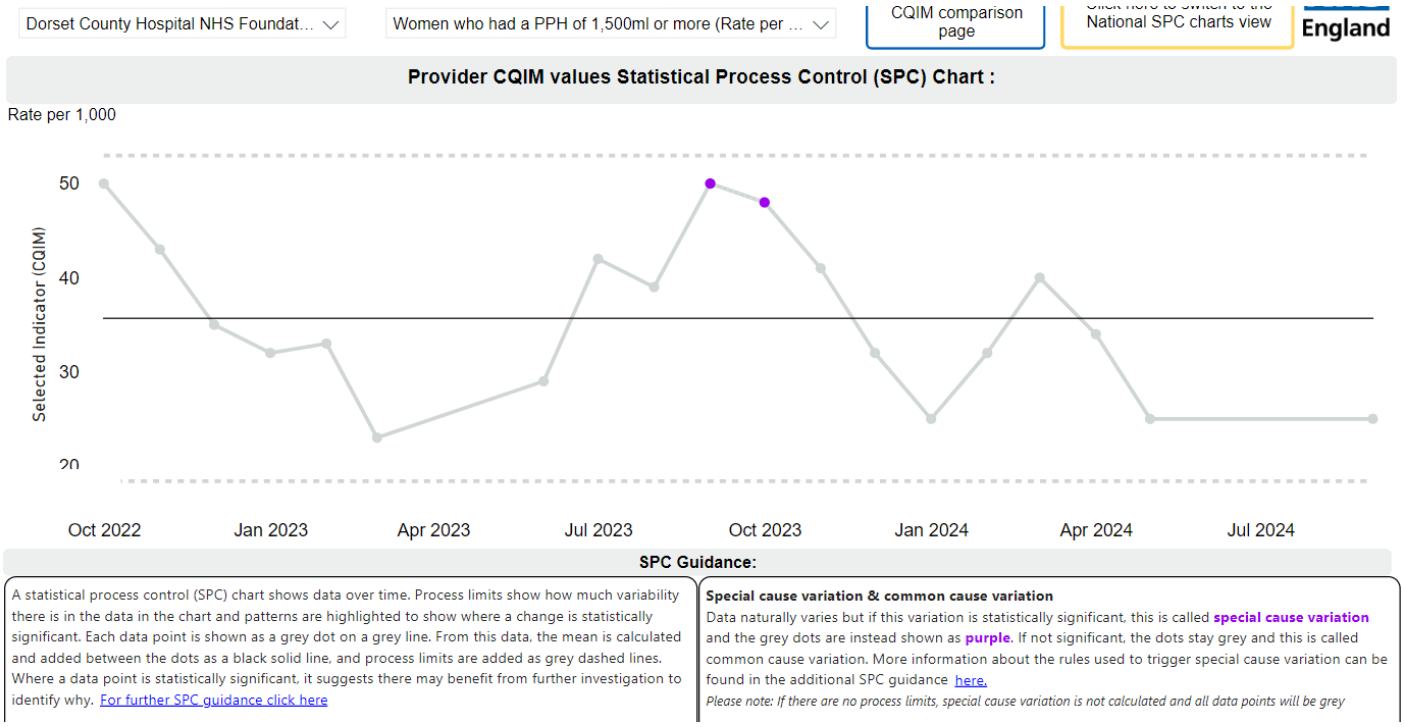
Activity

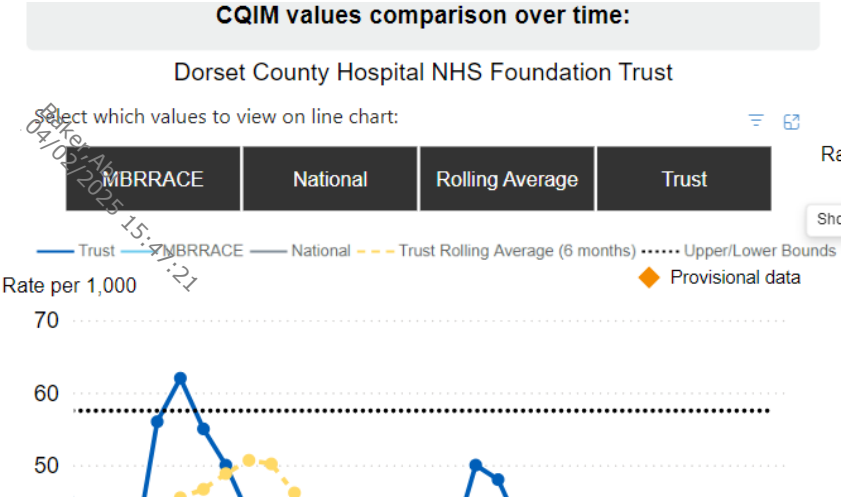
Exception report for SPC charts (NTI – no target identified)

Metric	Target	Current position and mitigation/actions
% babies born by elective caesarean	NTI	20.3%
% babies born by emergency caesarean	NTI	22%
% women on a continuity of care pathway by 28 weeks	NTI	18.1%
% women smoking at time of delivery	6%	6.6%
% CO recorded at booking	95%	89.7%
% CO record at 36 weeks	95%	92.7%
Number of stillbirths		nil

Number of neonatal deaths		nil
% babies >37 weeks admitted to SCBU	5%	1.7%
Rates per 1000 of PPH >1500mls (current 3 months)	30	63.7
Rates per 1000 of 3rd/4th degree tears (current 3 months)	25	9.3
% live births <37 weeks gestation	6%	4.1%
Babies transferred to a level 2 or 3 Neonatal unit	NTI	2
Hypoxic Ischemic Encephalopathy incidents		Nil
Percentage of babies with 1st feed maternal	NTI	74.4%

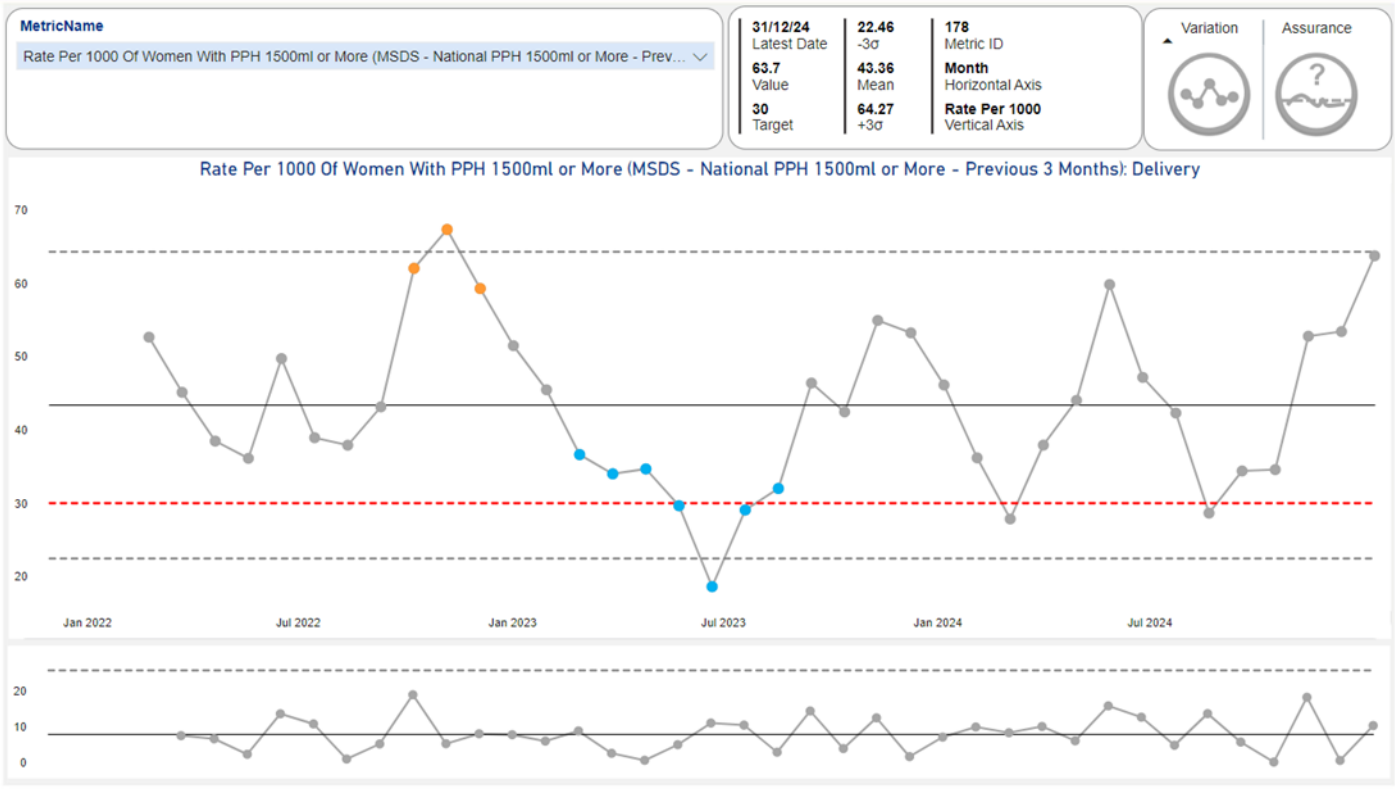
This SPC chart showing DCH PPH rates over 1500mls is produced by NHSE on the National Maternity Dashboard. It shows a sustained period of common cause variation and provides assurance about the measures taken to reduce the rates over time. up until Oct 2024

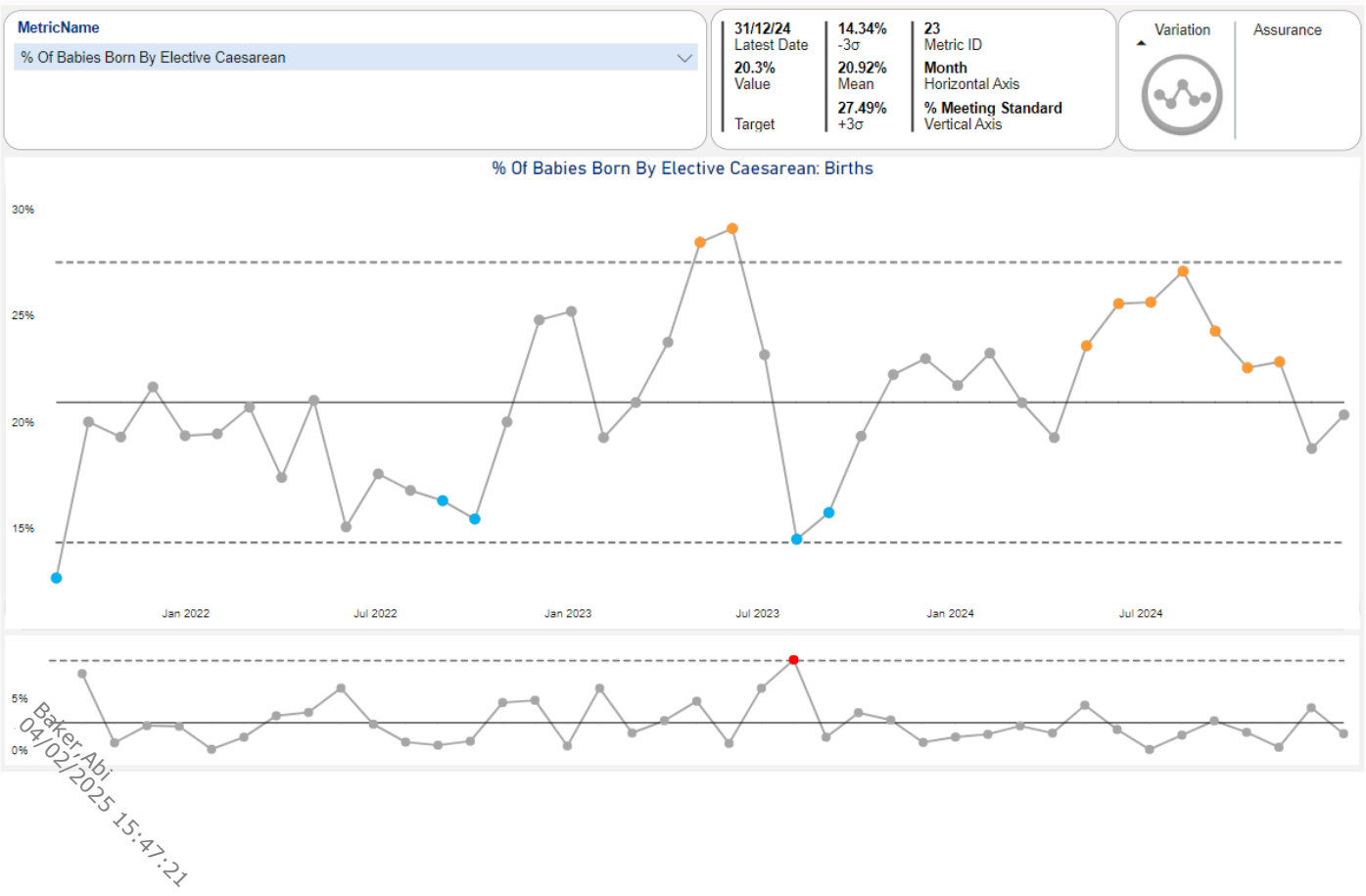




This CQIM values comparison chart from the NHSE Maternity Dashboard using the rolling average rate demonstrates improvement in PPH rates

>1500mls. Up until Oct 2024

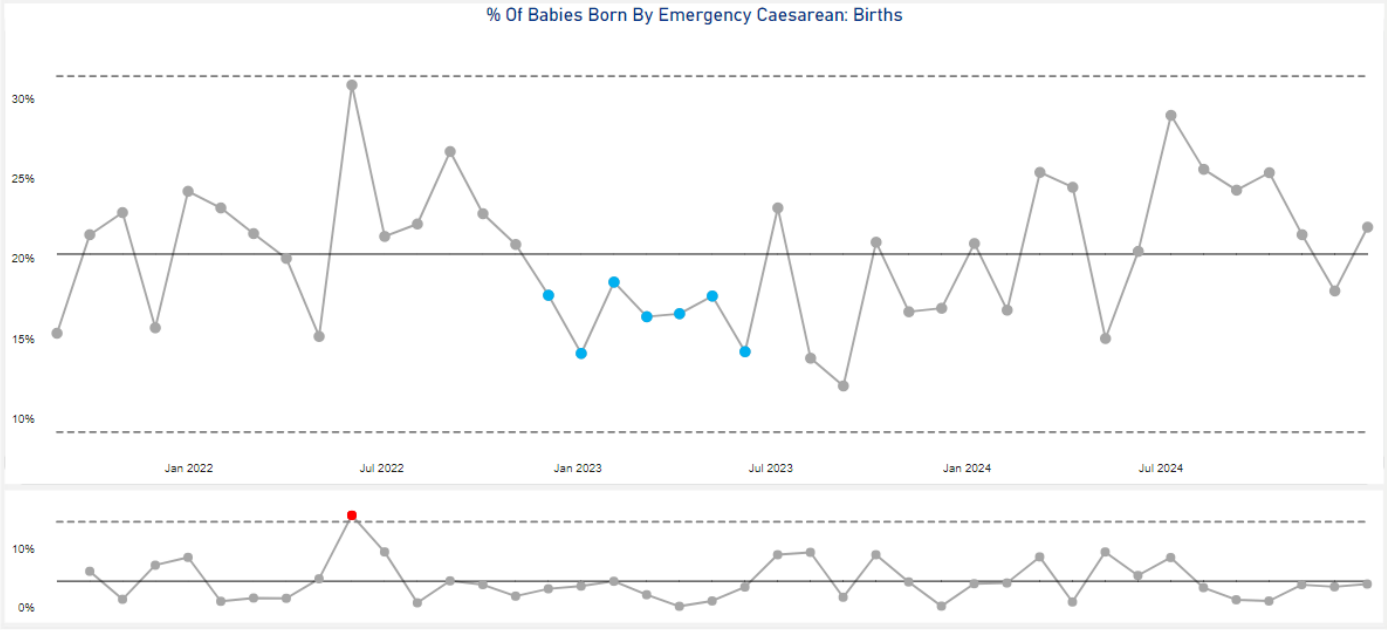




MetricName

% Of Babies Born By Emergency Caesarean

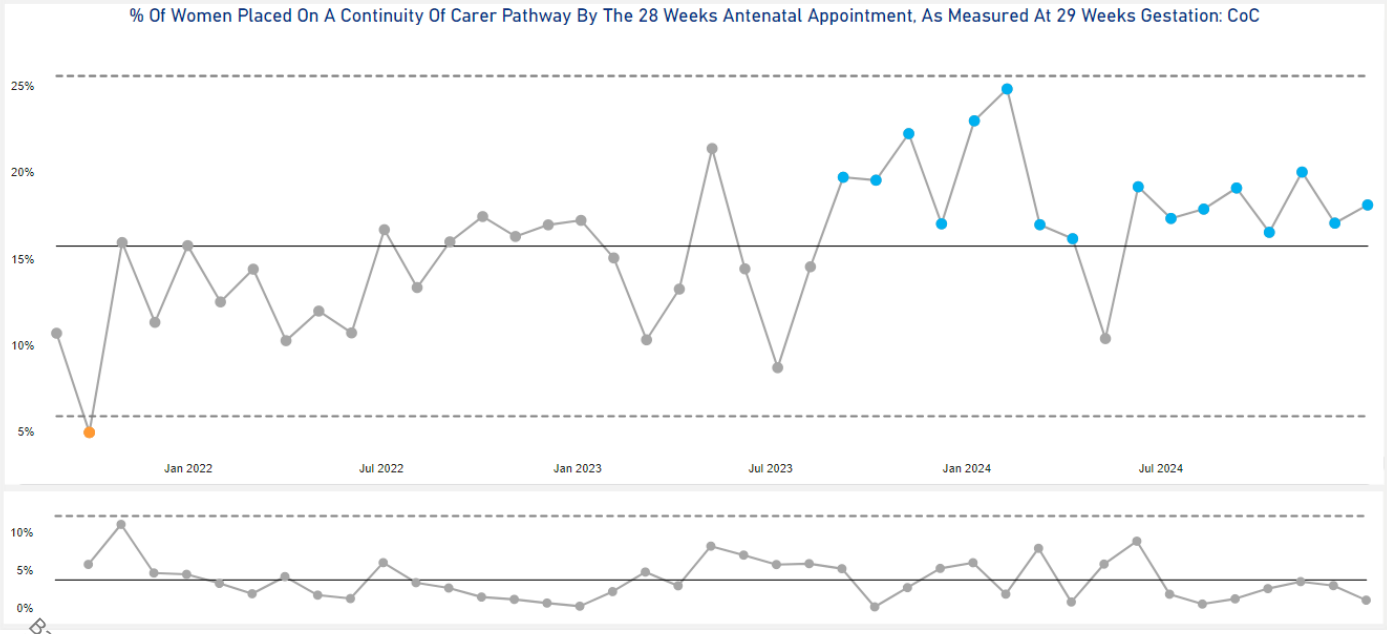
31/12/24 Latest Date	**9.16%** -3σ	**24** Metric ID	Variation	Assurance
22% Value	**20.27%** Mean	**Month** Horizontal Axis		
Target	**31.38%** +3σ	**% Meeting Standard** Vertical Axis		



MetricName

% Of Women Placed On A Continuity Of Carer Pathway By The 28 Weeks Antenatal Appointment, ...

31/12/24 Latest Date	**5.9%** -3σ	**139** Metric ID	Variation	Assurance
18.1% Value	**15.72%** Mean	**Month** Horizontal Axis		
Target	**25.55%** +3σ	**% Meeting Standard** Vertical Axis		

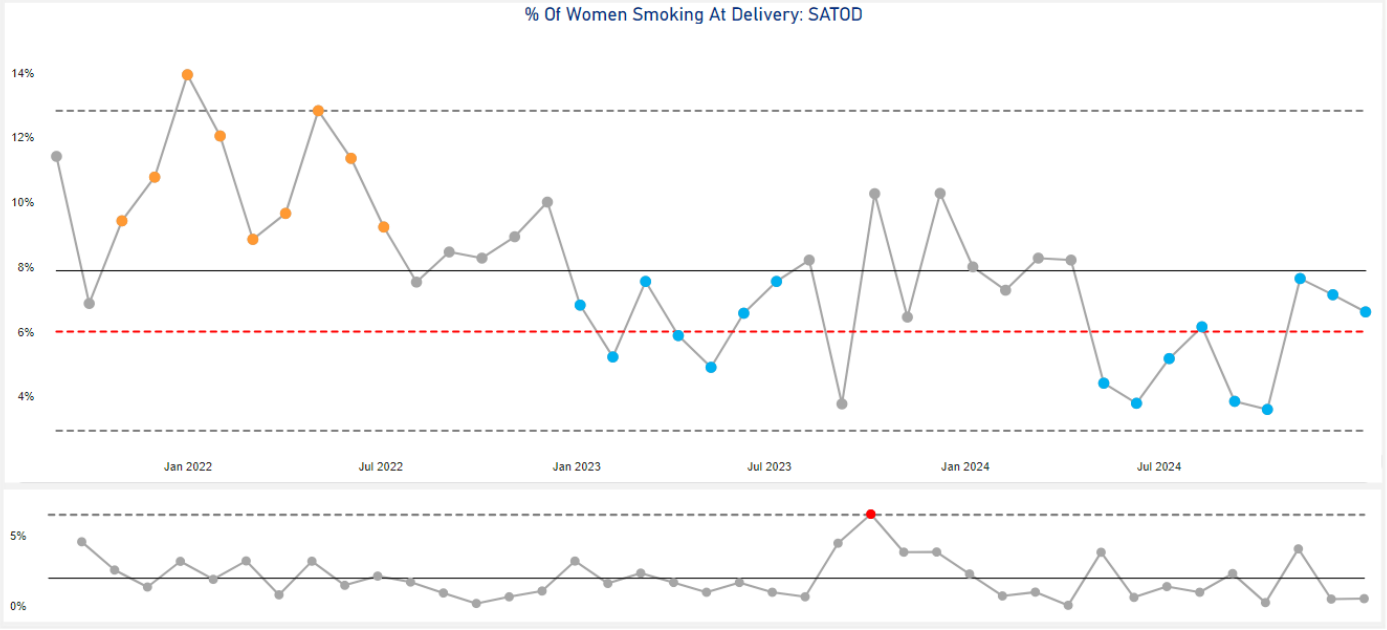


MetricName

% Of Women Smoking At Delivery

31/12/24 Latest Date	**2.94%** -3σ	**56** Metric ID
6.6% Value	**7.88%** Mean	**Month** Horizontal Axis
6% Target	**12.82%** +3σ	**% Meeting Standard** Vertical Axis

Variation: L | Assurance: ?

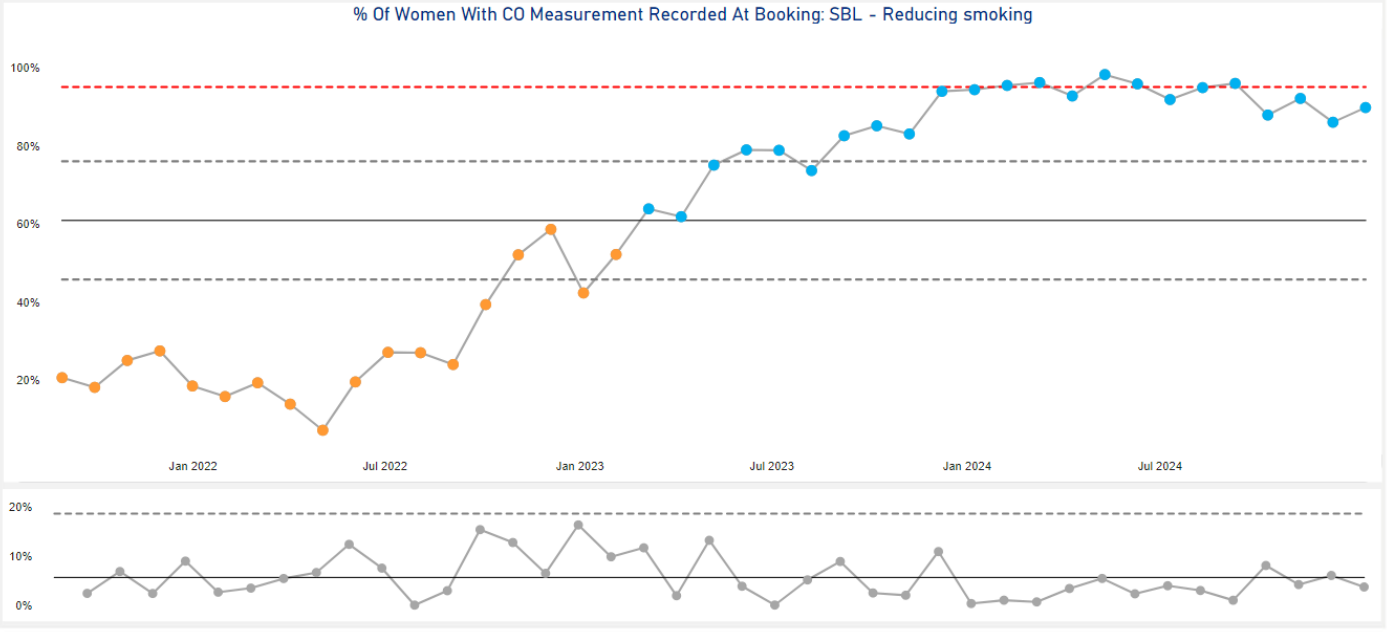


MetricName

% Of Women With CO Measurement Recorded At Booking

31/12/24 Latest Date	**45.72%** -3σ	**75** Metric ID
89.7% Value	**60.84%** Mean	**Month** Horizontal Axis
95% Target	**75.97%** +3σ	**% Meeting Standard** Vertical Axis

Variation: H | Assurance: F



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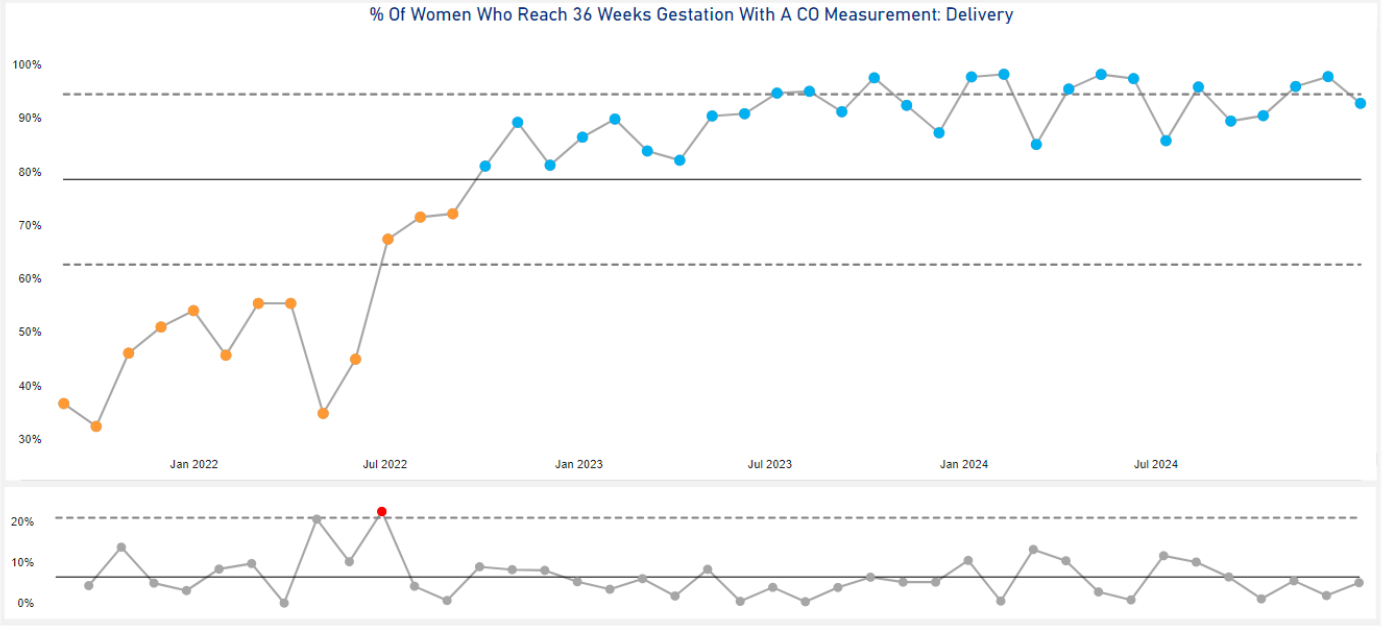
MetricName

% Of Women Who Reach 36 Weeks Gestation With A CO Measurement

31/12/24 Latest Date	**62.57%** -3σ	**169** Metric ID
92.7% Value	**78.47%** Mean	**Month** Horizontal Axis
Target	**94.37%** +3σ	**% Meeting Standard** Vertical Axis

Variation | Assurance

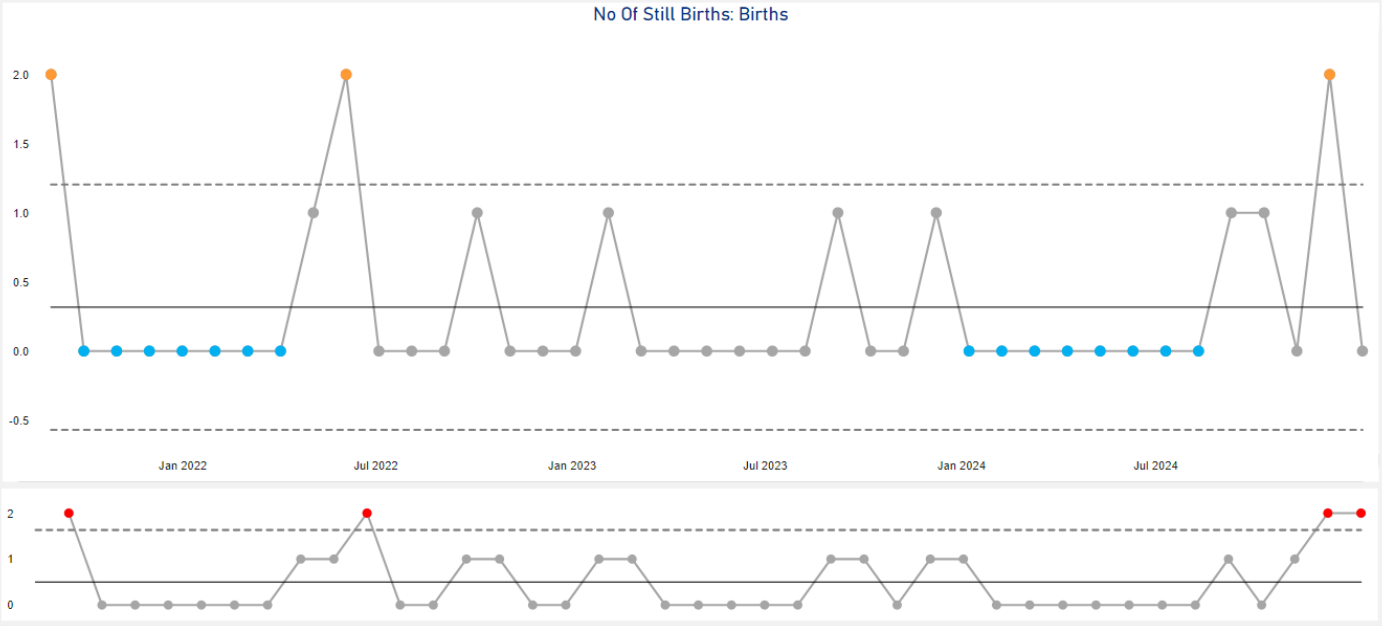


MetricName

No Of Still Births

31/12/24 Latest Date	**-0.57** -3σ	**11** Metric ID
0 Value	**0.32** Mean	**Month** Horizontal Axis
Target	**1.2** +3σ	**Number Of Births** Vertical Axis

Variation | Assurance



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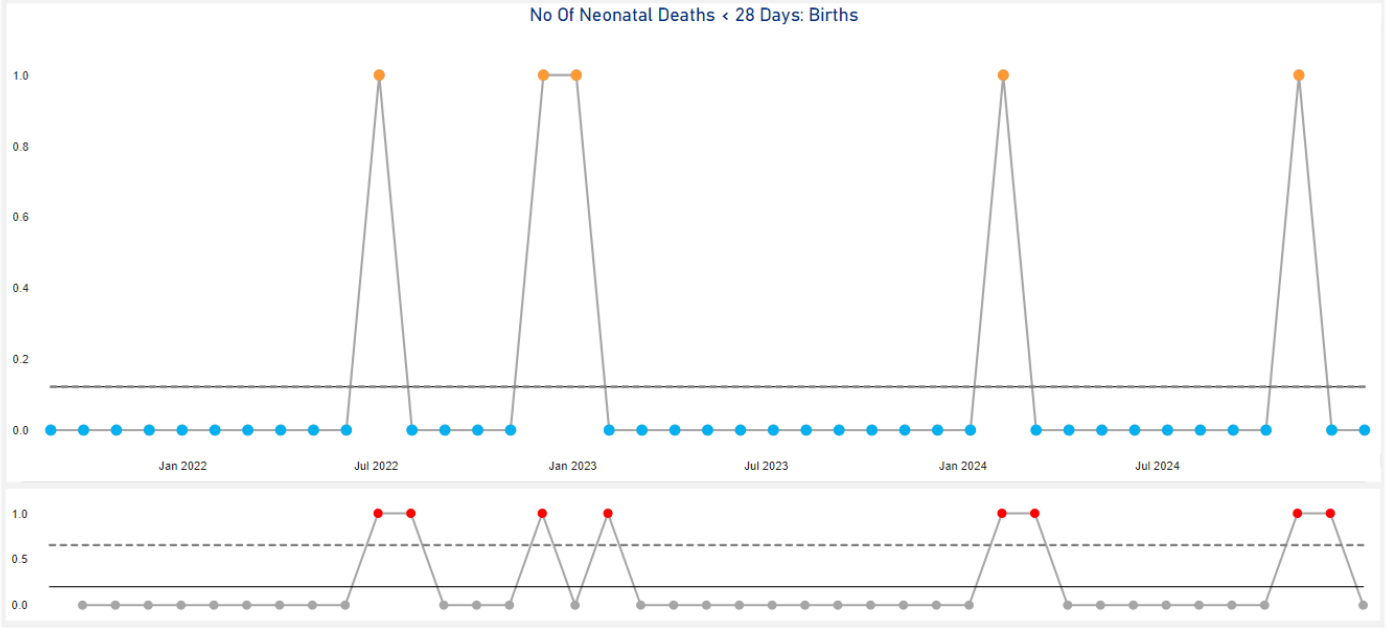
MetricName

No Of Neonatal Deaths < 28 Days

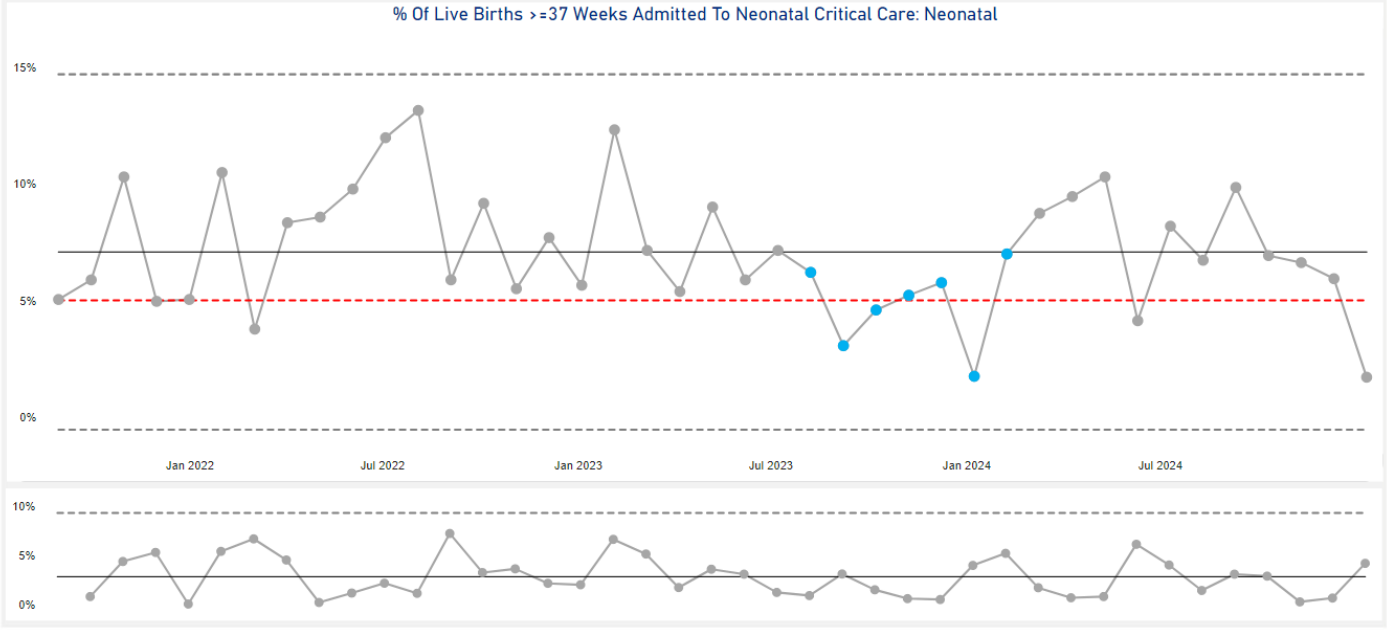
31/12/24 Latest Date	**0.12** -3σ	**13** Metric ID	Variation	Assurance
0 Value	**0.12** Mean	**Month** Horizontal Axis		
Target	**0.12** +3σ	**Number Of Births** Vertical Axis		

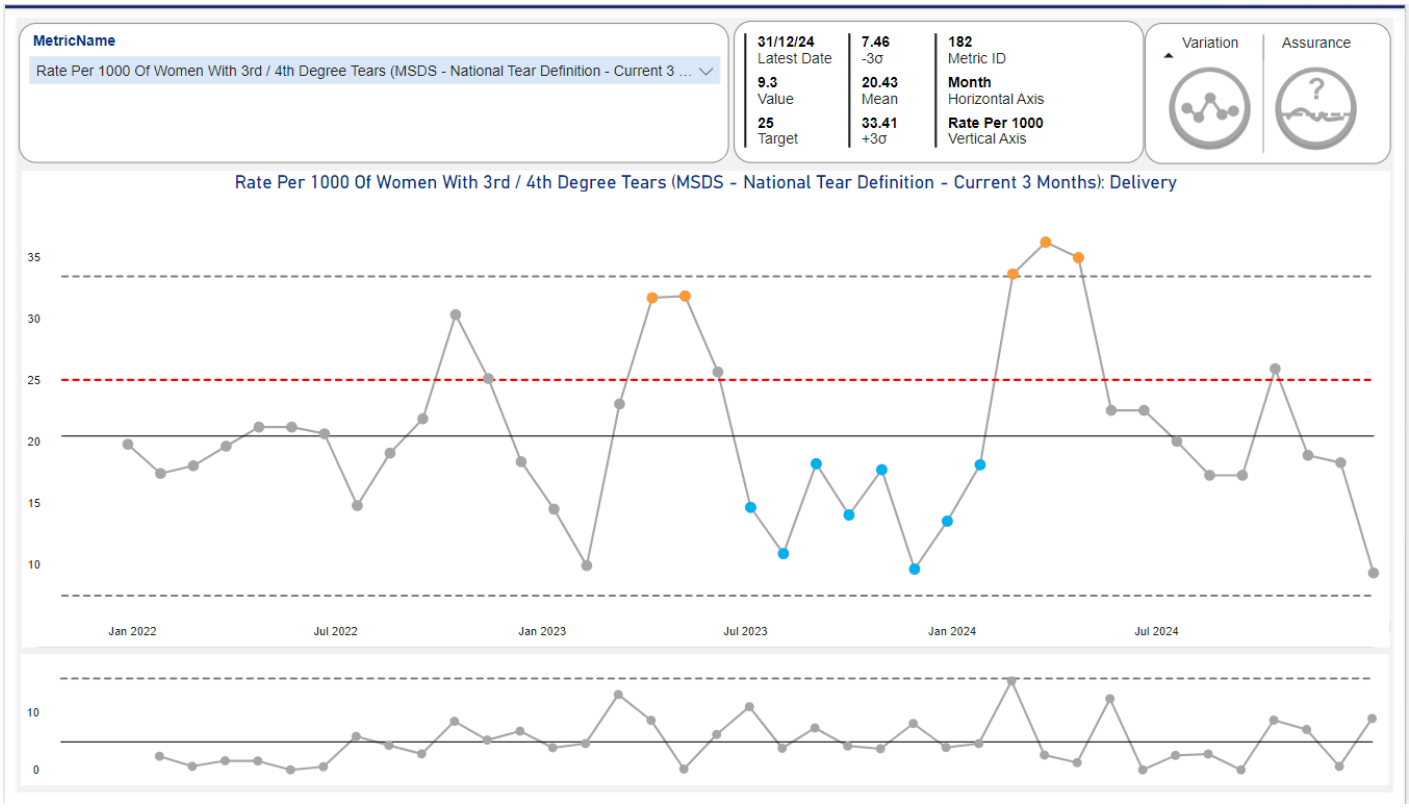


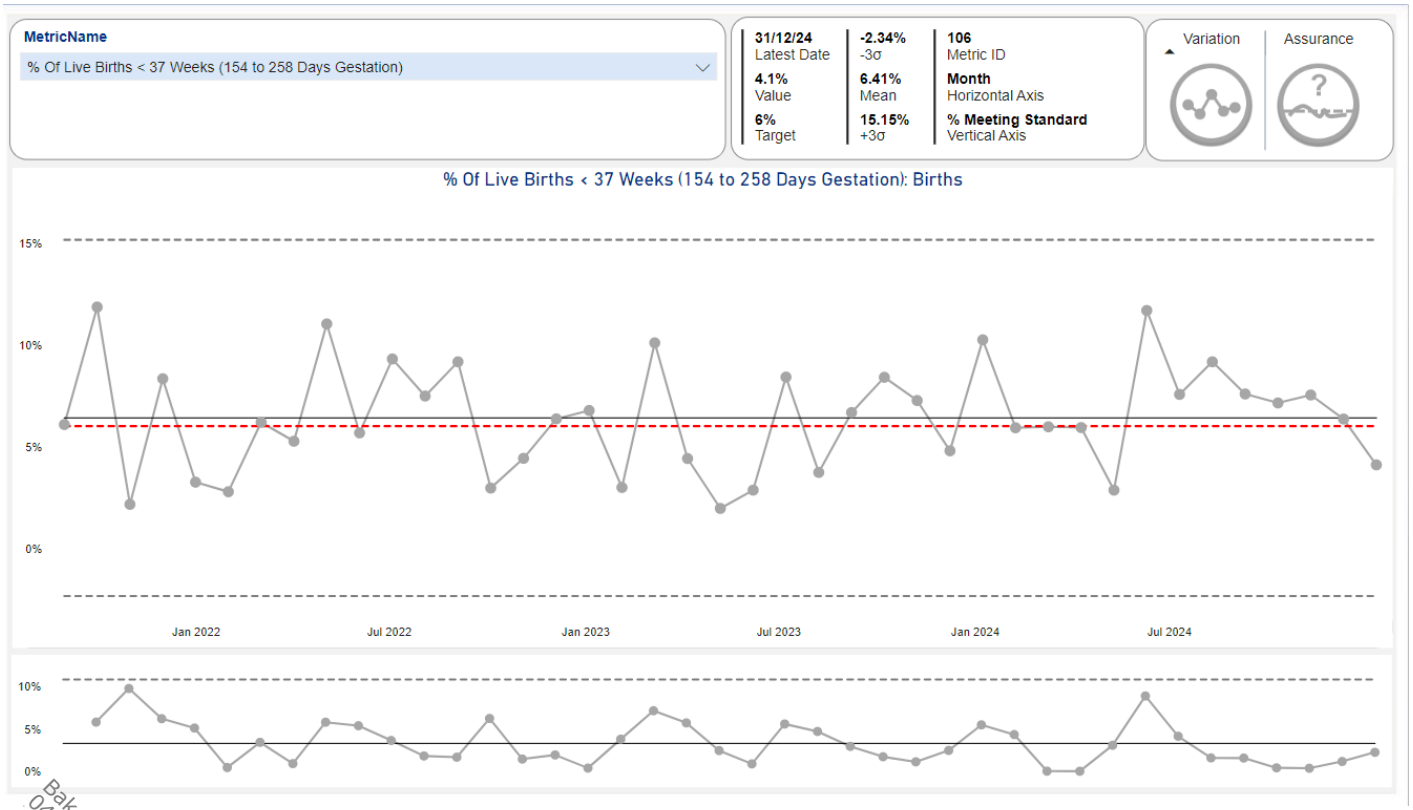
MetricName

% Of Live Births >=37 Weeks Admitted To Neonatal Critical Care

31/12/24 Latest Date	**-0.54%** -3σ	**101** Metric ID	Variation	Assurance
1.7% Value	**7.07%** Mean	**Month** Horizontal Axis		
5% Target	**14.69%** +3σ	**% Meeting Standard** Vertical Axis		







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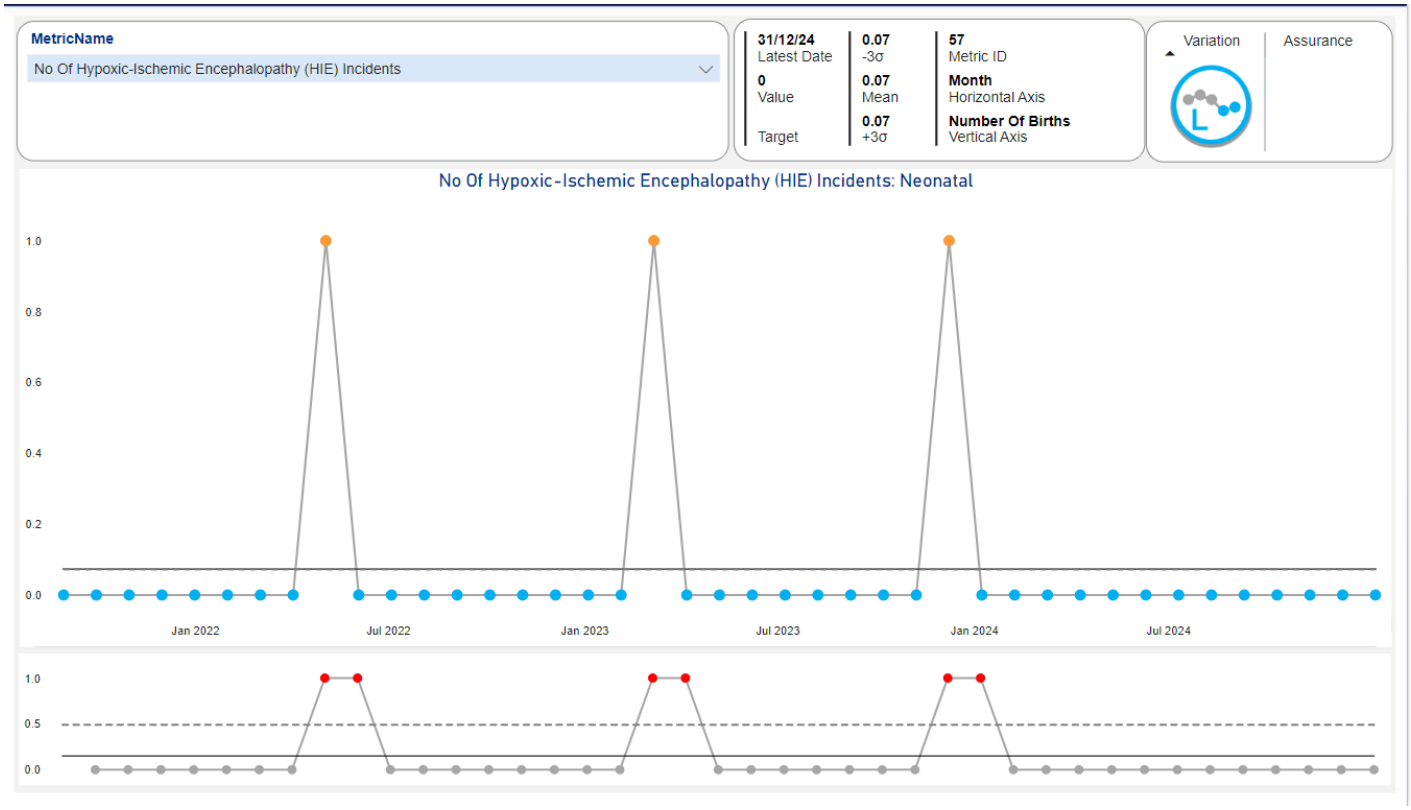
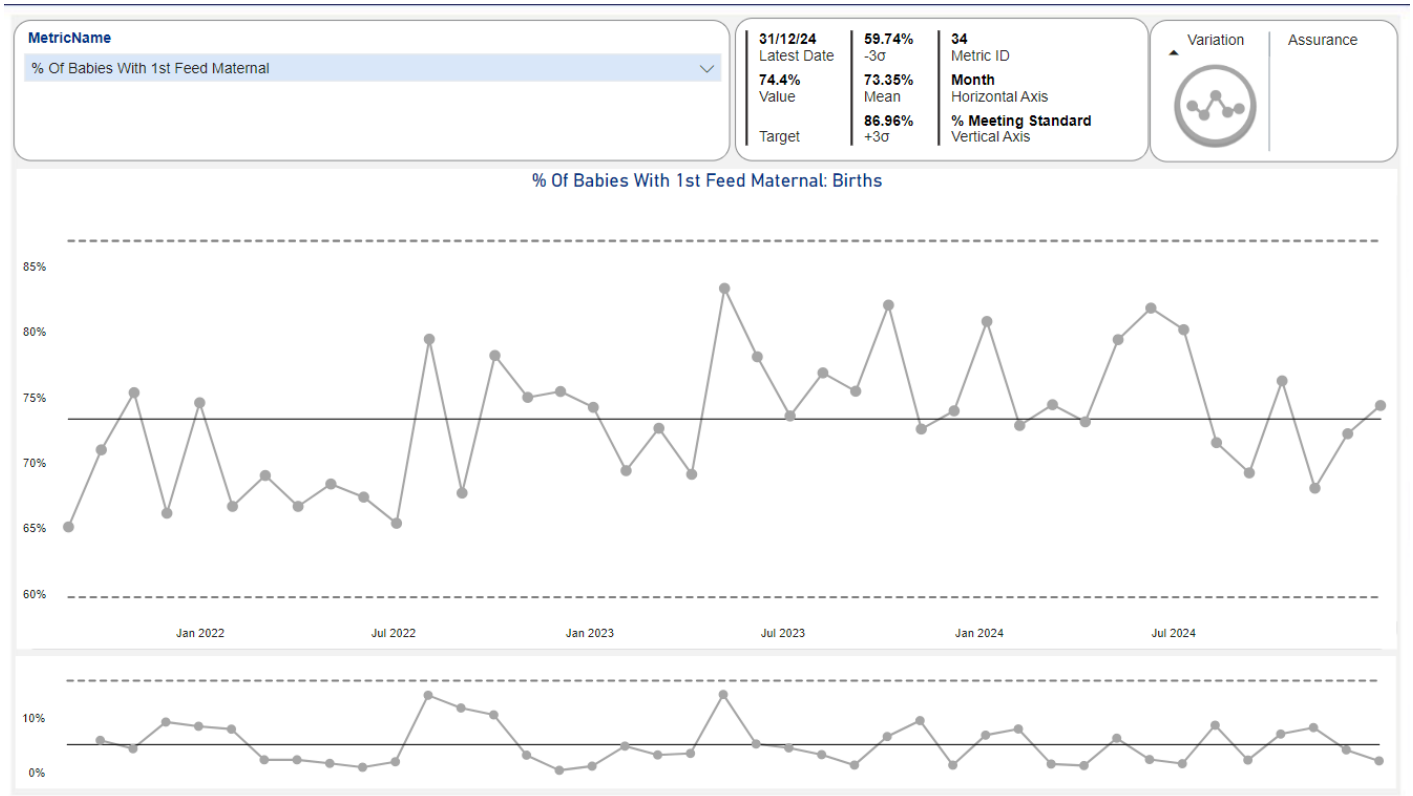




Total Number of Incidents submitted for December 2024

maternity & neonatal
79

Red Flag incidents: A midwifery red flag event is a warning sign that something may be wrong with staffing.

Red flag	Descriptor	Incidents for December
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	1 for SCBU, 1 for maternity
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	1 delayed IOL
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	0
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
UHD	1 x 29+6, vaginal bleed and risk of preterm birth
Portsmouth	1 x 22+4, contracting. Gave birth at Portsmouth 23weeks gestation

Incidents graded as moderate harm or above for December

Reference	incident	Action
DCH101740	Diagnostic delay for a baby due to a lack of information on the ultrasound request form	Currently a near miss as waiting for grade of harm to be confirmed depending on the success of the treatment
DCH101705	Deteriorating postnatal patient	. This case will be reviewed at a future M&M meeting

3rd & 4th degree tears December

Parity	Baby's position	Grade of tear	Mode of birth	hands	OASI	Position of woman	Referral made
0	Not defined	4th	spontaneous	on	yes	Semi prone	yes

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
1980	EPAC restricted service	Originally this risk related to the national requirement to have a 7 day EPAC service. However, a resignation has resulted in a rota gap as of the end of January. Currently unable to recruit into the vacancy as the additional post was a cost pressure added > 1 year ago. The consequence is EPAC will only open 3-4 days a week from February 2025. Increasing demand on ED when the service isn't available and providing a poorer patient experience for women anxious about their pregnancy		15	division
2031	Maternity Reception Cover	Currently, maternity reception is not always staffed. This is a risk to security and impacts on the Day Assessment staff who are repeatedly asked to open the door. This takes them away from clinical care and puts their patients at risk. This was identified at the Insight Visit as a significant risk and one that required immediate attention. Currently in consultation with staff to change working patterns to provide more cover. Maternity Support Workers are being allocated, where possible to cover Reception when required.	19/12/2024, Jo Hartley, DoMN Services, monthly review	Moderate 12	Division.
2020	Completion of Neonatal Screening on day 5 as Required by National Screening Team	National Screening Team expect all babies to receive their NBBS (newborn blood spot screening) on the 5th day of life. DCH does not have community services on a weekend and has a drop-in on a Sunday only. Therefore, babies due their NBBS on Saturday, receive it on Sunday, day 6. No clinical consequences identified **Update** In January, we are trialing a weekend drop-in postnatal clinic on both Saturday and Sunday. If sustainable, this will mitigate the problem of not completing the test on day 5 (other than for those families who refuse to attend)	03/12/2024 Janet Johns, Screening Coordinator, quarterly review	Moderate 8	Care group

1959	IT systems allowing manual input of pathology results by clinical teams	It has been recently brought to the attention of Serious Hazards of Transfusion (SHOT) that the UK maternity patient data management system as supplied by Badgernet allows clinical staff to manually input patient pathology and other test results into the system. This may impact decisions related to patient care including blood group, red cell antibody screen and identification results. Other clinical systems that use pathology data may be similarly impacted. A preliminary national review of cases submitted to SHOT in the last 3 years revealed at least 12 incidents where the cause of the preventable error was a manual transcription error in the maternity IT system. **Mitigation** The process of transcribing has not changed since the use of paper notes, however, the care pathways and treatment is generated by the maternity BadgerNet system by the manual input of results. Staff are prompted on the system to double check when inputting results. The digital team and laboratory management team are working together to identified a suitable and safe solution. **No specific update**	06/09/2024 Chloe Mackenzie, Digital Lead Midwife, quarterly review	Moderate 8	Care group
1881	Neonatal Nursing	Current neonatal nursing establishment not compliant with safe levels of staffing according with BAPM and Neonatal Nursing workforce Calculator. Regular bank and overtime hours required each month to cover the unit with 2 RN and 1 HCA. Agency is used too, when no other option is available. Establishment not sufficient to cover 3 members of staff on duty at all times. And no additional nursing wte for supernumerary shift lead coordinator (as per National Service specification). **Update** Neonatal Nursing staff are expected to deliver care inside the different rooms in the unit, on labour ward, post-natal ward and in some emergency situations attending A&E and Main Theatres. To maintain safety of staff, infants and carers we require a minimum of 18.21WTE (3 x 6.07), as per the Neonatal Nursing workforce Calculator. Our establishment only accommodates a total of 15.18wte. **Update** Awaiting confirmation of new funding from business case. Staffing remains the same with 21% of the next roster vacant	01/05/2024 Debora Coalwood-Horta, Maternity Matron, monthly review	High 15	corporate

1827	Electronic health record unavailable for SCBU	Paper documentation used for infants admitted to SCBU. Electronic health record (Badgernet) plus minimal use of paper records used for infants under Transitional Care. This has resulted in two different systems being used for infants admitted to SCBU/TC by the same team. Additionally, SCBU staff are reliant upon desktop PC's rather than the Ipads **Update** No update	26/02/2024 Debora Pascoal-Horta Neonatal Matron, quarterly review	Moderate 9	Care group
1825	Ventilator SLE 5000	Current ventilators available in SCBU (X3) reached end of life and the period of maintained support has now passed. The current models in the unit ceased manufacturing in May 2015 and the 7year period of maintenance support has now passed. Currently the devices only have a standard service contract. This means that a repair is not guaranteed due to non-availability of spare parts. Standard contract until 28/02/2025. Risk highlighted in the 2024/25 Capital Programme for prioritisation as needing replacement as soon as possible **Update** Scoping of cost to replace ventilators underway. No further update	26/02/2024, Debora Pascoal-Horta, neonatal matron, quarterly review	Moderate 9	care group
1898	Resuscitaires for labour ward	The CQC inspection and report highlighted the need to have a resuscitaire for every labour room. This requires the purchase of two new resuscitaires. Scoping exercise underway to identify a suitable model. Possibility of procurement with neighbouring trust. Initially sat with the Capital Replacement Programme but likely need to seek charitable funding. There have been no cases of a resuscitaire not being available for every labouring woman **Update** Awaiting delivery of the new machines	28/05/2024, managed by Jo Hartley DoM, monthly review	Moderate 9	division

1689	Opening a second theatre in an emergency &the elective pathway	All incidents where a second theatre is required are reviewed by the Safety Team and where relevant through M&M or other specialist groups. A second issue is the lack of a senior midwife to accompany the team to a second theatre out of hours (only one band 7 midwife overnight). This inevitably results in a midwife with considerably less experience coordinating a high-risk situation (as the coordinator cannot leave labour ward). Discussions starting about establishing a pathway for elective theatre work - planned caesareans. This would require 4 split theatre sessions a week, a theatre team including surgical first assistant, anaesthetic and obstetric consultant availability **Update** Risk assessment required in relation to the SOP for management of a second theatre in an emergency. To review choice of theatre location, equipment provision, allocation of a resuscitaire, transport of neonate, care of partner **Update** task and finish group arranged, support from senior leaders, meeting arranged with stakeholders to discuss theatre provisions to include national requirement for elective pathway for maternity ELCS separate from maternity emergency work. **Update** Currently scoping the options including building a second maternity theatre – thought to likely cost >£2million	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
1742 & 1759	additional obstetric consultant capacity required to meet national KPIs	currently providing obstetric and gynae services on a 1:7 rota with 8 consultants. Unable to provide nationally mandated level of care to some high-risk groups of women. Also unable to provide a consultant evening (8pm) face to face handover. New consultant has made a very successful start with the service. F2F handover and ward round acknowledged as a priority but will require job plan review as changes in on call provision from some consultants impacts these arrangements. Likely funding for tenth consultant – awaiting confirmation **Update** Interview 15 January	013/10/2023, managed by James Male, service Manager, quarterly review	Moderate - 12	Division

1578	Triage and the use of BSOTS Birmingham Symptom Specific Obstetric Triage System	BSOTS was commenced in our DAU on Monday 11th November. Monthly audit completed today and positive results demonstrating good compliance around KPIs relating to triage - approaching 90%. There is evidence that reduced compliance relates directly to reduced staff in ANDAU **Update** BSOTS to be used by all staff when triaging women in DAU and on Labour Ward, when DAU is closed	08/01/2023 Managed by Nichola Coliandris, Matron quarterly review	Moderate 8	Corporate
1497	Emergency buzzers not heard consistently throughout the Maternity unit when activated	Awaiting commencement of work. Most recent costing significantly more than original costing causing a delay **Update** New call bell system in place and working well. Risk to be closed	02/09/2022 Managed by Paul Daniell, Estates. quarterly review	closed	divisional
876	Maternity Staffing	Heathroster being reviewed in line with funding streams to ensure all posts are represented in the business case. BR Plus audit if safe staffing commenced. Vacant shifts continue relating to LTS, STS, maternity leave. Staff reallocated from community and specialist roles to ensure safety on labour ward but evidence of staff burnout and stress levels increasing. **Update** BR Plus report received. Cover sheet currently being written for submission. Currently carrying approximately 4wte vacancy for midwives through maternity leave. These vacancies will be advertised as fixed term but unlikely to attract band 6 midwives on a fixed term contract. Recent months have demonstrated improved staffing on shift. However, the next off-duty has a substantial number of vacant shifts currently	21/09/2021 Managed by Jo Hartley, Director of Midwifery, Monthly reviews	High 15	corporate

Complaints for maternity and SCBU

Total informal and formal

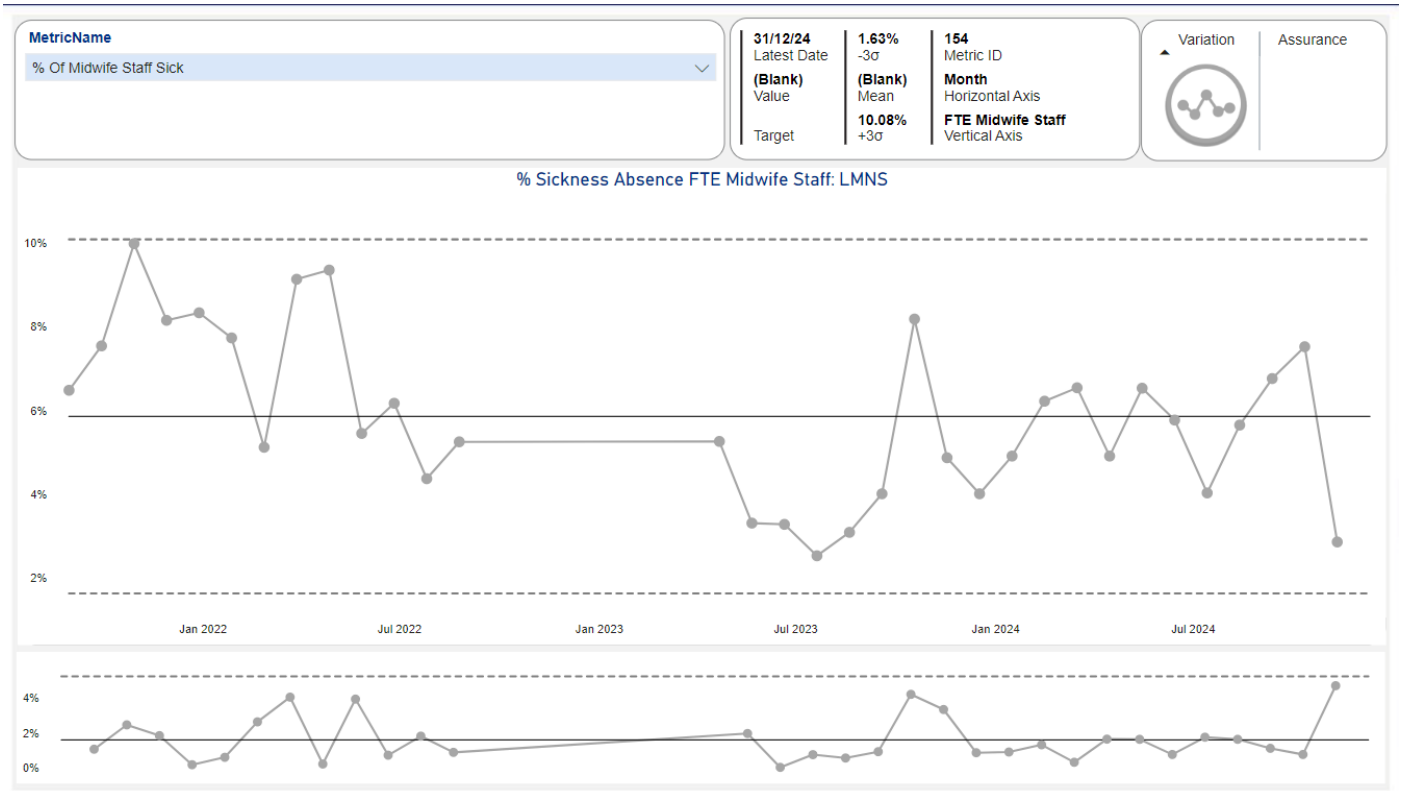
Month	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec
total	1	2	2	6	3	2	1	1	1	1	1	3

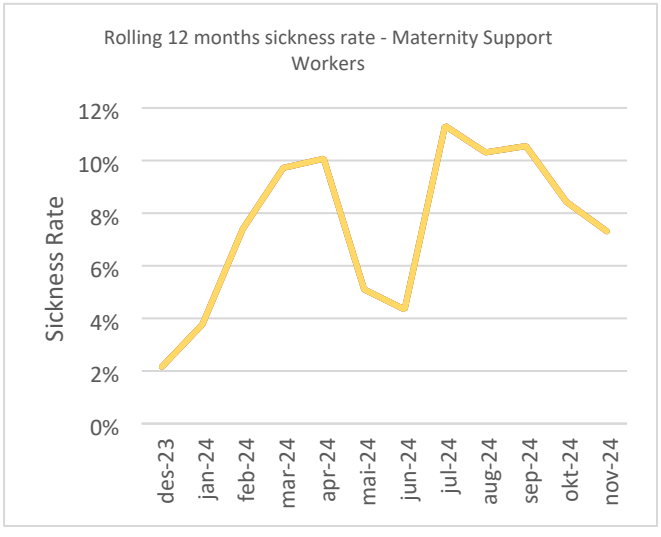
Themes
The importance of managing patients' data correctly and ensuring all staff understand expectations around Information Governance
Communication and sensitivity when caring for families with a baby in the neonatal unit
The third case is complex and requires a review of intrapartum and neonatal care

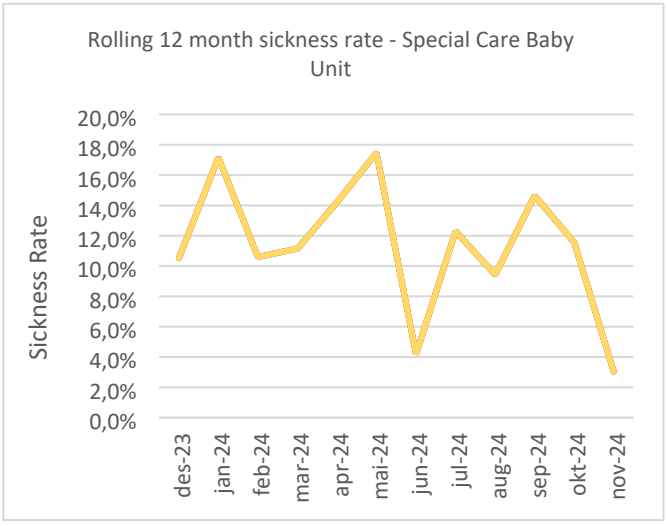
Neonatal transfer out data for December

Nil

Workforce data

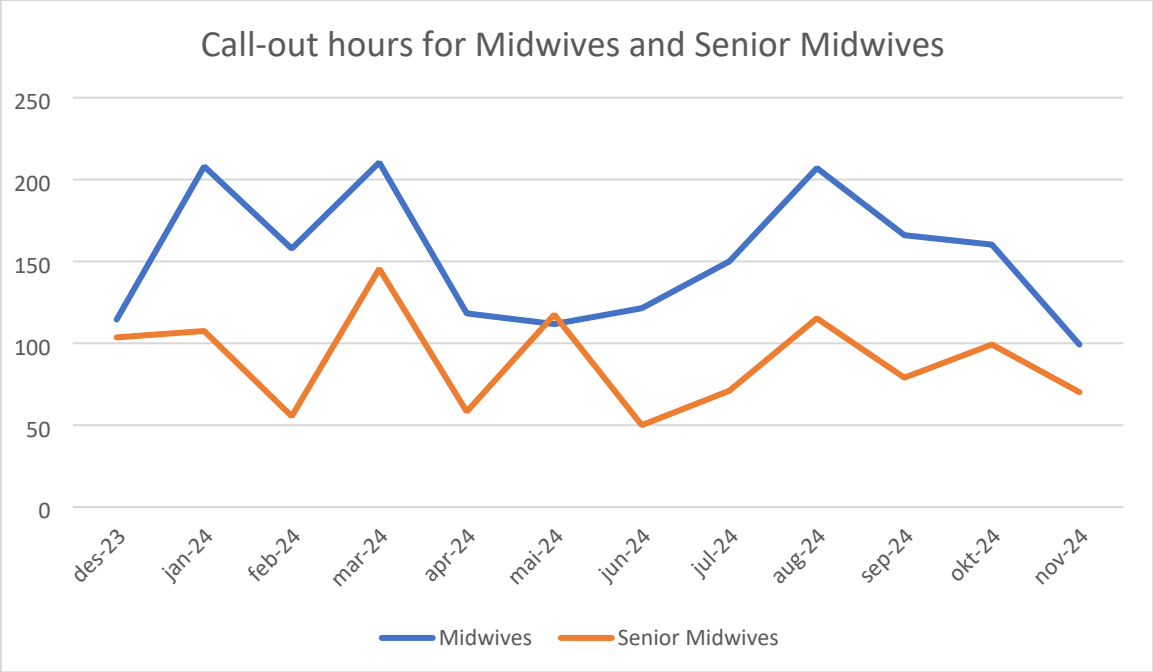






November Call-Out Hours

Midwife call-out for the unit – **99.25 hours.**
Senior Midwives call-out – **70.15 hours**



Bank and Excess hours

	Maternity Unit/ DAU	MSW's / DAU	SCBU Band 5/6	SCBU Band 3
Bank	188.75 hrs / 123.75 hrs	81.75/ 64 hrs	173 hrs	40 hrs
Excess/Overtime	377.5 hrs	89 hrs	228 hrs	

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		**Special Care Baby Unit**	
Day Shift	8.6%	Band 5/6	1 shift not covered
Night Shift	8.3%	Band 2	1 shift not covered
Total	**8.5%**		
Maternity Support Workers			
Day Shift	10.8%		
Night Shift	1.6%		
Total	**7.7%**		

Babyloss for December

I case

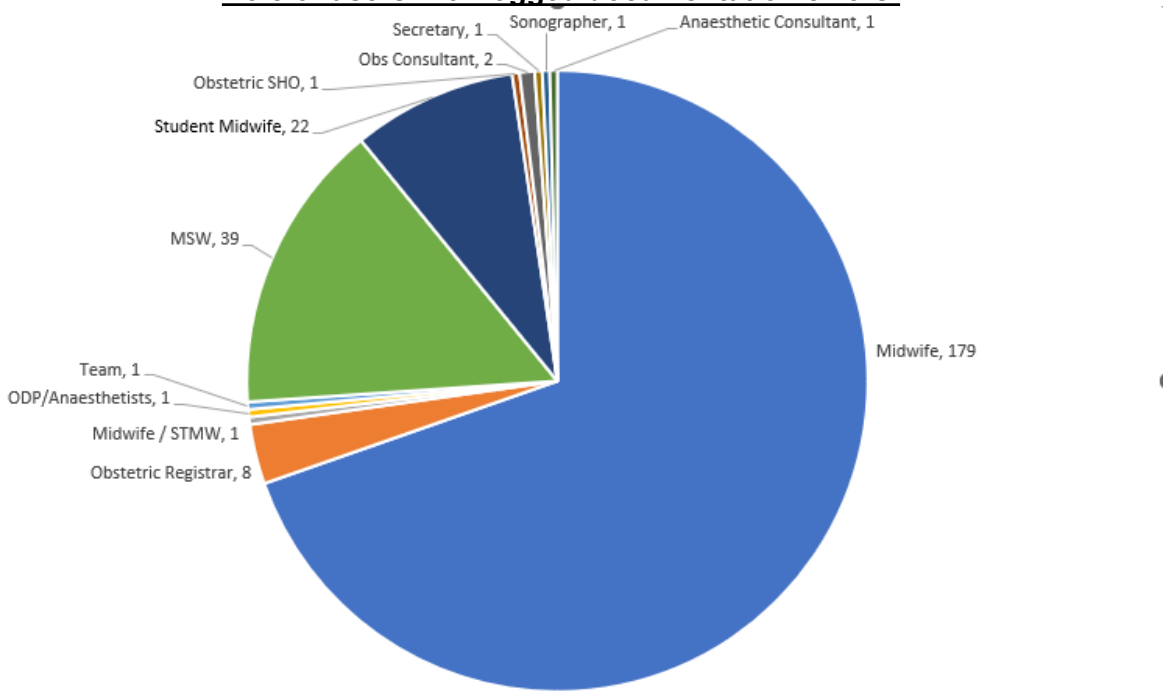
Documentation errors report Q2

This report will look at documentation errors on BadgerNet Maternity System logged by the digital maternity team in the months reported. The information is captured via:

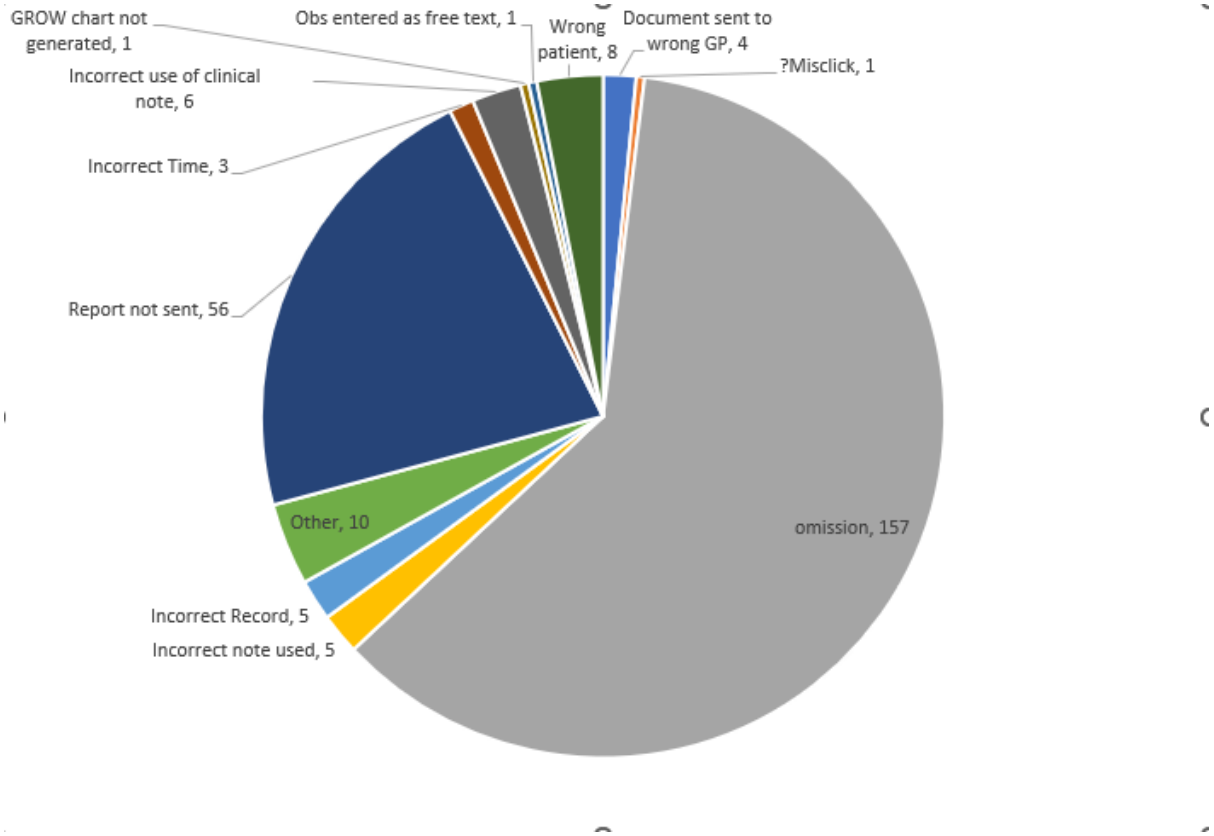
- A user emailing the team with relevant information of an error.
- A review of notes completed by the team or other members of the senior midwifery team (during a datix investigation or fetal monitoring review etc.).
- Data quality errors reported during national submissions (MSDS, smoking cessation reports etc.)
- Data completeness reports on BadgerNet Maternity system

Please note that this report will only contain on errors noticed using methods above, this may not be comprehensive of all documentation errors on the system.
257 errors have been logged in this period and the data is broken down below. This has increased by 84 since the last quarter.

Role of users with logged documentation errors:



Type of errors logged:



Average length of time (days) passed prior to error being noticed and recorded: **20.0** days. This has reduced by 7 days since the last report which shows errors are being noticed more promptly.

Themes	Actions/update
Birth notifications not being sent	• Digital Maternity Team to continue to monitor and inform staff that miss this step. • Checklists are being deployed with System C so staff will be prompted from the system to complete this step.
No end time on triage assessment	• This has been escalated to the DAU Lead Midwife as she is auditing this data • Staff in DAU encouraged to use the handover board on the desktop version of BadgerNet as records will remain on there until the end date and time has been added to the system. • Staff are also encouraged in training to complete all documentation at the bedside, therefore when they leave the bedside having entered the end date and time, the record is complete.

Report to	Board of Directors, Part 1	
Date of Meeting	11 February 2025	
Report Title	Birthrate Plus report	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Quality Committee, 28 January 2025	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 – Safety and quality	
Financial	Achieving the Maternity Incentive Scheme (MIS) provides approx. £250k rebate to maternity services	
Statutory & Regulatory	Elements in this report relate directly to Maternity Incentive Scheme	
Equality, Diversity & Inclusion	Not specifically	
Co-production & Partnership	Nil	

Executive Summary

Maternity Incentive Scheme guidance in relation to BR Plus
Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated?
Evidence should include:
● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

The Report
Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Annual birth activity

Delivery Suite	1421
Home	94
Total Births	**1515**

The staffing recommendation includes an allowance of 24% uplift for annual, sick and study leave and 1.8wte midwives to contribute to the Maternity Advice Line, provided currently by UHD for Dorset.

Conclusion
Comparison of Clinical Staffing

Current Funded Establishment bands 3 – 7	Birthrate Plus® establishment bands 3 – 7	Variance Bands 3 – 7
65.57	72.90	-7.33

There is a deficit in the current funded clinical establishment of **-7.33 wte**.

Next step

1) Discussion about the DCH contribution to the Maternity Advice Line
2) Consideration of the specialist roles in relation to their total 11.93 wte plus 3wte for two matrons and Head of Midwifery and Neonatal Services.
3) Consideration of recommended headroom of 24%

Recommendation

Members are requested to:

- **Receive the report for assurance**

BIRTHRATE PLUS® ASSOCIATES LIMITED

MIDWIFERY WORKFORCE REPORT

NOVEMBER 2024

DORSET COUNTY HOSPITAL
NHS FOUNDATION TRUST

Table of Contents

Section 1

Birthrate Plus®: The methodology and factors affecting maternity services.

Birthrate Plus® is a framework for workforce planning and strategic decision-making and has been in constant use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus® methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives (RCM).

The RCM recommends using Birthrate Plus® to undertake a systematic assessment of workforce requirements, since it is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3). Both the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) (NHSR 2023) and the Three-year delivery plan for maternity and neonatal services (NHSE 2023) include reference to using Birthrate Plus® as a midwifery staffing tool.

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have in excess of 8000 births. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and birth. Each of the indicators has a weighted score designed to reflect the different processes of labour and birth and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and birth with a higher score reflecting medical comorbidity or the need or request for intervention during the labour and birth.

Other categories classify women admitted to the birth suite for other reasons than for labour and birth.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. These are reviewed and updated in line with recommendation from national reviews such as Ockenden (2002) and Kirkup (2023). Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick and study leave allowance and for travel in community**.**

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Shorter postnatal stays before transfer home requires sufficient midwifery input in order to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

The emphasis of community based care is on ‘normal/low risk/need care’ being provided in the woman’s home and other community setting by midwives and midwifery support workers. However, care of women and babies with safeguarding needs is an increasing demand upon community midwifery services.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there are women who birth in a particular hospital but from out of area so are ‘exported’ to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows.

The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwives once pregnancy is confirmed. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal women.

Section 2a

Discussion of Results for Hospital based care.

1. This is a final report of the midwifery workforce requirement for maternity services in Dorset County Hospital NHSFT. The results show information for Dorset County Hospital (DCH) and the local community.

2. The Birthrate Plus staffing is primarily based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

3. Day to day management by ward and department managers, community team leaders and coordination of intrapartum services are included in the clinical establishments.

4. The decision was made to collect new casemix. The casemix has the major impact on the midwifery establishment especially for intrapartum care as the additional time applied to Categories III to V results in an increase from the one midwife to one woman ratio for Categories I and II. A 4 months' sample from December 2023 to March 2024 was obtained by the midwifery team and additional scrutiny provided by the Birthrate Plus consultant.

5. Table 1 shows the current casemix.

Casemix	**%Cat I**	**%Cat II**	**%Cat III**	**%Cat IV**	**%Cat V**
Delivery Suite	5.6	10.2	16.3	28.6	39.3
	32.1%			*67.9%*	

Table 1: Casemix

6. There has been an increase in the percentage of cases in the higher categories of IV and V compared to the previous studies (from 61.3% to 67.9%), which may reflect changes to pathways of care and increased medical comorbidities.

7. Table 2 shows the total annual birth activity.

	Annual Total
	DCH
Delivery Suite	1421
Home	94
Total Births	**1515**

Table 2: Annual Activity

8. All delivery suites have antenatal cases where women require monitoring and often treatment for obstetric or medical problems such as antepartum haemorrhage, preterm labour, reduced fetal movements, etc. Often the women are transferred to the maternity ward or to another unit if need a higher level of neonatal services. In addition, most maternity services provide care for women experiencing a pregnancy loss or termination for medical reasons. Postnatal readmissions may require a theatre procedure or enhanced midwifery care for conditions such as sepsis.

9. Table 3 shows all the recorded activity in DCH delivery suite and recommended staffing wte for each care activity. The roster template per shift is also included.

Intrapartum Services - Delivery Suite	**Annual Total**	**WTE**
Births	1421	17.46
Other activity	**Annual Total**	**WTE**
Antenatal Cases	540	2.76
In-utero transfers out	50	0.25
Non-viable cases	14	0.16
Total WTE		**20.63**
Roster template per shift		3.72

Table 3: DCH Intrapartum services – births and other activity

10. Often the inpatient antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital-based care. The antenatal admission episodes to the ward excludes inductions and elective sections.

11. Medical inductions of labour are mostly carried out on the ward with some taking place on delivery suite. The annual total are actual insertions but may be less women as some may have multiple insertions.

12. The ‘extra care babies’ are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is also covered in the casemix as more hours are allocated to women in the higher categories IV and V.

13. There is some readmission activity to the ward which may be mothers and or babies.

14. Staffing is included for the NIPE service provided by the ward midwives. NIPE for home births is routinely included in the community staffing.

15. Table 4 shows the annual activity on Maternity ward along with the recommend clinical staffing wte and roster template per shift.

Maternity ward	Annual Total	WTE
Antenatal care		
Antenatal admissions	442	1.19
Induction of labour	1688	3.09
Postnatal care	**Annual Total**	**WTE**
Postnatal women	1421	14.35
Postnatal Re-admissions	176	0.95
NIPE	750	0.38
Extra Care Babies	108	0.73
Frenulotomies	196	0.13
Total WTE		**16.54**
Roster template per shift		3.70

Table 4: Maternity Ward Activity

16. The staffing provision for Triage covers a 24-hour period, seven [7] days per week with 1 midwife on duty throughout the 24-hour period plus an additional 8 hours each day for the peak activity period. This is in line with the RCOG guidance paper 17, 2023 and BSOTS model (Birmingham Symptom-specific Obstetric Triage System).

17. In addition, there is 1.8wte included for a telephone assessment service which is run in conjunction with University Hospital Dorset.

18. The Day Unit is staffed according to the current staffing model which is adequate for the activity.

19. Outpatient Clinic services at the Trust are based on the average hours of each session time and numbers of staff to cover these, rather than on the number of women attending and a dependency classification. Professional judgement is used to assess the numbers of midwives and support staff required to 'staff' the clinics/sessions. The outpatients' profile is unique to each maternity service.

20. The staffing figures (Table 5) include an allowance of 24% uplift for annual, sick and study leave. This is higher than the current uplift but the service advise they are moving to this percentage, which is in line with many maternity units in England.

Breakdown of Birthrate Plus® Clinical Staffing for DCH

	DCH	Staff group
Intrapartum Services	20.63	RMs
Labour Line (with UHD)	1.80	RMs
Triage	7.41	RMs
Maternity Ward	20.82	RMs
Outpatient Services	1.45	RMs
Day Unit	1.52	RMs
Total Clinical wte	**53.63**	**RMs**

Table 5: Birthrate Plus® Staffing 24 %

Section 2b

Discussion of Results for Community based care

21. The community annual total includes women who birth in neighbouring units and receive either antenatal or postnatal care, or a combination of both, from the Trust midwives (community imports). The birth episodes are provided by neighbouring units.

22. Every Trust will have a proportion of women with safeguarding needs that may not reach the threshold for formal intervention but require a significant input from the community midwives such as increased surveillance, support, and signposting to other services. Additional staffing resource has been included for this additional care.

23. All Trusts have attrition cases, namely, women who may book and/or see a midwife in early pregnancy but either move out of area or have a pregnancy loss.

24. In addition, many Trusts will have export cases; women who birth in their Trust but live outside of the geographical area and therefore receive community care in their local trust. Table 7 includes this figure for reference.

25. The total community cases in table 6 includes all imports and home births but excludes exports, and attrition cases

26. The total community activity in table 6 refers to all women being cared for and includes all community as noted in point 26 as well as the attrition cases.

27. The annual community activity is more than the hospital births. Community cases often differ to the birth numbers, and this should be considered when understanding the staffing required for each area.

28. The staffing figures (Table 6) include the current allowance of 24% uplift for annual, sick and study leave, and 15% for travelling time.

COMMUNITY SERVICES	DCH	
	Annual Total	WTE
Home Births	94	2.81
Community Cases (own births)	1264	13.14
Imports AN & PN care	32	0.33
Imports AN Care only	10	0.06
Imports PN Care only	23	0.11
Attrition Cases	219	0.30
Additional Safeguarding	516	2.52
*Exports **	*157*	
Total Community Cases		1423
Total Community Activity		1642
Hospital births		1421
Community activity compared to hospital births		221
Total WTE		**19.27**
*figure included for reference only.		

Table 6: Community activity and wte at 24% uplift

Section 3

Specialist Midwifery and Managerial Roles

29. The total clinical establishment shown in Table 8 above excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services.

30. All maternity units have Specialist Midwives who provide expert midwifery care to groups of women or provide support and training to colleagues.

31. In addition, they may have a strategic role in service delivery (RCM).

32. Some Specialist Midwives may have both a clinical and non-clinical role. It is a local decision of senior midwifery management as to the % contribution to the clinical staffing. The Specialist midwifery team contribute 4.45wte to the clinical care of women, directly through their specialist roles. The remaining % is included in the non-clinical roles (education, audit, quality improvement, policy development etc).

33. In addition, *every* maternity unit, irrespective of size of number of births, requires specific non-clinical managerial and leadership roles to support the overall functioning of the unit.

34. Table 7 below shows the Specialist roles along with the managerial posts at DCH.

DORSET COUNTY HOSPITAL					
Funded Specialist Midwives	WTE	*Clinical input*	Nonclinical WTE	Senior Management band 8a and above*(list roles)*	WTE
Recruitment and retention	1.00		1.00	HOM	1.00
Preceptorship Lead	0.20		0.20	Matrons	2.00
Preterm Birth Lead	0.20	*0.10*	0.10		
PMAs	0.40		0.40		
Digital Midwives	1.76		1.76		
Debrief Team	0.15	*0.15*	0.00		
Tongue Tie	0.20	*0.20*	0.00		
Bereavement	1.40	*0.90*	0.50		
UNICEF Baby Friendly	1.00	*0.60*	0.40		
Public Health	1.00	*0.60*	0.40		
Fetal Monitoring Lead	0.40		0.40		
Screening co-ordinators	1.00	*0.60*	0.40		
Audit Lead Midwife	1.00		1.00		
Safeguarding	1.00	*0.50*	0.50		
Practice Educators	1.27		1.27		
E-Roster midwife	0.20		0.20		
PNMH	1.00	*0.80*	0.20		
Safety Lead MW	1.30		1.30		
Guidance and NICE Lead	0.50		0.50		
Student Link Midwife	0.40		0.40		
Governance Lead	1.00		1.00		
TOTALS	**16.38**	***4.45***	**11.93**		**3.00**

Table 7: Specialist and Managerial posts

35. In addition to the above posts, consideration should also be given to recommendations from national reports such as Ockendon 2022 with regards to new roles, and the manifesto produced by the RCM in August 2019 which sets out seven steps to strengthen midwifery leadership.

36. The service may wish to consider the introduction of a Consultant Midwife post, to provide expert clinical midwifery leadership and supporting service development through evidence-based care.

37. Additional reports that have require specialist midwifery posts are shown with links in Appendix 2 page 16. A brief list is below:

    i. Maternity and Neonatal Safety Improvement Programme (NHSE 2021)
    ii. The Culture and Leadership Programme (NHSE 2020/21)
    iii. Maternal (and perinatal) Incentive Scheme Year 6 v1.2 (NHS Resolution Sept 2024)
    iv. National Bereavement Care Pathway (2018)
    v. Service Specification: perinatal pelvic health services (NHSE October 2023)
    vi. Birth Trauma Report (APPG January 2024)
    vii. Independent Culture Review (NMC July 2024)
    viii. National Review of maternity services in England 2022 to 2024 (Care Quality Commission September 2024)
    ix. Saving Lives, Improving Mothers' Care. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK October 2024)

38. Applying 15% to the Birthrate Plus® clinical wte provides 10.94wte additional staff for the above roles. It is a local decision as to which posts are required and appropriate hours allocated.

Section 4 – Comparison of current funded and recommended staffing including overall summary

Section 4a - Current Clinical Funded Bands 3 – 7

39. Comparisons are made with the current funded establishment as per table 8 below.

RMs Bands 5 – 7	Specialist Midwives contribution	Current Total Clinical wte
61.12	4.45	65.57

Table 8: Current Funded Establishment

Section 4b - Comparison of Clinical Staffing

Current Funded Establishment bands 3 – 7	Birthrate Plus® establishment bands 3 – 7	Variance Bands 3 – 7
65.57	72.90	-7.33

Table 9: Comparison of Clinical Staffing

40. There is a deficit in the current funded clinical establishment of **-7.33 wte**.

41. Larger maternity units apply a skill mix of 90/10 so that 10% of the clinical wte are suitably qualified MSWs (Band 3s), possibly Band 4 Nursery Nurses and sometimes Band 5 RNs working in postnatal services in the ward and on community. It is a local decision by the senior midwifery management team as to an appropriate skill mix, using professional judgement along with their local knowledge of the service.

42. The service does not apply a skill mix and this ensures that there is adequate support available for escalation of midwives during periods of high activity and acuity as well as ensuring an adequate number of RMs available for mentoring and supervision of students and support workers.

Section 4c - Comparison of non-clinical midwifery roles

Current Funded Establishment	Birthrate Plus® recommended	Variance
14.93	10.94	**3.99**

Table 10: Comparison of additional specialist and management wte

43. There is a positive variance in the current funded establishment for non-clinical roles of **3.99wte.** This is typical of many smaller maternity services who have the same requirement for core Specialist and managerial roles as larger organisations. This also ensures that there are adequate senior midwives to support both the operational and strategic needs of the service whilst also providing resilience and succession planning.

Section 4d - Summary of results

Current Funded Clinical, Specialist and Management wte	Birthrate Plus® Total recommended wte	Variance wte
80.50	83.84	-3.34

Table 11: Total Clinical, Specialist and Management wte

44. **Overall, the results show there is a deficit in the total funded establishment of 3.34wte**

birthrateplus® | Safe Staffing for Maternity Services

SUMMARY of DATA & REQUIRED WTE for **BIRTHRATE PLUS®**

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

Final version 05/11/2024

Annual Data Period 2023/24

24.00% **15.00%**

5.56

Total births in service **1515**

Dec 2023 - Mar 2024	Cat I	Cat II	Cat III	Cat IV	Cat V
% Casemix	5.6	10.2	16.3	28.6	39.3
		32.1		67.9	

	Annual Nos.	Required WTE	
Intrapartum Care			
Births	1421	17.46	*17.46*
Other Activity			
Antenatal Cases	*540*	2.76	*3.17*
Escorted Transfers OUT	*50*	0.25	
Non-viables	*14*	0.16	
Triage	*1686*	7.41	*7.41*
Labour Line with UHD		1.80	*1.80*
Antenatal Care			
Antenatal admissions	*442*	1.19	*4.28*
A/N Ward Attenders	*0*	0.00	
Induction doses	*1688*	3.09	
Postnatal Care			
Postnatal women	*1421*	14.35	*16.54*
Postnatal Ward Attenders	*0*	0.00	
Postnatal Re-admissions	*176*	0.95	
NIPE	*750*	0.38	
Extra Care babies	*108*	0.73	
Frenotomies	*196*	0.13	
OUTPATIENT SERVICES			
Antenatal Clinics			
DCH Obstetric & Specialist Clinics		1.01	*1.45*
Outreach Clinics		0.44	
Maternity Day Unit	*0*	1.52	*1.52*
COMMUNITY SERVICES			
Home Births	*94*	2.81	*19.27*
Community Cases (own births)	*1264*	13.14	
Community Imports (ante & postnatal care)	*32*	0.33	
Community Imports (antenatal care)	*10*	0.06	
Community Imports (postnatal care)	*23*	0.11	
Attrition Cases	*219*	0.30	
Additional Safeguarding	*516*	2.52	
Exports	*157*		

CLINICAL MIDWIFERY WTE REQUIRED *72.90*

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Birth

There are five [5] categories for mothers who have given birth during their time in the birth suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal birth with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental birth with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal birth will also be Category IV, as will those having a straightforward instrumental birth.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-birth. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.

NHS
Dorset County Hospital
NHS Foundation Trust

PMRTReport to	Board of Directors. Part 1	
Date of Meeting	11 February 2025	
Report Title	Perinatal Mortality Review Tool (PMRT) Quarterly Report (Q3)	
Prepared By	Lindsey Burningham Head of Midwifery & Neonatal Services	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Quality Governance Group Quality Committee 28/01/2025	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Nil	
Statutory & Regulatory	NHSR Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) standards require a report to be received by the Trust Executive Board (or appropriate sub-committee) each quarter which includes details of the perinatal deaths reviewed.	
Equality, Diversity & Inclusion	This report includes population demographics concerning health equity and equality data in relation to perinatal deaths	
Co-production & Partnership	Nil	

Executive Summary

The quarterly report provides assurance that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) via the Perinatal Mortality Review Tool (PMRT) and that following this referral there is a robust review of the quality of care provided and actions and learning are identified.

- **3 perinatal deaths occurring at DCH reported to MBRRACE-UK via the PMRT**
- **3 PMRT reviews from previous quarters were completed and closed**
- **4 cases remain under review from previous quarters (3 DCH, 1 other provider). Immediate learning and actions undertaken.**
- **Compliance with standards for MIS CNST Year 6 achieved which completes the MIS reporting year timeframe**
- **Equity & Equality thematic analysis undertaken for 2024 (10 cases) inclusive of Saving Babies Lives Care Bundle benchmarking – smoking, deprivation and vulnerabilities highlighted in 50% of cases**

The full report has not been submitted to the public Board meeting due to the confidential nature of some of the content. The full report is available to Board members on request.

Recommendation

Members are requested to:

- Receive this front sheet for **assurance**

CYP Parity of Esteem

Flagship Programme

NHS
Dorset County Hospital
NHS Foundation Trust

NHS
Dorset HealthCare
University
NHS Foundation Trust

CYP PoE Programme

Our Aim

Support children and young people with social, emotional and mental health needs in the acute setting

Create a high-quality integrated pathway to care

Provide a skilled multi-agency triage in ED (at the front door) that determines the

right intervention to support the needs of that young person and their families.

Work has been progressed in the spirit of co-production, ensuring engagement with clinicians, operational managers, partners across the health and care system, as well as involvement from individuals with Lived and Living expertise and Voluntary Sector through workshops and engagement events.

Baker,Abi
04/02/2025 15:47:21

Approach

7 Workshops
Plus 1 ED focused Workshop

Project Management Team Weekly Meetings Bringing together skill mix, experience and passion

Workshops covered:

- Data Insights
- Designing ED Front Door/Clinical Model
- 15 Steps Challenge
- Family Help Hub
- Your Voice Survey

Integrated working:

- Staff in ED
- Staff on Kingfisher
- CAMHS
- VCSE
- People with Lived Experience

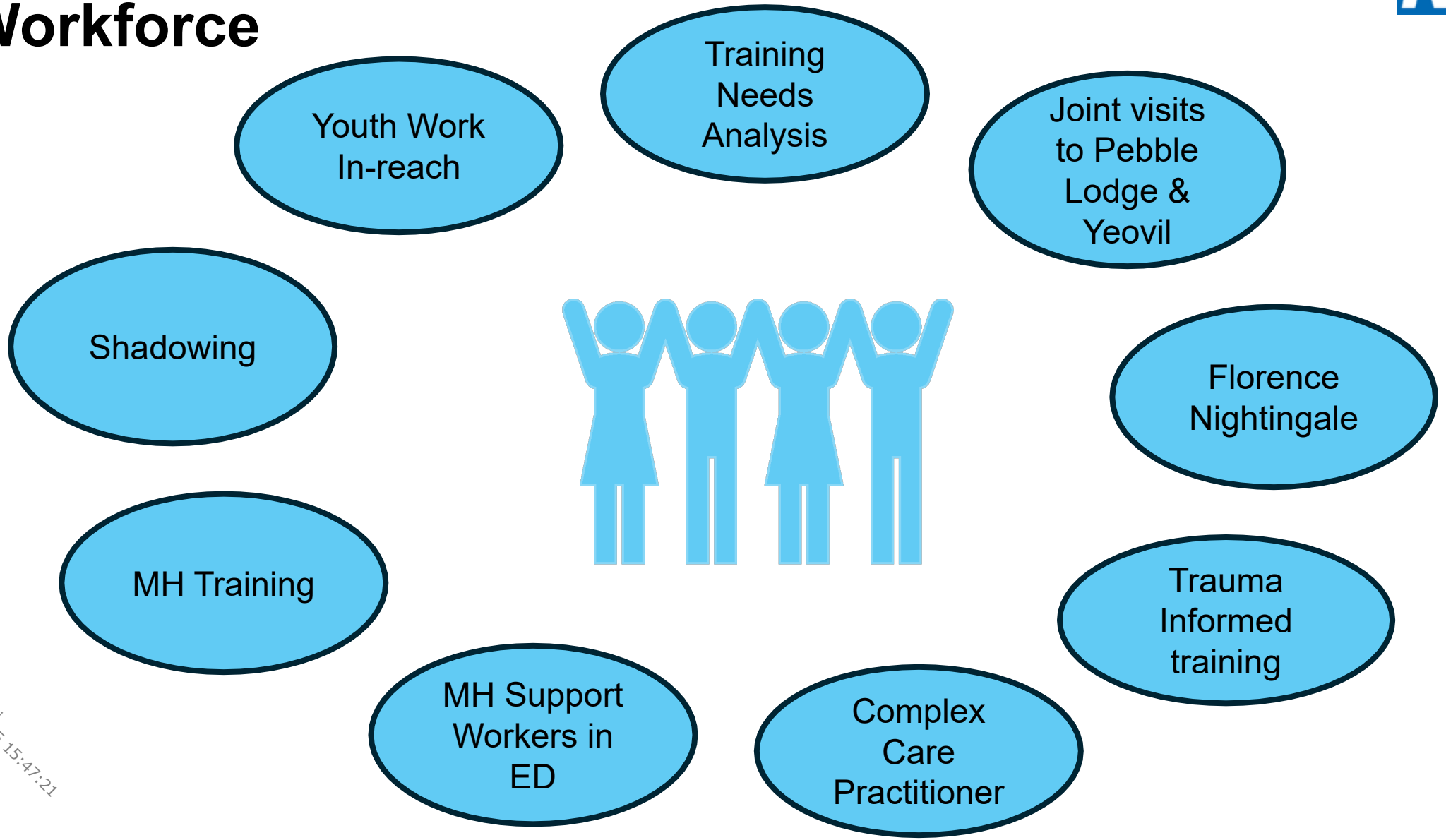
CYP PoE Programme

Developments

- MH Training Programme
- Development of Data Dashboard
- 15 Step Challenges
- RCEM Benchmarking Complete
- Information Available for CYP in ED
- Distraction Boxes

- Development of Youth Worker Model
- New Care Model
- HI User Group

Workforce



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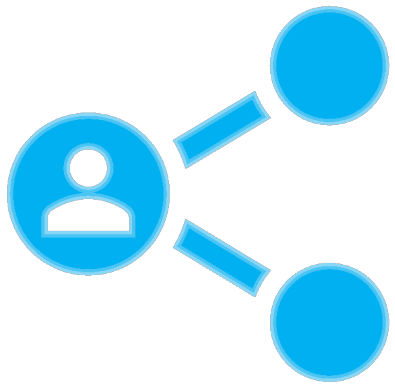
Next Steps



- Dorset CAMHS Transformation
- Multi-agency care planning with Police, SWAST and Local Authority
- New Hospital Programme- environment and workforce
- New care model at the Front Door
- Dorset Youth Association in-reach
- SOP for MH area in ED
- Routine monitoring of metrics – attendances; incidents, satisfaction
- SW Network presentation
- Business As Usual

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors – Part 1	
Date of Meeting	11th February 2025	
Report Title	Organ Donation Report	
Prepared By	NHS Blood and Transplant	
Approved by Accountable Executive	Alastair Hutchison, Chief Medical Officer	
Previously Considered By	Nil	
Action Required	**Approval**	-
	Assurance	-
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Nil	
Statutory & Regulatory	Relates to deemed consent (Max and Kiera's Law), introduced in May 2020.	
Equality, Diversity & Inclusion	Nil	
Co-production & Partnership	Nil	

Executive Summary

The letter sets out the organ and tissue donation and transplantation activity and quality of care between April and September 2024.

From three consented donors, Dorset County Hospital NHS Foundation Trust facilitated two actual solid organ donors resulting in five patients receiving a transplant during the time period. Additionally, four corneas were received by NHSHBT Eye Banks from your Trust.

Additionally, there were no missed donor referrals, no occasions when a Specialist Nurse was absent for th donation discussion, and no missed opportunities for best practice.

Recommendation

Members are requested to:

- Receive the report for **information**

NHS
Blood and Transplant
www.nhsbt.nhs.uk

November 2024

Dear Mr Bryant and Professor Hutchison,

I would like to acknowledge the huge efforts of all our colleagues involved in the donation to transplantation pathway. Please accept our recognition and thanks for the efforts of your staff. Despite these efforts the number of donors and transplants in the UK has still not returned to pre-pandemic levels and we continue to work to ensure every potential donor counts.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - Apr-Sep 2024

From 3 consented donors, Dorset County Hospital NHS Foundation Trust facilitated 2 actual solid organ donors resulting in 5 patients receiving a transplant during the time period. Additionally, 4 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - Apr-Sep 2024

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Trust referred 11 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 5 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse participated in 2 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- Thank you for missing no opportunities to follow best practice out of 7 during the time period. Your Trust also missed no opportunities out of 2 in the first six months of 2023/24.
- In South West, 50% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

Up to date Trust metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - England

England introduced deemed consent (Max and Keira's Law) in May 2020. In England between 20 May 2020 – 30 September 2024, there were 2005 occasions when consent was deemed from 3648 occasions where deemed consent applied.

Why it matters

In the first six months of 2024/25, 124 people benefited from a solid organ transplant in the South West. However sadly, 15 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Baker-Abi 04/02/2025 15:47:21

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Business Disability Forum
Building disability-smart organisations

POSITIVE ABOUT DISABLED PEOPLE

Dorset County Hospital
Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Monday 27 January 2025

Chair:	**Executive Lead:**	**Date of Next Meeting:**
Dave Underwood	Chris Hearn Rachel Small Anita Thomas	Monday 24 March 2025
Quoracy met?	Yes	
Purpose of the report	To assure the Board on the main items discussed by the Finance and Performance Committee in Common and, if necessary, escalate any matter(s) of concern or urgent business which the Finance and Performance Committee in Common is unable to conclude.	
Recommendation	To receive the report for **assurance**	

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Nil to note
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **Performance report (DCH)** ○ For November 4 hour trajectory achieved, but not for December due to compromised hospital flow. ○ No Reason To Reside (NRTR) remains off trajectory. ○ Elective Care waiting list size has decreased and has met trajectory for the last two months. Referral volumes year to date being 6.33% up on the previous year, but activity volumes are now achieving more than the referral rate growth. In Tier 2 of performance oversight framework but forecasted to have zero 65+ week waits at the end of March 2025. ○ Theatre utilisation has improved. Trust moved to 4th best performing provider in the Region for capped theatre utilisation and is the second best in the country for time lost due to early finishes. ○ Cancer performance continues to be strong, but the demand remains high - growth rate of 10.30% compared to last year and 44.96% up on 2019/20. ○ Diagnostic performance has improved, but the trajectory was not met. This metric is at risk of not delivering the end of year trajectory. • **Performance report (DHC)** ○ Early Intervention in Psychosis (EIS) below threshold due to long term absence which is expected to continue during Q4.

- Dorset Dementia Service Access/waiting times and Dementia Diagnosis Rate see incremental improvements being made, error noted in prior period reporting now rectified.
- Urgent and Emergency Referrals to CMHT's - issue with the report build impacting on compliance, however a significant upturn in compliance has been noted for AMH emergency referrals in November and December.
- Dorset All Age Eating Disorder Service - Recovery plan is in place developed in conjunction with the ICB. Recovery funding secured to March 25, Recovery trajectories planned to December 24 and are slightly off track.
- IUCS Call backs within 20 minutes 25.8% against a target of 90% and IUCS Call backs over 20 minutes (KPI 5b): 41.7% against a target of 90%. Actions being taken to optimise staffing and improve performance.

- **Finance Report (DCH)**
  - M9 delivered a deficit of £1.6 million after technical adjustments, being £2.5 million away from plan of £0.9 million surplus. Year to date position is £7.3 million away from the reported plan standing at an actual deficit of £11.8 million. Position broadly in line with the Trusts risk adjusted forecast outturn trajectory plan of a £11.5 million planned deficit position.
  - A significant challenge to meet this, with a focus on delivery of cost-improvement plan with £10m required to meet the plan. The use of non-recurrent savings was highlighted. Noted good progress delivery CIP year to date in excess of full year for 2023/34.
  - Cash remains a high risk area with modelling indicating further cash support will be required for the remainder of the financial year and beyond pending 2025/26 funding allocations. National revenue support request submitted for December and January rejected by the national team due to the reported. System mitigations in place to manage on year position.
- **External Structural Deficit Review (DCH)**
  - Independent review completed to understand underlying deficit for DCH. The deficit drivers have been validated and classified as: Structural (£11.7m), Strategic (£11m) and Operational (£10m). The Trust will continue to work with the ICB throughout 25/26 planning to determine how to take forwards the finding of the report.
- **Finance Report (DHC)**
  - Delivered an adjusted year-to-date deficit of £0.52m at month 9. Equates to a deficit of £0.09m against the plan submitted to NHSE for 2024/25.
  - Majority of services are overspent at month 9, with particular challenges around medical agency costs and unachieved savings. The forecast indicates a potential year end deficit of £2.49m against plan, if no further BQBV savings are found and spend continues at current rates. The Trust has confirmed and removed £11.83m of Best Quality Best Value savings from budgets, against a target of £19.15m.
- **Results of National Benchmarking Exercise (DCH / DHC)**

- Noted results of national benchmarking exercise and discussed the availability of comparative data.
- Noted Corporate costs have reduced in both Trusts over the last 5 years, however some areas continue to be in the highest quartile nationally, indicating cost saving opportunities are possible.

- **Joint Business Planning Approach 2025/26 (DCH / DHC)**
  - Received assurance on joint approach and timescales to fit in with regional and national deadlines. Commended team on joint working and comprehensive approach.
- **Dorset Healthcare IT Contracts (DHC)**
  - Noted expenditure on IT systems historically been undertaken on an ad-hoc basis, with insufficient oversight of Trust wide system usage resulting in a significant number of Single Tender Waivers being used to procure and extend systems.
  - Received assurance work is underway to complete the system landscape review to identify and document the IT systems in use within the Trust to allow proactive management of contracts and avoid overuse of STWs.
  - Development of a Digital Strategy will further enhance management of effective and efficient IT systems, working collaboratively to achieving economies of scale.
  - Proactive supplier management and system lifecycle management approach will be implemented with Digital Services, Finance and Procurement to have quarterly reviews of contracts and expiry/renewal dates.
- **Fortuneswell Pharmacy (DCH)**
  - Received outline of the current arrangements between the Trust and Fortuneswell Pharmacy to provide context of pharmacy developments ahead of a more extensive review paper planned to be brought back to FPCIC and DCH Trust Board in March 2025. Noted overview in preparation for more detailed report.
- **Board Assurance Framework (DCH/DHC)**
- Three risks assigned to this Committee:
  - SR4 Capacity and Demand
  - SR5 Estates
  - SR6 Finance
- Dorset County Hospital
- The scores in respect of SR5 Estates and SR6 Finance were increased following the last meeting of the Committee to reflect the increased risk in these areas.
- Where actions not achieved by the due date revised dates have been provided and Committee assured on plans in place.
- Discussed cash position and agreed to keep under review. No updates proposed by the Committee.
- Dorset HealthCare
- The score for SR6 Finance has been reduced to reflect the forecast year end position.
- Where actions not achieved by the due date revised dates have been provided and Committee assured on plans in place.
- No updates were proposed by the Committee.

- **Corporate Risk Register (DCH / DHC)**
- Noted that there is a plan to align the approach to reporting across both Trusts, including the threshold for reporting to Committee. Agreed that further work required on risk registers to refine presentation and mechanisms underpinning production. Acknowledged request for trend analysis from DHC Audit Committee but was more important to first resolve system issues initially.
- Dorset County Hospital
- 3 new risks scoring 20 or above have been added in the period under review. 6 risks scoring 20+ assigned to Committee.
- 3 new risks scoring 15-19 have been added in the period under review. 44 risks scoring 15-19 assigned to Committee.
- Dorset HealthCare
- Noted no new risks scoring over 12 reported in the period. There are 7 risks scoring 12+ and 2 risks scoring 15+.
- No risks scoring 12+ closed in the period or change in score or added.
- Noted one risks were overdue for review and an escalation process has been followed and reminders sent.

- **Assurance Reports**
- The following assurance reports were received:
  - CPSUG 291124 and 030125
  - EPRG Assurance Report 20 Jan 25 - DCH
  - DCH Value Delivery Board 15 Nov 24 and 20 Dec 24
  - DHC Capital Investment Meeting 16.01.2025
  - DHC Better Quality Better Value Delivery group 13.01.2025

- **Any Other Business - Procurement Route of the New Hospital Programme - Ward Refurbishments at St Ann's Hospital (DCH)**
- Committee received and noted the report. Due to limited time available to review paper agreed it would be noted by Committee and reviewed in full by Board.

Decisions made at the meeting

- Approval of Access Agreement for Agency Staffing (DCH)
- Recommend approval of contract award Southern Counties Pathology Managed Service Contract (Lot 5) (DCH) P*ost meeting note this be delayed due to change in specification*
- Recommended approval of short business case related to DHC Trust Headquarters (DHC)
- Procurement Route of the New Hospital Programme - Ward Refurbishments at St Ann's Hospital (DCH) – to be considered ib full by Board

Issues / actions referred to other committees / groups

- DHC Audit Committee – to re-consider need for trend analysis in light of impending new system and resource required for manual process to achieve this.

Report to	Board of Directors	
Date of Meeting	11th February 2025	
Report Title	Balanced Scorecard- An integrated report for the reporting month of December 2024	
Prepared By	Adam Savin, Director of Operational Planning and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer Claire Abraham, Deputy Chief Finance Officer Emma Hallett, Deputy Chief People Officer Jo Howarth, Director of Nursing (Acute Care)	
Action Required	**Approval**	
	Assurance	X
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Safety and Quality, capacity and demand and strategic risks	
Financial	ERF	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

The Trusts Balanced Scorecard brings together key indicators under four dashboards of Quality and Safety, performance, People and finance.

All indicators are covered in detail in the respective sub-board committees and therefore, this paper does not attempt to duplicate the committees work or the deep dives, but rather provider an oversight of them combined. The pack of Board papers include the sub-board committee escalation reports, which have been written by each Chair and in conjunction with this report, provides the opportunity for triangulation.

Key areas to highlight:
Quality

- Emergency readmissions within 30 days of discharge has reduced slightly to 9.47% from 9.5% and is below the 13% target
- Electronic Discharge Summary sent within 24h of discharge remains below target at 63.73%. This is a decrease since last reporting by nearly 10%.
- SHMI has remained within the expected range

Performance

- UEC performance against the 4 hour standard, did not meet the national planning guidance of 78% on December.

- Cancer performance is being impacted by increasing demand, but a return to achievement of 28 day to diagnosis and the 62d treatment standard has been achieved
- Patients waiting the longest for elective treatment have reduced and the total waiting list is starting to reduce
- Diagnostic performance has improved

People
- Essential skills rate remained at 88%, 2% below target
- Appraisal rate remained at 76%, remaining below target
- Vacancy rate increased to 3.3% but remains better than the target
- Turnover remained at 9.4% and remains better than target
- Sickness rate reduced to 4.4%, above the target

Finance
- Adjusted financial plan showing as a confirmed overspend.
- Agency spend reducing and with improved medical and nursing agency spend.
- Capital expenditure is slightly behind plan, due to timings of spend.

Recommendation
The Board are asked to receive the report for **assurance**

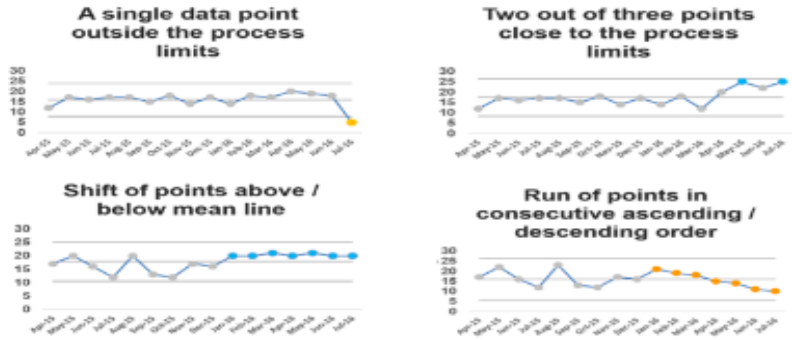
1) Understanding Statical Control Charts (SPC)

Is Performance Changing?

Statistical process control (SPC) charts help us understand if the performance of a metric is changing significantly.

We use rules (examples seen on the right) to identify significant unusual variation, which is highlighted on the charts.

Once significant variation has been identified we can focus attention on areas that need investigation and action.



What are Summary Icons showing?

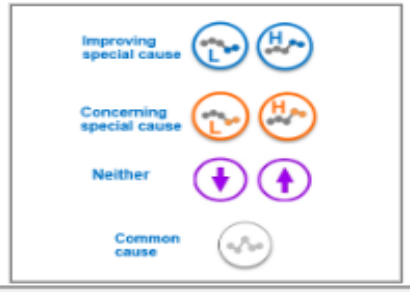
Blue icons indicate significant improvement or low pressure.

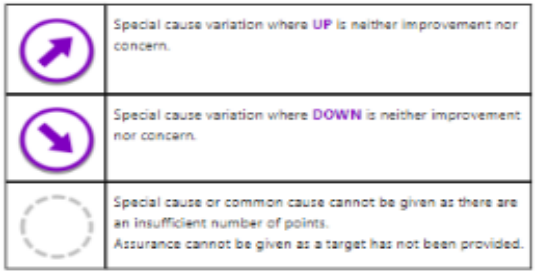
Orange icons indicate significant concern or high pressure.

Purple icons indicate direction of change, for metrics where a judgement of improvement or concern is not appropriate.

Grey icons indicate no significant change ('Hit and Miss').

For further details please refer to 'SPC Icon Descriptions' tab.





What is a Moving Range Chart showing?

Moving range chart (seen on right) helps to assess the variation in a process by taking the absolute difference between consecutive points.

The chart can determine the data points wherein the special cause variation may be present.

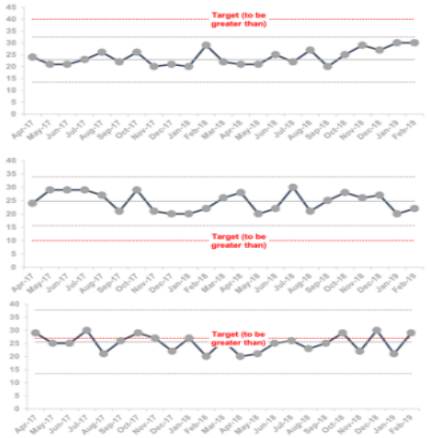
The centre line is the average value of all moving ranges.

The dashed line is the upper process limit and if a point breaches this line, this is where special cause variation may be present.

The moving range chart will display below all SPC visualisations.

Assurance icon

Up is good (need to be greater than the target



Failing process
target way above the process limits so it's a failing process, unlikely to ever meet the target without redesign and we use an orange F for FAIL

Capable process
target way below the process limits so it's a capable process and likely to always meet the target and we use a blue P for PASS

Unreliable process (flip flop)
where the target falls in the middle of the process limits and is likely to flip flop and we use a grey ?
This is to show the process may or may not meet target consistently

Variance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ◌
H	Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.
L	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.
~	Common cause variation, no significant change. This process is capable and will consistently PASS the target.	Common cause variation, no significant change. This process will not consistently HIT OR MISS the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
H	Special cause of a concerning nature where the measure is significantly HIGHER. The process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.
L	Special cause of a concerning nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.

2) Executive Summary

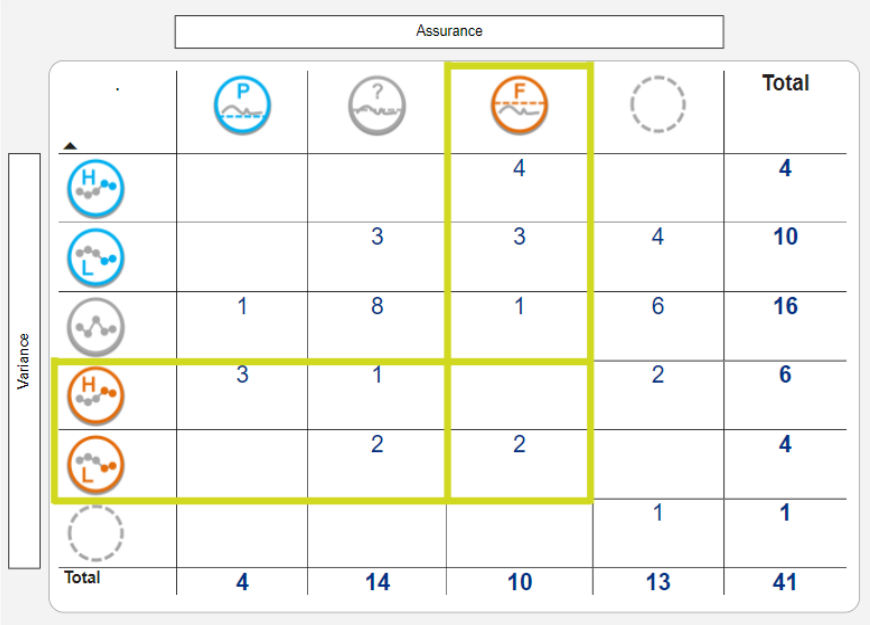
For the reporting month of December 2024, there are 11 indicators that are failing the target or are unstable (hit or miss) and showing as special cause for concern, this compares to 8 in the reporting month of November 2024.

This may mean the process does not easily lend itself to representation as an SPC chart or that without intervention the process will not deliver the required outcome. Each is addressed below and where appropriate other measures described which give a more rounded perspective on the Trust performance within that section.

For the people dashboard, 1 metric has a variance of special cause variation of a worsening nature, all others are improving or common cause variation. For finance, 2 have a variance of special cause variance of a declining nature, 2 of an improving nature and the rest common cause variation. For performance, 5 metrics are of a worsening nature, 8 improving and 1 common cause variation. For quality and safety, 5 metrics are a declining nature, 6 an improving and 2 common cause variation.

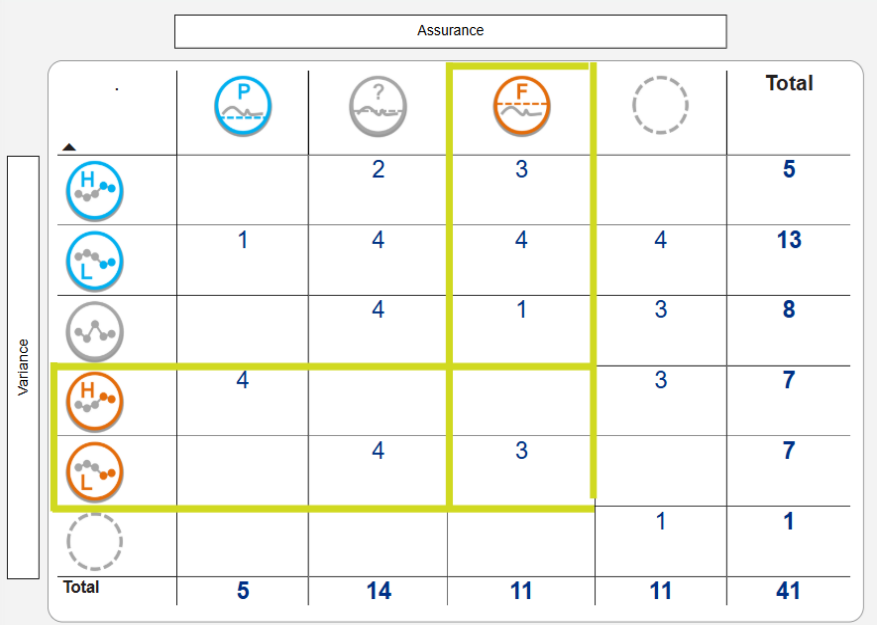
There are 11 indicators, across all dashboards (therefore the balanced scorecard) that have not got a target, therefore assurance cannot be given either way, this is 1 lower than the last reporting round.

November 2024 data



Variance \ Assurance	P	?	F		Total
H			4		4
L		3	3	4	10
?	1	8	1	6	16
H	3	1		2	6
L		2	2		4
				1	1
Total	4	14	10	13	41

December 2024 data



Variance \ Assurance	P	?	F		Total
H		2	3		5
L	1	4	4	4	13
?		4	1	3	8
H	4			3	7
L		4	3		7
				1	1
Total	5	14	11	11	41

The matrix summaries the number of metrics (at Trust level) under each variance and assurance category. The Trust is aiming for the top left of the grid (special of improving nature, passing the target). Items for escalation based on indicators which are failing target or unstable (hit and miss) and showing special cause for concern are highlighted in yellow.

3) Quality and Safety dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Effectiveness	Inpatient - EDS % Available < 24 Hours of Discharge	0 - Total	Dec-24	63.73%	90%	-26.27%	77.08%	75.76%	63.73%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Dec-24	85.25%	100%	-14.75%	87.47%	84.67%	85.25%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	Nov-24	9.47%	13%	-3.53%	8.37%	9.18%	9.47%		
Experience	Complaints - Formal Complaints Received	0 - Total	Dec-24	0			24.72	28	100		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Dec-24	98.09%	94%	4.09%	91.98%	91.38%	98.09%		
Incidents - Falls Resulting in Severe Harm or Death by Incident Date	Incidents - Falls Resulting in Severe Harm or Death by Incident Date	0 - Total	Dec-24	1			0.13	0	1		
Incidents - Medication Incidents by Incident Date	Incidents - Medication Incidents by Incident Date	0 - Total	Dec-24	82			63.61	80	782		
Incidents - Pressure Ulcers Category 4 Hospital Acquired by Incident Date	Incidents - Pressure Ulcers Category 4 Hospital Acquired by Incident Date	0 - Total	Dec-24	0	0	0.00	0.1	0	2		
Safety	Incidents - Confirmed Never Events	0 - Total	Dec-24	0	0.02	-0.02	0.07	0	1		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan...	0 - Total	Dec-24	0	0	0.00	0.41	0	1		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Dec-24	2	3	-1.00	2.62	2	24		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Dec-24	4	5	-1.00	2.93	1	21		
Safety	Inpatient - SHMI Value	0 - Total	Jul-24	1.06	1	0.06	1.14	1.12	1.06		

IPC

Seasonal increase in flu cases, appropriate management supported by POCT within ED and paediatric areas. No outbreaks of respiratory infections (flu, covid, RSV) reported, proactive cohorting of patients within designated areas.

Tissue Viability

Roll out of PURPOSE T continues and on course to be completed by end of Q4. Focus continues on pressure ulcers, incidence is continuing to level. We received 35 hybrid mattresses during December and immediately allocated into ward areas.

Complaints

The Patient Experience Complaints Policy was launched in December in line with NHS Complaints Standards. Main focus is to work towards early resolution.

FFT

In December 98.1% of patients would recommend the service. We received a 0% return from ED, volunteers are currently supporting the department to promote completion, plan to move towards introducing QR codes. Acknowledge the challenges in attendees completing FFT responses.

Mixed sex accommodation

There has been an increase in the number of breaches reporting

during December. This is a consequence of being in Opel 4 escalation, reduced patient flow and additional escalation areas in use. This continues to be an area of focus for improvement.

Renal transport

There has been a further reduction in the number of Renal Transport Incidents now down to 24 in December. The risk score will be reviewed and updated as the mitigations are now having a positive impact.

Other

- EDS % <24hrs performance is recognition of the challenging period of increased acuity and activity with sustained periods of OPEL 4 status.
- EDS % < 7 days remains consistent at a current average of 85%.
- Quality Governance team are leading on a QI project with 5 Resident Drs to review the EDS process
- Re-admissions within 1 month remain constantly below 10% and demonstrate a reducing trend for the last 3 months.
- Standardised Hospital Mortality Rate continues to improve and is demonstrating a positive special cause variation as it tracks closer to 1.00

**Narrative provided by Louisa Way, Deputy Director of Nursing (Acute Care).*

4) Performance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Cancer	Cancer - 28 Day Faster Diagnosis Standard Performance	0 - Total	Dec-24	78.75%	77%	1.75%	71.48%	73.58%	78.75%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Dec-24	91.19%	96%	-4.81%	96.06%	96.47%	91.19%		
Cancer	Cancer - Patients Waiting 62+ Days from Referral to Treatment	0 - Total	Dec-24	64			79.05	79	659		
Elective	Theatres - Capped Utilisation	0 - Total	Dec-24	76.47%	85%	-8.53%	69.06%	72.05%	76.47%		
Elective	Theatres - Uncapped Utilisation	0 - Total	Dec-24	81.24%	85%	-3.76%	74.12%	75.91%	81.24%		
Outpatient	Diagnostic - Percentage Patients Waiting <6 Weeks Test	0 - Total	Dec-24	80.03%	95%	-14.97%	76.22%	84.16%	80.03%		
Outpatient	RTT - 65+ Week Waits	0 - Total	Dec-24	28			606.39	374	28		
Outpatient	RTT - 78+ Week Waits	0 - Total	Dec-24	0			267.52	39	0		
Outpatient	RTT - Waiting List Size	0 - Total	Dec-24	21868			19797.89	21067	21868		
UEC	ED - Ambulance Handovers Average (Minutes)	0 - Total	Dec-24	26.67	30	-3.33	14.28	28.39	26.67		
UEC	ED - DCH 4 Hour Performance %	0 - Total	Dec-24	52.4%	70%	-17.60%	69.11%	60.17%	52.4%		
UEC	ED - ED Attendances % Waiting 12+ Hours	0 - Total	Dec-24	11.89%	7.91%	3.98%	4.33%	8.91%	11.89%		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Dec-24	74.9%	78%	-3.10%	81.79%	76.57%	74.9%		
UEC	Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occup...	0 - Total	Dec-24	19.94%			20.95%	18.21%	19.94%		
UEC	Inpatient - Average Number of No Criteria to Reside Patients	0 - Total	Dec-24	63	38	25.00	75.82	55	63		

For the reporting month of December 2024, 8 out of 15 metrics were special cause variation of an improving nature, 1 were common cause variation and 6 of a declining nature.

The 31-day cancer indicator did not achieve the target. The assurance is hit or miss for the 31-day standard, which occurs when the target lies between the process limits. For December, the trust achieved the 62-day treatment standard and the 28 day to diagnosis standard, with strong performance at DCH in recognised by the Region.

The two theatre utilisation indicators have improved, both capped and uncapped theatre utilisation is special cause of an improving nature, but with an assurance rating of fail, with the process not capable and will continue to fail the target without process redesign. In the latest national performance upload, DCH has moved to quartile 3, the second-best quartile and fourth in the Region. DCH is highlighted in black in the graph below. In the same reporting period, DCH were the second best in the country (best in the Region) for the percentage of time lost due to an early finish. The trust also benchmarked well for late starts, performing in the best quartile and 3rd best in the Region.

The percentage of patients waiting 6 weeks or less for a diagnostic procedure has improved and with consistent improvements for the last few months, it is showing as special cause of an improving nature but with assurance of fail. Cardiology has further reduced their backlog, but endoscopy has seen an increase in breaches, so the bottom-line improvement isn't as large as planned.

In terms of the elective waiting list, the number of patients waiting over 65 and 78 weeks is special cause variation of an improving nature as the cohort of patients that have been waiting the longest, continues to reduce. The size of the waiting list in November and December hit the trajectory, as set out in the operating plan, as activity levels are now higher than the growth in referrals.

Average ambulance handover times have increased since the last Board reporting, the indicator is special cause of a concerning nature however, and with an assurance of pass, the process is capable of consistently passing the target. Performance of the ED 4-hour standard all (including MIUs) is special cause variation of an improving nature, with no significant changes and the process will continuously hit or miss the target. Performance fell in December and did not achieve the national planning guidance target of 78%.

Full details of this and all metrics within the performance dashboard, are covered in the Finance and Performance Committee.

**Narrative provided by Adam Savin, Director of Operational Planning and Performance.*

5) People dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Growing for our Future	Essential Skill Rate	0 - Total	Dec-24	88%	90%	-2.00%	88.83%	90%	88%		
Looking After our People	Appraisal rate	0 - Total	Dec-24	76.69%	90%	-13.31%	75.7%	77.3...	76.69%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	Nov-24	4.42%	3.75%	0.67%	4.03%	4.55%	4.42%		
Looking After our People	Staff Turnover Rate	0 - Total	Dec-24	9.35%	12%	-2.65%	9.68%	10.8...	9.35%		
Looking After our People	Vacancy Rate	0 - Total	Dec-24	3.31%	5%	-1.69%	6.62%	6.3%	3.31%		

- Essential skills rate remained at 88%, 2% below target
- Appraisal rate remained at 76%, remaining below target
- Vacancy rate increased to 3.3% but remains better than the target
- Turnover remained at 9.4% and remains better than target
- Sickness rate reduced to 4.4%, above the target

Essential skills remained at 88%, 2% short of achieving the target. At present this is common cause variation with no significant change, although due to the fluctuating nature of this indicator, the assurance classification remains as fail, without process redesign. Recovery plans are underway in the four training elements where individual compliance is under 80%. The increase in appraisal rate which occurred in Month 5 is being sustained, but the percentage has plateaued. The overall appraisal rate in Month 9 was 76%, this remains common cause variation with no significant change. The assurance classification remains as fail, without process redesign. Wider work on the appraisal and talent management processes is underway as part of the People Promise Exemplar Programme. Both the turnover and vacancy rates remain unchanged in month, the indicators remain special cause of an improving nature, with processes capable of consistently passing the targets. Sickness absence (reported one month in arrears) reduced to 4.4%, but remains above target, indicating special cause of a concerning nature, although the trend matches the usual seasonal pattern of absences. There has been an encouraging reduction in long term sickness over the past quarter.

**Narrative provided by Emma Hallett, Deputy Chief People Officer.*

6) Finance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure	0 - Total	Dec-24	1454	2921	-1,467.00	1944.09	2045	14541		
Capital	Cash Position	0 - Total	Dec-24	3664	6099	-2,435.00	8304.67		3664		
Revenue	Adjusted Financial Position	0 - Total	Dec-24	-1593	947	-2,540.00	-330.71	-1074	-11813		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Dec-24	14.55%			22.83%	20.25%	14.55%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Dec-24	2.56%			6.89%	6.32%	2.56%		
Value Board	Agency Spend	0 - Total	Dec-24	414.26	807	-392.74	991.34	1003	5235.8		
Value Board	Efficiency Delivery	0 - Total	Dec-24	660	1400	-740.00	243.41	405	5207		
Value Board	Off Framework Agency Spend	0 - Total	Dec-24	21	83	-62.00	87.81	74	234		

Adjusted Financial Position (against control total)- Overspend against planned deficit position linked to increased Insourcing due to 65 ww and activity above originally planned levels, unachieved CIP, costs supporting Industrial Action, inflationary RPI costs above planned levels, pay award shortfall, 33% increase for drugs specifically Gastro, Derm and blood thinner drugs being patient specific, catering incl provisions, laundry and utilities/rates, redundancies incurred, offset by agency improvement against plan although slowing pace and medical cover for sickness. Broadly in line with RAFOT trajectory delivery for M9.

Agency Spend- Nursing agency improvement with medical locum usage Ophthal, Anaest, Obs & gynae curbed in December however expected to resume in January. Nursing challenging patient specialing and cover for SCBU, ED and Stroke. Medical agency usage escalated to SRO CMO for enhanced oversight and action plans.

Off Framework Agency Spend- Decreases in usage of Off Framework noting areas of essential usage reviewed and limited to Emergency Department, Critical Care, Kingfisher paediatric ward and Special Care Baby Unit (SCBU), aligned to national off framework removal expected from July 2024 - break glass protocol only in use.

Efficiency Delivery- Significant delivery in month with focus on low & medium risk schemes for delivery, especilay security and income generation schemes having been delyed delayed (Dir of E&F action plan focus) offset by Covid related cost savings in month and cost reduction linked to agency improved spend against plan. Deep dive report presented to October F&PC and weekly update report to Recovery Group.

Cash- 23/24 ERF payment received along with pay award funding paid out and HEE income for January. National revenue support received in April totalling £1.5m with further request submitted for February noting December and January requests were declined, Board approved pending national outcome. Continued risk of cash shortfall expected Q4 and beyond pending 25/26 allocations.

Capital Expenditure (total)- Behind plan due to NHP enabling works timing, offset by internally funded schemes ahead of plan (Ridgeway, East Wing and medical equipment purchases timing).

*Narrative provided by Claire Abraham, Deputy Chief Financial Officer.

7) All metric glossary

MetricName	MetricDescription
Cancer - 28 Day Faster Diagnosis Standard Performance	Percentage of patients meeting the 28 day faster diagnosis cancer standard (from referral to point where given an all clear or confirmed diagnosis). Sourced from Somerset Cancer Register (SCR).
Cancer - 31 Day Decision to Treatment Standard Performance	Percentage of patients meeting the 31 day decision to treatment cancer standard (based Treatment for DCH treated patients). Sourced from Somerset Cancer Register (SCR).
Cancer - Patients Waiting 62+ Days from Referral to Treatment	Number of patients waiting longer than 62 days from cancer referral to treatment following a screening service referral. Sourced from the DCH Manual Data Collection Portal via the Cancer Team.
Complaints - Formal Complaints Received	Number of formal and complex complaints raised based on received date. Sourced from Datix.
Diagnostic - Patients % Waiting < 6 Weeks for Diagnostic Test	Percentage of Patients waiting less than 6 weeks for a diagnostic test in line with DM01 methodology. Sourced from DM01 Monthly Position.
ED - Ambulance Handovers Average (Minutes)	Average DCH ambulance handovers in Minutes against 30 Minute Average Target. Sourced from ED SWAST information.
ED - DCH 4 Hour Performance %	Percentage of patients with an unplanned DCH Emergency Department visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS.
ED - ED Attendances % Waiting 12+ Hours	Percentage of patients with an unplanned DCH Emergency Department visit lasting longer than 12 hours. Excludes patients marked as streamed. Sourced from ED Agyle/PAS information.
ED - Overall 4 Hour Performance %	Percentage of patients with an unplanned Emergency Department/MIU visits lasting longer than the 4 hour peformance standard. Sourced from ED Agyle/PAS and MIU information.
Finance - Adjusted Financial Position	Finance Spend (£000) Adjusted financial performance surplus or deficit. Sourced from Finance team.
Finance - Agency Spend	Agency Spend (£000). Sourced from Finance team.
Finance - Capital Expenditure	Capital Expenditure (£000). Sourced from Finance team.
Finance - Cost Position	Cash position of the Trust (£000) noting this is a key risk area for 2024/25. Sourced from the Finance Team.
Finance - Efficiency Delivery	Paid CIP (£000) for efficiency delivery. Sourced from Finance team.
Finance - Local Supplier % of Catering Spend	Percentage of catering spend with local suppliers. Sourced from the Procurement team.
Finance - Local Supplier % of Total Spend	Percentage of total spend with local suppliers. Sourced from the Procurement team.
Finance - Off Framework Agency Spend	Off Framework Agency Spend (£000). Sourced from Finance team.
Friends and Family - Overall % Recommendation Rate	Percentage of overall Friends and Family recommendation. Sourced from the Patient and Public Experience team.
Incidents - Confirmed Never Events	Number of occurances of confirmed Never Events based on updated date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Falls Resulting in Severe Harm or Death by Reported Date	Number of occurances of falls catagorised as severe or death severity of harm caused, based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Medication Incidents by Reported Date	Number of occurances of medicine incidents based on reported date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Pressure Ulcers Reportable Confirmed Avoidable and Hospital Acquired (Category 3) by Reported Date	Number of occurances of hospital acquired (confirmed) category 3 pressure ulcers by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Incidents - Serious Incidents Investigated and Confirmed Avoidable by Panel Date	Number of occurances of serious incidents investigated and confirmed avoidable by panel date excluding any rejected or duplicated incidents. Sourced from Datix.
Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	Number of occurances of hospital onset healthcare associated Clostridium difficile (C. diff) incidents by specimen date. Sourced from HCAI data.
Infection Control - Gram Negative Blood Stream Hospital Onset Infections	Number of occurances of hospital onset gram negative blood stream infection incidents by specimen date. Sourced from HCAI data.
Inpatient - Adult General and Acute (G&A) % No Criteria to Reside Bed Occupancy	Percentage of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS /
Inpatient - Average Number of No Criteria to Reside Patients	Number of total adult G&A beds occupied (as per reported in UEC Daily SitRep) by No Reason To Reside (NRTR) patients (as per reported in EPPR Daily Discharge SitRep). Original source PAS /
Inpatient - EDS % Available < 24 Hours of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 24 hours of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - EDS % Available < 7 Days of Discharge	Percentage of electronic discharge summaries (EDS) available for GPs to access within 7 days of discharge from an inpatient spell. Sourced from EDS reporting, original source ICE / PAS.
Inpatient - Emergency Re-Admissions % (1 month in arrears)	Percentage of emergency re-admissions to hospital within 30 days of previous admission. Excludes patients under the age of 16 on original admission. Sourced from Emergency Readmission
Inpatient - SHMI Value (5 months in arrears)	Ratio result of Summary Hospital-level Mortality Indicator (SHMI) which reports applicable deaths within hospital, or within 30 days post discharge against expected (does not include Covid related deaths). Results show the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of
RTT - 65+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 65 weeks or longer. Sourced from PAS.
RTT - 78+ Week Waits	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment for 78 weeks or longer. Sourced from PAS.
RTT - Waiting List Size	Number of referral to treatment (RTT) patients on an admitted or non-admitted pathway waiting to start treatment. Sourced from PAS.
Theatres - Capped Utilisation	Percentage of planned theatre sessions that were utilised, based on Capped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Theatres - Uncapped Utilisation	Percentage of planned theatre sessions that were utilised, based on Uncapped methodology for theatres within a Day Surgery or Main Theatres location. Sourced from Theatre Reporting, original source PAS.
Workforce - Appraisal rate	Percentage of applicable appraisals completed within time frame expected. Sourced from Workforce team.
Workforce - Essential Skill Rate	Percentage of applicable essential skills completed within time frame expected. Sourced from Workforce team.
Workforce - Sickness Rate (1 month in arrears)	Sickness Rate. Full Time Equivalent (FTE) sick / FTE Days Available. Source ESR.
Workforce - Staff Turnover Rate	Percentage showing staff turnover rate based on a 12 month rolling view. Sourced from Workforce team, original source ESR.
Workforce - Vacancy Rate	Percentage showing Trust vacancy rate (budgeted FTE minus staff in post). Excludes positions with a frozen or proposed Hiring Status, positions with Org Level 2 of Honorary, Widows & Widowers, Dump Posts, Volunteers or Nurse Bank, positions with a Cost Centre of Nursing Relief Pool RN or HCA, and positions noted as Registered Nursing Degree Apprentices. Sourced from ESR.

Report to	Board of Directors – Part 1	
Date of Meeting	11th February 2025	
Report Title	DCH Finance Report – Month 9 2024/25	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	n/a	
Action Required	**Approval**	
	Assurance	Y
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR6: Finance Identify risks and mitigations associated with plan delivery, financial sustainability	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	System financial plan delivery	

Executive Summary

Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a break even plan to NHS England (NHSE) on 10th June 2024 for the financial year 2024/25.

Key Messages

Month nine delivered a deficit of £1.6 million after technical adjustments, being £2.5 million away from plan of £0.9 million surplus. The year to date position is £7.3 million away from the reported plan standing at an actual deficit of £11.8 million. This position is however broadly in line with the Trusts risk adjusted forecast outturn trajectory plan of a £11.5 million planned deficit position.

Insourcing above original planned phased levels; ongoing challenges with drugs; an increase in computer licence costs and shortfall in efficiency delivery against planned levels have driven the worsening of the position in month.

The risk adjusted forecast outturn by year end remains intact noting the highlighted risks and focus on identified mitigating actions. Active dialogue is underway with system partners and the national team with regards to the outcome of the overall risk adjusted forecast outturn (RAFOT) delivery position, with a verbal update to be provided to the Committee noting this fast paced changing landscape.

Factors driving the year to date overspend remain as previously reported: costs supporting Industrial Action; other high drugs costs specifically for Gastroenterology, Dermatology, Rheumatology, Pediatrics and blood products which are largely patient specific. Costs supporting operational pressures including levels of patients with no criteria to reside, and inflationary RPI costs above planned levels are being incurred for provisions, catering, laundry and utilities.

The Trust continues to see increased patient acuity throughout the month with escalated beds used in the region of 18, and circa 49 no criteria to reside (NCTR) patients being supported which were captured at the end of December (not average).

Agency expenditure has continued at lower than budgeted levels, with total month spend of £0.4 million split across Nursing areas and medical agency cover for sickness and vacancies in Ophthalmology, Anesthetics and Obs & Gynae specialties.
Break glass Off Framework expenditure is being incurred each month, with £0.02 million incurred in month nine resulting in £0.3 million year to date, with NHS England expecting nil Off Framework spend from July 2024.

An estimated income position for elective recovery funding (ERF) following the national baseline target revision to 109% for Dorset has been included in the position in line with NHSE methodology.

The Trust wide efficiency target for the year stands at £14.4 million and is circa 5% of expenditure budgets in line with peers and national planning expectations.
The target has been identified in full with year to date delivery at 36% of the target being £5.2 million, however efficiency delivery remains a significant risk for the Trust in achieving the break even plan for the year, as detailed in the deep dive report presented to the Committee recently. Progress against planned delivery has significantly picked up pace since month eight with a renewed focus required in order to deliver the identified schemes in the latter parts of the financial year.

Capital expenditure for month nine is behind plan at £1.5 million due to timing of equipment purchases. Year to date spend is £14.5 million and behind plan by £6.5 million largely due to NHP enabling works offset by internal schemes being ahead of plan by £0.6 million, both due to timing.

The cash position to December amounts to £3.7 million, being ahead of expected forecast due to timing of supplier payments made.

Cash remains a high risk area for the Trust with modelling indicating further cash support will be required for the remainder of the financial year and beyond pending 2025/26 funding allocations.

The national revenue support request submitted for December and January for £1.4 million of cash support and £1.5 million of working capital, was rejected by the national team due to the reported variance against financial plan year to date. The Trust has lobbied this decision and subsequently submitted a revenue support request for February, with the Trust awaiting the outcome of this request at the time of writing. A verbal update will follow for the Committee. In anticipation of a third rejection in national revenue support, the Trust is actively agreeing mitigations with system partners.

Key Actions

- The Trust is actively deploying targeted recovery actions to ensure mitigations and corrective steps are in place for all overspending areas in order to support delivery of the break even position by year end, noting significant challenges associated and risk to delivery of this as outlined in the report. A weekly Executive led DCH Recovery Group is driving mitigating actions to tackle the risks to the position.

- Target areas include Non clinical bank pay; Facilities incl non pay & provisions; external security; medical additional sessions and medical agency usage; theatre utilisation, NCTR and escalation beds.

- Efficiency support meetings led by CFO ongoing with all areas, overseen by Value Delivery Board
- Working group in place to recover WTE to March 2023 levels overseen by Executive led SRO and DCH Recovery Group meeting, noting a staged approach to recover to March 2024 levels in the first instance (3470 WTE)
- Ongoing daily cash monitoring – cash shortfall risk in Q4 with ongoing efficiency delivery essential in line with planned levels and grip and control paramount
- Agency monitoring continues with medical focus escalated to CMO
- Capital programme monitoring noting over subscription and current internal programme overspend.

Recommendation

The Board of Directors are recommended to:

1) Received the report for **Assurance,** noting the month nine financial position for the financial year 2024/25 and associated risk to delivering the break even position with key recovery actions taking place.

NHS
Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2024/25

December 2024 - Month 9

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

Financial Position Update - December 2024

Executive Summary

Dorset County Hospital NHS Foundation Trust

A summary of progress is presented for the period of December 2024 and is compared with the re-phased plan submitted on 10th June 2024 to NHS England (NHSE).

In December 2024, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a month 9 deficit of £1.6 million after technical adjustments, an adverse performance of £2.5 million against the revised plan of £0.9 million surplus.

This overspend in month has been driven by; increased insourced activity including 65 ww investment and inflationary RPI costs above planned levels for provisions, catering, laundry, utilities and drugs, specifically Gastroenterology, Dermatology and blood products. The Trust has also seen heightened operational pressures and increased patient acuity throughout the month, including continued specific pressure around Mental Health patients and increased use of off framework agency. Escalated beds at the end of the month were 18 with circa 49 no criteria to reside (NCTR) patients being supported. Agency expenditure has maintained a reduction against 2023/24 totals due to the impact of the agency rate reduction and increase in substantive recruitment, however ongoing medical rota gaps across ED, General Medicine and Urology are being covered at higher rates than budgeted.

The Trust wide efficiency target for the year stands at £14.4 million and is circa 5% of expenditure budgets in line with peers and national planning expectations. The programme is fully identified however contains 47% of high risk schemes. Delivery to date stands at £5.2 million. This is c£3.9 million behind phased plan of delivery to month 9. In addtion to this delivery, contributing cost avoidance and cost reduction is now being detailed (£2.7 million YTD). Efficiency delivery remains a significant high risk for the Trust with laser focus required from all responsible officers to deliver schemes as planned.

Pay is over plan mainly due to the 2024/25 pay award including backdated payments for months 1-9, impact of this pay award has not been included in the plan figures. Others areas above plan include increase in successful registration of training nurses and the national/system agreed increase of Band 2 to Band 3 Agenda for change movement. Agency usage to cover vacancies and to support operational pressures has continued, albeit at a lower rate than previous months. Non pay is over plan due to high consumable costs including drugs and activity volumes linked to recovery of elective services in conjunction with heightened inflationary pressures.

The Trust is progressing with the capital programme for 2024/25, month 9 YTD spend totalling £14.5 million, a net £6.5 million behind rephased plan due to underspends on externally funded projects. Externally funded projects are £5.9 million behind plan due to the changes in the spend profile of the New Hospital Programme (NHP) enabling works. Purchases of IFRS16 Leases are a further £0.8 million behind plan but the internally funded and donated projects are ahead of plan by £0.2 million relating to early spend on East Wing Theatre and 2023/24 rollover spend on Ridgeway. There is significant pressure on the internally funded programme this year due to works on the two significant Estates schemes (Chemo and East Wing Theatre) and high demand for backlog works and medical device replacement.

The cash position as at 30 December was £3.6 million, £2.4 million behind plan due to the YTD deficit position and delay to CIP achievement. The Trust requested and was granted £1.5m of national revenue support received in April and has requested a further £4.1m of cash support in February as modelling indicates a cash shortfall by the end of the year, noting the December and January national revenue support request was rejected by NHSE. Alternative arrangements are being discussed with system partners at pace.

Financial Position Update - December 2024

Key Risks

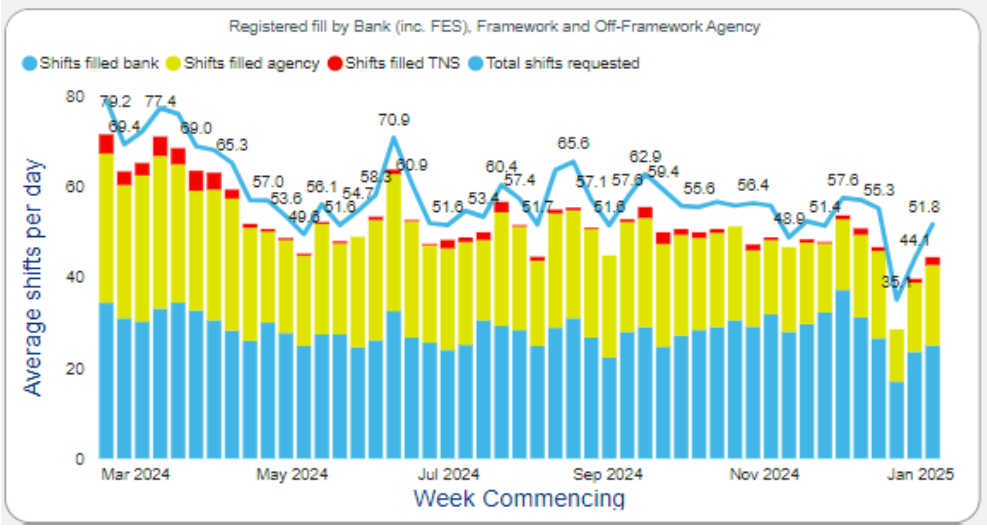
Dorset County Hospital NHS Foundation Trust

Red Risks:

The Trust has an efficiency delivery requirement of £14.4 million in order to reach the planned full year break even position. The target is now fully identified, however £6.8 million of the this is made up of High Risks schemes (47%) including workforce review and productivity stretch. Without continued development of these schemes, the Trust's deficit position will worsen. Efficiencies delivered non recurrently where recurrent is expected will also negatively impact the Trusts underlying deficit position.

The Trusts approach to efficiency delivery is led by the Value Delivery Board. This is designed to reinforce the accountability and deliverables of programmes across the Trust.

Agency expenditure has improved since last year due to a combination of factors including system agency rate reduction and vacancy level decreases. NHSE mandated all off framework agency spends to cease completely from July 2024. The Trust has managed to largely achieve this, with the exception of Mental Health escalation requirements. This has resulted in the Trust exceeding it's FYE reduction of £1 million on spend, which currently stands at £2.1 million. The opening of Portisham Ward to support the extreme pressures seen in ED has also seen an impact on the usage of agency since month 5. Active plans in place as part of the internal High Cost Agency Reduction group, which is primarily focusing on nursing, are continuing to help prevent further deterioration of the position against plan and begin to work further on medical agency and locum spend. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust is beginning to increase bank usage whilst decrease agency usage (maintaining patient and staff safety and quality levels). Agency notice has now reduced to 48 hours in order for Bank Staff to access the shifts in the first instance. So far, this has not impacted fill rates.



Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Key Risks

Dorset County Hospital NHS Foundation Trust

Red Risks:

Financial Forecast Risk

There is a risk of delivering the break even position. Drivers include supporting industrial action, patient specific high drugs costs, escalated bed base and operational pressures, agency usage, efficiency under delivery and inflationary costs above planned levels. The Trust is actively deploying targeted support towards recovery and mitigations, led by the CFO and supported by the wider Executive team in order to mitigate the risk to financial balance with stretch targets agreed for efficiencies, productivity and agency to the end of the financial year.

System Elective Services Recovery - income performance

The government has made Elective Services Recovery Funding (ESRF) available to each Integrated Care Board (ICBs) to eventually achieve around 30% more elective activity than was achieved before the COVID-19 pandemic. The financial year 2024/25 national target aims to reach 109% of the activity levels seen in 2019/20 (pre-pandemic).

Dorset County Hospitals target is set at 104% of 2019/20 Elective Activity and as a Dorset system has an ambition to reach 109% of its 2019/20 activity, this will be to alleviate some of the financial pressures within the system and reducing the size of the Dorset waiting list.

National ESRF calculations will not be available until later in Q3 to inform actual ESRF payments. Estimated ESRF payments will be calculated using the NHSE methodology used to inform lost ESRF payments due to Industrial Action in 2023/24. This methodology applies an average tariff by point of delivery for the count of elective activity over or under the baseline.

Cash Position

There is a risk to cash levels throughout the year due to deficits in the first 9 months of the year and challenging efficiency targets. This risk has been highlighted to NHSE with a request for additional Provider Revenue Support successful for April, with £1.5 million drawn down in the form of Public Dividend Capital, and a further request in progress of £4.1m submitted for February. A December and January request for cash was rejected on the basis of unachievement against YTD financial plan, CIP delivery and Workforce reduction, discussion is ongoing with the regional team to work through this to aid a positive outcome for the February request. In the meantime cash is scrutinised daily and the Trust has agreed some principles with Dorset ICB to facilitate earlier payments to reduce the cash risk. Ongoing mitigating solutions include review of local payment terms and driving income collection at pace will continue to be used to minimise this risk. System conversations to request support are also still active on this subject.

Internally Funded Capital

The Trust is set a capital envelope each year which details the maximum internally funded capital spend allowed by the Trust (£7.4 million). Due to significant demands on the capital programme this year there is a risk of exceeding this envelope. The 2024/25 Estates schemes include two large projects (Chemo and East Wing Theatre) plus roll over spend from 2023/24 on Ridgeway and there are significant digital projects also ongoing in year. Consequently there is limited capital budget available for backlog and medical device replacements which are now becoming urgent and unavoidable, resulting in over subscription against the internally funded capital programme. The Capital Planning and Space Utilisation Group (CPSUG) has collated a priortised and risk scored list from each area to actively oversee, identify and manage this risk.

Dorset County Hospital
NHS Foundation Trust

Key Risks

Amber Risk:

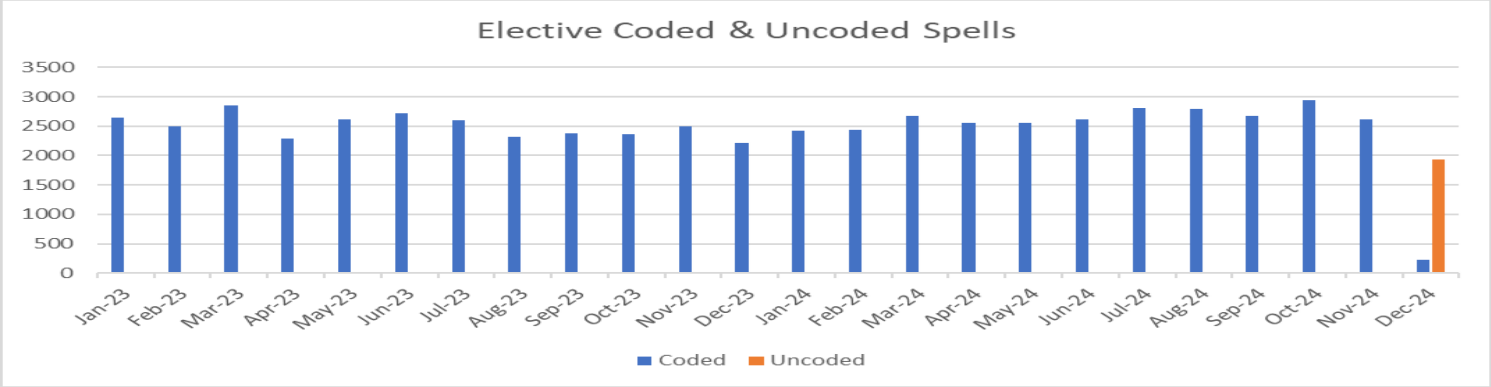
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable element. The variable element of the contract will cover most elective activity: Elective Inpatients, Day cases, Outpatient First Attendances, Outpatient Procedures, Chemotherapy delivery and Diagnostics.

An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National Tariff. Any underperformance against baseline will be repaid at 100% of the national tariff and any over performance will be received at 100% of the national tariff.

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any elective activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at December 2024 the Trust has 4,519 uncoded spells,1,956 are for Elective activity and 2,563 are for Emergency. As demonstrated in the graph below, there is a 2 month lag at the end of each period where coding is completed to meet the applicable freeze dates. Based on coding trends captured over a two year rolling period, no significant coding issues have been incurred.



2024/25 Flex Freeze Dates

Month	Flex	Freeze
Apr-24	20 May 24	19 Jun 24
May-24	19 Jun 24	17 Jul 24
Jun-24	17 Jul 24	19 Aug 24
Jul-24	19 Aug 24	18 Sep 24
Aug-24	18 Sep 24	17 Oct 24
Sep-24	17 Oct 24	19 Nov 24
Oct-24	19 Nov 24	17 Dec 24
Nov-24	17 Dec 24	20 Jan 25
Dec-24	20 Jan 25	19 Feb 25
Jan-25	19 Feb 25	19 Mar 25
Feb-25	19 Mar 25	17 Apr 25
Mar-25	17 Apr 25	20 May 25

Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Financial Position Update - December 2024

Recovery Plans

Dorset County Hospital NHS Foundation Trust

Weekly Executive Recovery Group meeting established with Targeted Service Areas and Recovery Plans
- Weekly Senior Leadership recovery meetings are taking place with specific focus areas
- Recovery plans for overspending areas are identified, with focus on strong cost controls and identification and removal of avoidable costs. Possible mitigations to be considered with additional governance support to evidence efficient working processes
- Regular messaging about Financial position and required efficiency focus is being provided at Divisional Managers weekly meeting, Value Delivery Board and Senior Leadership Group
- Analysis of non-clinical bank pay is taking place with plans to reduce spend in this area
- Other key focus area's include; facilities including non pay & provisions, external security, medical additional sessions, medical agency usage, along with theatre utilisation, NCTR and escalation beds

Income recovery
- Maximise private patient income and ERF income within insourcing budget
- Review activity coding for completeness

Workforce measures
- Strong recruitment controls in place, formal Exec approval needed from weekly Recruitment Control Panel
- Working group in place to recover WTE to March 2023 levels overseen by Exec led SRO - a staged approach has been adopted with recovery back to March 2024 levels (3470 WTE) by year end
- Agency monitoring continues with medical focus escalated to CMO

Investment Reviews
- Review prior investments to gain understanding and assurance that expected benefits will be delivered, reconsider continuation if necessary
- Review investments in progress, ensure in-year benefits or recognised high risk drivers. Current investments paused, while financial implications for 2024/25 are considered

CIP and efficiencies
- CFO CIP support meetings ongoing with all areas, overseen by Value Delivery Board
- Meetings with all areas in train with focus on identified into delivery, all low and medium schemes to be delivered
- Active system recovery meetings in train with unpalatables under review
- Update to progress of Medium and Low risk schemes is reported back to the Recovery Group every week

Cash
- Ongoing daily cash monitoring and weekly cashflow review
- Timely invoicing and early and effective debt collection
- Revenue Support request has been submitted for February (December and January rejected)
- Ongoing discussion with Dorset ICB to ensure all cash payments are received without delay
- System conversations to request support are also still active on this subject.

Financial Position Update - December 2024
Income & Expenditure

NHS
Dorset County Hospital
NHS Foundation Trust

Income and Expenditure

The overall revenue position is a £1.6 million in month actual deficit, £2.5 million adverse to plan after technical adjustments. The YTD position is £6.4 million away from plan. Increased insourced activity, along with continued inflationary pressures drive this. CIP achievement in month was c£700k behind plan, however c£3m behind plan YTD.

The Operating Income from patient care activities in month variance is due to; out of contract income, estimated month 1 - 9 Elective Services Recovery Fund (ESRF) income and high cost drugs income offset with expenditure.

Pay costs are over plan due to pay award including backdated payments, supporting industrial action in quarter 1, ongoing bank and agency usage covering vacancies, sickness and supporting operational pressures, noting increased patient acuity and a number of patients requiring mental health support. December has seen a continued improved trend in agency costs against 2023/24 levels, however an increase to the last quarter of last year due to high risk Mental Health patients treated in July and a small peak again in September and again in October. The large pay variance is offset largely by income received for externally funded posts - an exercise is currently underway to transfer budget to the appropriate pay lines. The impact of the recent pay award is still being reviewed and discussed with Commissioners.

Non pay is over plan due to ongoing above plan drugs costs, inflationary pressures, in particular energy, catering supplies, maintenance contracts, laundry and blood products. Drugs specifically in Gastro have off patent drugs are expected to come into use towards the end of the year to start addressing this area of continued overspend.

Recovery plans are underway with all overspending areas to ensure mitigations are applied to support recovery of the adverse position.

STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)		
	Budget	Actual	Variance	Budget	Actual	Variance
Operating income from patient care activities	22,026	23,874	1,848	197,257	212,719	15,462
Private Patients	87	53	(33)	780	725	(54)
Other clinical revenue	37	532	495	333	1,677	1,344
Other non-clinical revenue	2,033	1,307	(726)	18,005	20,099	2,094
Operating Income	**24,183**	**25,767**	**1,584**	**216,374**	**235,220**	**18,845**
Total Income	**24,183**	**25,767**	**1,584**	**216,374**	**235,220**	**18,845**
Raw materials and consumables used	(3,173)	(4,511)	(1,338)	(32,918)	(41,538)	(8,620)
Employee benefit expenses:						
Substantive	(14,021)	(15,855)	(1,834)	(126,403)	(140,772)	(14,370)
Bank	(730)	(1,144)	(414)	(7,661)	(9,659)	(1,998)
Agency	(833)	(414)	419	(7,559)	(5,256)	2,303
Other operating expenses (excl. depreciation)	(2,988)	(4,025)	(1,037)	(32,917)	(36,871)	(3,954)
Operating Expenses	**(21,745)**	**(25,950)**	**(4,205)**	**(207,459)**	**(234,097)**	**(26,638)**
Profit/(loss) from Operations (EBITDA)	**2,438**	**(182)**	**(2,621)**	**8,916**	**1,123**	**(7,793)**
Other Non-Operating income (asset disposals)	(4)	10	14	(6)	20	26
Total Depreciation and Amortisation	(1,035)	(1,034)	1	(9,317)	(9,315)	2
PDC Dividend expense	(408)	(408)	(0)	(3,674)	(3,674)	(0)
Total finance income	20	56	36	196	626	430
Total interest expense	(64)	(71)	(7)	(580)	(566)	14
Total other finance costs	(0)	(1)	(1)	(£0)	(£2)	(2)
SURPLUS/ (DEFICIT)	**947**	**(1,631)**	**(2,578)**	**(4,465)**	**(11,788)**	**(7,323)**
Technical Items Adjusted for:						
Donations Non-Cash Assets	(40)	2	42	(360)	(346)	14
Depreciation Donated Assets	40	36	(4)	360	321	(39)
SURPLUS/ (DEFICIT)	**947**	**(1,593)**	**(2,540)**	**(4,465)**	**(11,813)**	**(7,348)**

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Financial Position Update - December 2024
Risk Adjusted Forecast Outturn

NHS
Dorset County Hospital
NHS Foundation Trust

RAFOT Narrative
There is currently a risk to the delivery of the break even plan for financial year 2024/25. For the Dorset system this is circa £25m away from submitted deficit plan of £20m noting active discussions are underway with both NHSE and system partners to review and improve upon this position where possible. The year to date position for the Trust is off plan by £7.3 million and there remains significant ongoing pressures in the latter part of the financial year specifically in relation to high risk efficiency scheme delivery (£6.8m), ongoing drugs growth, inflationary challenges and bed levels above those initially planned for noting operational pressures. Costs supporting Industrial action have not been fully offset by the national funding allocation available leaving a shortfall which also contributes to the deficit position. A number of mitgations have been identified and are being closely monitored through the Trusts weekly Executive led DCH Recovery Group. This is an active area of focus both locally and nationally, with updates taking place at a substantial pace. Currently outline plans are being worked through to support the Trust to deliver a break even position however not without risk. This is under review at present.

	Position to Month 9		
Organisation	**M9 YTD plan**	**M9 position**	**YTD Variance to plan**
DCHFT	(4.5)	(11.8)	(7.3)

Forecast Outturn 24/25 £m	**DCHFT**
Forecast deficit driven by:	
Impact of Industrial Action	(0.1)
ERF above 107.2% to ICB plus 65ww	(2.7)
Inflation not in plan/FYE RPI contracts	(2.3)
Drugs pressures	(6.0)
NCTR/cost of cover	(4.1)
Efficiency Shortfall risk	(6.8)
Increased consumables/IMS TBC/computer licences	(1.4)
Agency improvement offset	2.3
CIP delivered YTD	5.2
Total Forecast Deficit Excl mitigations (worst case):	**(15.9)**
Potential Mitigations (best case):	
CIP delivery (low & med)	2.8
Insourcing FOT recovery	0.3
Expediate catering, commercial & private patient income	0.3
Further agency improvement stretch	1.0
Catering/facilities pay expenditure review	0.4
Expediate staff car parking	0.2
Benchmarking & Model Health opportunities/procurement	0.2
Partially mitigate ERF risk	0.8
Cost controls - PO/non discretionary spend actions plus 10 CIP sche	1.0
2024/25 forecast, with mitigations	**(9.0)**
Planned Surplus/(Deficit)	**0.0**
Total 2024/25 forecast risk, with mitigations	**(9.0)**

Expanded Risk Adjusted Forecast continued:

Total 2024/25 forecast, with mitigations	**(9.0)**
Further Stretch:	
Federated model/system opportunities	2.0
Joint working/collaboration	1.0
Revised Total 2024/25 forecast, with mitigations	**(6.0)**
TBC route to £25m:	
Asset valuation/bal sheet review (min scope DCH)	1.0
Stretched performance	1.0
Total 2024/25 with TBC mitigations	**(4.0)**
System adjustment	4.0
Total 2024/25 with TBC mitigations	**(0.0)**

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Financial Position Update - December 2024
Industrial Action

Dorset County Hospital
NHS Foundation Trust

2024/25 Industrial Action
Costs incurred in June and the initial part of July supporting Industrial Action amount to £0.196m with a further £0.255m estimate of lost activity income. Of which, for July reporting purposes, £0.062m of net staff cost and an estimated £0.102m of lost activity income were incurred. For DCHFT, June & July 2024 the combined net cost & lost elective recovery activity is estimated at £0.4m. This total estimated cost covering the full industrial action period during June and July has been reported to NHS England (NHSE) as part of national reporting requirements. In M6 NHS England notified Trusts of their Industrial Action funding envelopes, Dorset County Hospital received £0.272m leaving an unfunded pressure of £0.137m.

2024/25 Industrial Action Staff Group	Junior Doctors £'000	Junior Doctors £'000	Total £'000
Strike Date	***27-30 Jun***	***1-2 July***	
Immediate backfill costs to cover services	*£118*	*£78*	**£196**
Offset by Salary Savings	*-£25*	*-£17*	**-£42**
Net Cost	***£92***	***£62***	**£154**
Number of Industrial Action Days	*3*	*2*	5
Estimate of Lost ERF Activity	*£153*	*£102*	**£255**
Net Cost & ERF Income Loss	**£245**	**£164**	**£409**
Estimated Cost Per Day £'000	£82	£82	£82

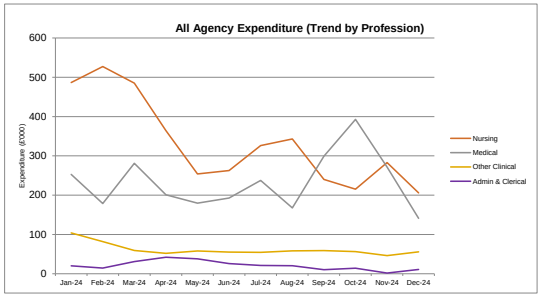
	£'000
Industrial Action partial funding received	£272
Net cost & ERF income loss due to IA	£409
Industrial Action funding shortfall/cost pressure	**-£137**

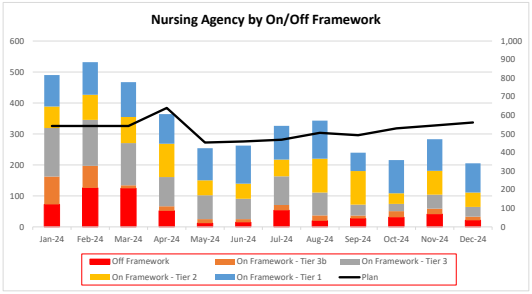
Rescheduled Elective Inpatients	6	4	**10**
Rescheduled Day Case Activity	77	51	**128**
Reschedule Outpatient Appointments	362	241	**603**

Financial Position Update - December 2024
Trust Wide Performance: Agency

NHS
Dorset County Hospital
NHS Foundation Trust

Pay Analysis - Agency
Agency costs equated to £0.4 million of actual expenditure in month against a plan of £0.8 million, showing a c£0.1 million decrease on last month . This lower spend was largely due to reduced Mental Health interventions and some one of in month reductions in medical agency spend.
Agency expenditure remains over the 3.2% of total pay NHSE target set for 2024/25 YTD, to 3.4% of pay budgets - however, these has been steadily decreasing over the last few months and achieving the target in month.
Although there is continued improvement in agency expenditure, ED remains an area of focus to reduce spend, which is supported through the safer staffing and high cost agency working groups.
Agency reduction remains a high priority for the Trust noting expected achievement of the NHSE applied System spend cap of 3.2% of pay budget for 2024/25 and the mandation of no use of Off Framework from 1st July 2024 with a break glass procedure adopted to maintain essential safety only.
System collaborative workstreams including a 15% agency rate reduction being applied from 2nd January 2024 by all organisations which has driven the improved position in conjunction with a decrease in overall vacancies for the Trust. A further % rate reduction was applied as a system from the end of March 2024.





Agency Spend by Profession (£'000)	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD Actual	YTD Plan	Variance
Nursing	487	527	485	364	254	263	326	343	240	215	283	206	2,494	4,660	2,166
Medical	253	179	281	201	180	193	238	167	299	393	271	141	2,083	2,009	-74
Other Clinical	104	82	59	52	58	55	54	58	59	56	46	56	495	600	105
Admin & Clerical	20	15	31	42	38	26	21	21	10	14	2	11	185	290	105
Totals 2023/24 & 2024/25 YTD	**864**	**802**	**856**	**659**	**530**	**536**	**639**	**589**	**608**	**679**	**602**	**414**	**5,256**	**7,559**	**2,302**

Nursing Agency Category	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Off Framework	73	126	125	52	12	15	54	20	27	31	41	21
On Framework - Tier 3b	90	71	10	15	13	10	17	17	10	20	18	12
On Framework - Tier 3	157	148	136	94	77	66	93	74	35	23	45	31
On Framework - Tier 2	69	81	84	107	48	49	54	109	108	34	77	46
On Framework - Tier 1	102	105	113	96	104	123	109	123	59	107	102	94
Plan	543	543	543	640	454	460	469	506	493	530	546	562
Orders awaiting allocation	0	0	0	0	0	0	0	0	0	0	0	0
Totals 2023/24 & 2024/25 YTD	**487**	**527**	**485**	**364**	**254**	**263**	**326**	**343**	**240**	**215**	**283**	**206**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	2.4%	3.4%
Off framework expenditure as % of total agency	5.2%	4.8%

Areas Using Nursing Agency Including Off Framework YTD (£'000)

Area	On Framework	Off Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	44	438	36	482	19%
Moreton Ward - Respiratory	2	228		229	9%
Day Surgery Unit	4	218		222	9%
Purbeck Wd	0	179		179	7%
Lulworth Ward	2	138	0	140	6%
Abbotsbury Ward	18	119	27	137	6%
Stroke Unit	16	118	36	134	5%
Ilchester Integrated Assessment	2	128	2	131	5%
CRCU	42	85		126	5%
Fortuneswell Ward	1	101		103	4%
Kingfisher Ward	58	46	3	104	4%
The Mary Anning Unit	2	78	6	79	3%
SCBU	81	-		81	3%
DCH Dialysis	-	60		60	2%
Frailty SDEC	0	56		57	2%
Ridgeway Wd	0	55		55	2%
Eversho Ward	1	51		50	2%
Prince Of Wales	1	43		44	2%
Theatre Suites	-	32		32	1%
Cardiology Care Ward	2	28		30	1%
Surge Area	-	9		9	0%
SDEC	0	5		6	0%
B'Mth Dialysis	-	3		3	0%
Discharge Team	-	1		1	0%
	-	-			
Total Nursing Agency YTD	**273**	**2,221**	**110**	**2,494**	

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Financial Position Update - December 2024

Insourcing

NHS
Dorset County Hospital
NHS Foundation Trust

Insourcing Narrative

The insourcing budget of £7.2 million is planned to; support the reopening of Weymouth Theatre, provide insourcing activity set via FPC at beginning of the year, fund substantive roles in ENT and Ophthalmology.

All substantive posts are now recruited to including within theatres, however there is an additional Medinet team in place in Weymouth to assist with training of new recruits. This is however temporary and this support will cease once training is complete.

Further executive approval to spend an additional £1.550m has been agreed to support delivery of 65 ww. Currently the forecast trajectory shows total spend of £9.1m which is circa £0.345m above the allowable expenditure. Key discussions are taking place to ensure actions to bring back in line with plan and deliver in line with £8.8m target.

The Trust is required to achieve a minimum of 104% of activity against the 2019/20 baseline, estimated delivery in December shows a trajectory of 114% achievement, although noting the associated non recoverable cost of delivering this activity.

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Outturn
Budget:	**788**	**788**	**905**	**827**	**827**	**654**	**457**	**450**	**445**	**445**	**446**	**212**	**7,243**
Spend:													
Breast	19	13	13	13	13	14							**85**
Cardiology	7												**7**
Dermatology	151	115	142	117	151	157	131	134	98	98	115	135	**1,544**
Endoscopy/Gastro	113	99	115	114	146	129	101	104	100	72	87	108	**1,290**
ENT	9	47	48	48	72	49	98	214	148	85	85	67	**971**
General Surgery	0	0	94	114	109	92	172	48	55	81	47	47	**858**
Gynaecology	95	99	83	78	129	83	76	74	61	54	54	0	**886**
OMF	152	174	120	33	114	110	119	63	108	75	75	194	**1,337**
Ophthalmology	26	44	31	90	35	35	18	59	4	4	4	4	**354**
Orthopaedics	52	83	62	52	88	78	43	97	62	83	83	104	**889**
Urology			2	32	48	16	13	5					**117**
Vascular						1							**1**
Pre Assessment						10	6	(15)					
Peads Surgery							33						
Theatre Staffing						102	202	135	82	82	82	82	**767**
Total spend	**625**	**674**	**712**	**691**	**906**	**875**	**1,012**	**918**	**718**	**634**	**632**	**741**	**9,139**
Surplus/(Deficit)	**162**	**114**	**193**	**135**	**(80)**	**(221)**	**(555)**	**(468)**	**(273)**	**(189)**	**(186)**	**(529)**	**(1,895)**

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Financial Position Update - December 2024
COVID Expenditure

NHS
Dorset County Hospital
NHS Foundation Trust

Covid Narrative
Covid spend has remained consistent over the last two months at c£70k during November and December. Onging underspends have meant YTD total CIP from COVID is c£0.582 million. Covid funding has reduced for 2024/25 (from £2.3 million) and all areas will be reviewed for only reasonable and expected Covid related costs - some of which have further been identified this month (i.e. additional cleaning). The Trust has reviewed its external security provision and is in the final stages of recruiting to an internal provision, however there has been a spike of external usage in month due to challenging patients. This roaming usage ceased from 7th October 2023, with ward based insourcing security trialed during November. This has proven succesful and with the exception of some mental health patient support, noting external ward costs have fallen.

	Description	2023/24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	YTD
Plan:		**£2,287**	**£211**	**£211**	**£209**	**£208**	**£205**	**£203**	**£199**	**£195**	**£190**	**£1,831**
Expenditure:												
Pay	Substantive	£282	£1	£1	£14	£34	£9	£9	£11	£10	£9	£89
	Bank	£108	£0	£3	£7	£0	£0	£0	£0	£4	£1	£14
	Agency	£1	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Pay		**£391**	**£1**	**£4**	**£21**	**£34**	**£9**	**£9**	**£11**	**£14**	**£10**	**£113**
Non-pay	Clinical Supplies and Services	£223	£32	£4	£22	£26	£52	£0	£91	£26	£26	£253
	General Supplies and Services	£0	£0	£0	£8	£5	£6	£4	£2	£2	£10	£28
	Establishment Expenditure	£6	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
	Other Non-Pay (security)	£472	£22	£21	£21	£23	£47	£15	£40	£14	£23	£203
	Premises and Fixed Plant	£162	£12	£12	£12	£3	-£12	£1	£0	£8	£0	£35
Total Non-pay		**£863**	**£65**	**£38**	**£62**	**£57**	**£93**	**£20**	**£133**	**£51**	**£59**	**£578**
Total Expenditure		**£1,254**	**£66**	**£41**	**£83**	**£91**	**£102**	**£29**	**£144**	**£65**	**£69**	**£691**
Total Surplus/(Deficit)		**£1,033**	**£145**	**£170**	**£126**	**£117**	**£103**	**£174**	**£55**	**£130**	**£121**	**£1,140**

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Financial Position Update - December 2024
Sustainability & Efficiency

Dorset County Hospital NHS Foundation Trust

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is circa 5% which equates to £14.4 million for the financial year.

In month delivery of c£0.7 million has been achieved, £0.040 million coming from agency cost reduction of Off Framework and the remainder largely from finance review savings (£0.175 million YTD savings) and pay slippage. YTD delivery stands at c£5.2 million (including £2.1 million of agency cost - for Off Framework reduction). This is c£3 million behind plan YTD. £2.7 million of cost avoidance schemes have also been achieved YTD (Reduction of agency usage against 2023/24 levels).

£7.1 million has been planned as fully identified schemes and in progress.
The remaining £6.8 million of schemes have now been identified as high risk (47%) and are yet to deliver any savings. Theses schemes have been identified and linked to workforce reviews, non recurrent delivery opportunities, pay sickness review and productivity.

Efficiencies identified so far include further Covid reduction against plan, procurement savings, corporate savings, non recurrent slippage against existing planned budgets, agency spend reduction and pharmacy review savings.

This programme of work has been shared with the Dorset System with collaborative opportunities being actively assessed and reviewed with focus on flow, bed usage noting improvements to productivity are essential, supported by System partners.

Efficiency by Division	Plan (excl Central Distribution)	Identified High Risk	Identified Medium Risk	Identified Low Risk	Total Identified
Family & Surgical Services	1,029		217	812	1,029
Urgent & Integrated Care	1,099		138	961	1,099
High Cost Agency & Off Framework Reduction	1,300			1,300	1,300
Finance, Estates & Facilities	1,350	100	647	603	1,350
Trust Wide Central Schemes Review	1,145		1,145		1,145
Non Recurrent Scheme Review	646		646		646
COVID Savings	500			500	500
Digital	339		339	-	339
Corporate	125			125	125
Private Patient Income	47		47		47
Human Resources	38		31	7	38
Workforce	24		24		24
Nursing	9		3	6	9
WTE Reduction	3,918	3,918			3,918
Productivity - CANDo etc	2,800	2,800			2,800
Grand Total	**14,369**	**6,818**	**3,237**	**4,314**	**14,369**

Total as at November 2024	**14,369**	**6,818**	**3,237**	**4,314**	**14,369**

Plan YTD	Actual YTD	% Achieved (FY Plan)
683	944	92%
737	992	90%
627	2,163	166%
840	386	29%
718	-	-
627	-	-
313	582	116%
208		0%
77	151	-
29		-
27	7	0
199		
10	7	77%
2,456		-
1,555	-	-
9,106	**5,232**	**36%**

9,106	

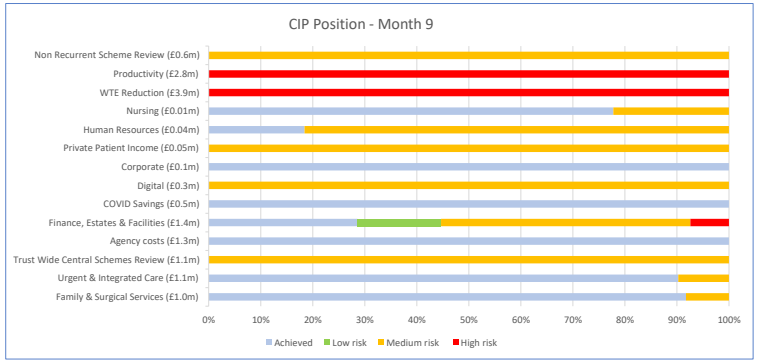
Scheme Status	Sustainable Workforce £'000	Productivity £'000	Variation £'000	Operational Efficiency £'000	Total £'000
Delivered	2,197		451	2,584	**5,232**
Identified - in progress			341	1,335	**1,676**
Identified - not started				643	**643**
Identified Stretch Targets (High Risk):					
Workforce WTE Review	3,918				**3,918**
Property leases Review				100	**100**
Productivity		2,800			**2,800**
Total CIP 5%	**6,115**	**2,800**	**792**	**4,662**	**14,369**

Cost Avoidance Schemes	£ Avoidance YTD
Family & Surgical Services	**1,102**
Income - Non-Patient Care	-
Pay - Agency - reduce the reliance on agency	1,102
Pay - Establishment reviews	-
Urgent & Integrated Care	**1,661**
Income - Non-Patient Care	
Non-Pay - Procurement (excl drugs)	126
Pay - Agency - reduce the reliance on agency	1,513
Admissions Avoidance	22
Pay - Establishment reviews	-
Grand Total	**2,763**

Total as at November 2024	**2,763**

Efficiency Plan	£'000	%	No of Schemes
Recurrent			
Pay	5,205		17
Non Pay	1,972		22
Income	230		16
Total Recurrent	**7,406**	**52%**	**55**
Non Recurrent			
Pay	2,338		24
Non Pay	4,306		23
Income	319		10
Total Recurrent	**6,962**	**48%**	**57**

Grand Total	**14,369**



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Financial Position Update - December 2024

Cash

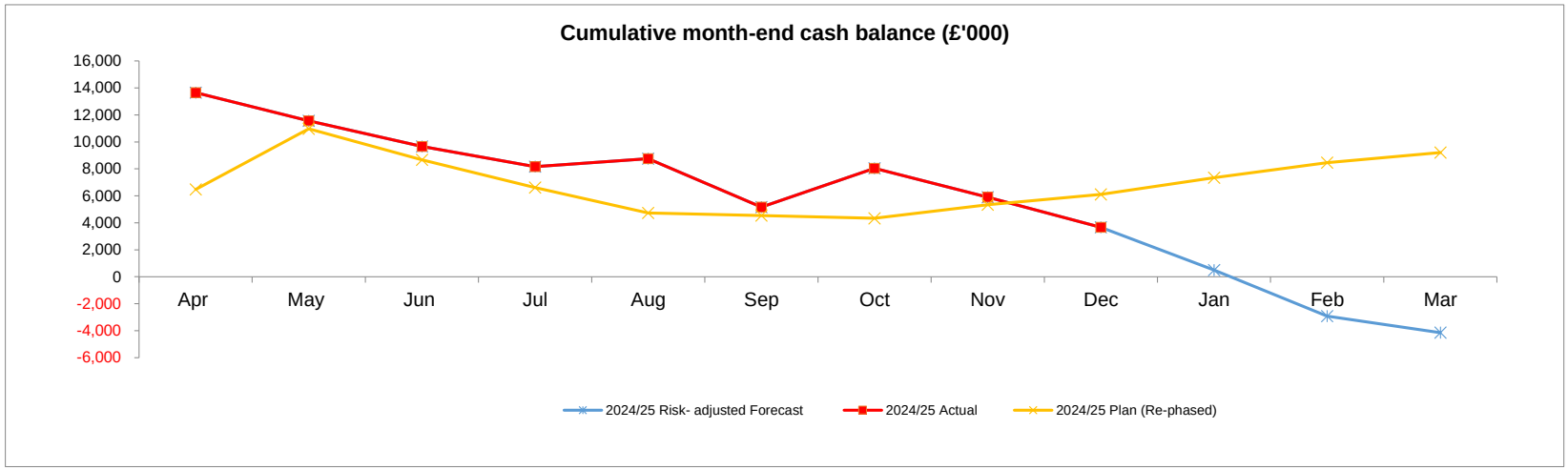
Cash Balance incl Forecast

The graph shows the trajectory of the actual year to date and forecast cash balance during the year, with identified direct intervention taking place to mitigate the shortfall in cash.

The cash position is currently £3.7 million at end of December, which is ahead of forecasted position of £3.4 million. Cash being £0.3m ahead of forecast relates to the timing of supplier payments.

The Plan assumed full delivery of the efficiency programme, however due to year to date slippages against these schemes, the Risk-adjusted forecast highlights cash shortfalls if delivery of schemes is not achieved. The CFO is leading regular support meetings to deliver all low and medium rated efficiency schemes, in conjunction with expediated system conversations regarding options for cash support.

The Trust received the first instalment of revenue support funding in April totalling £1.5m which supports the repayment of working capital. A subsequent request was made to NHSE for a further £2.9m cash support in December and January given the risk-adjusted forecast modelling, however this was rejected by the national team. A further request for £4.1m was submitted for February with the outcome expected 7th February 2025. Plans are being drawn up with system partners in the event of further rejection, including a proposed early drawdown of £3m ICB funding.



Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2024/25 Plan (Re-phased)	6,479	10,972	8,661	6,607	4,727	4,543	4,337	5,334	6,099	7,337	8,466	9,201
2024/25 Risk- adjusted Forecast										501	-2,920	-4,146
2024/25 Actual	13,650	11,566	9,660	8,164	8,752	5,158	8,037	5,901	3,664			

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Financial Position Update - December 2024

Capital

Dorset County Hospital
NHS Foundation Trust

Capital Programme Narrative

Capital expenditure year to date to the end of December was £14.5 million and behind plan by £6.5 million.

Internally Funded schemes and donated schemes are overall behind plan at the end of December by £0.6 million.

Digital and Medical Equipment Schemes were behind plan year to date due to timing of the purchase of replacement items.

Estates schemes are ahead of plan year to date due to timings of expenditure on East Wing Theatres and Ridgeway Ward, which has carried over from 2023/24.

There is a significant requirement for internally funded capital for both backlog works and medical device replacements, which is putting pressure on the programme of works as requests become urgent and unavoidable. All areas have provided an updated and prioritised list of works for review, including appropriate consideration and action.

In September, the Trust received confirmation from NHS England of external capital funding for the Colposcopy Service totalling £0.6 million. In December the Trust received notification from NHS England of external capital funding for Critical Infrastructure Risk of £0.3 million.

Externally Funded capital expenditure was £5.9m behind plan due to timings of expenditure on New Hospital Programme (NHP) enabling works.

Given the Trusts capital programme is over-subscribed, this is being closely monitored and overseen by Capital Planning & Space Utilisation Group (CPSUG) to ensure risks and priorities are managed appropriately throughout the year with all opportunities and slippage maximised.

Due to the significant capital projects and level of high risk demands on capital there is a risk that the Trust will overspend on Internally Funded schemes in year without careful and appropriate consideration.

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CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2024/25			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Chemotherapy Unit	224	146	78	1,648	331	1,317	1,932	1,932	1,932	0
East Wing Theatre	0	2	(2)	450	1,413	(963)	1,527	1,527	0	(1,527)
Estates Schemes	**39**	486	(447)	**1,150**	2,677	(1,527)	1,802	1,818	1,650	(168)
Digital Services										
Digital Schemes	**153**	152	1	**1,768**	1,322	446	1,630	1,630	2,291	661
Equipment										
East Wing Theatre Equipping	0	0	0	295	100	195	319	319	295	(24)
Other Equipment	295	31	264	973	556	417	240	240	1,272	1,032
Sub-Total Internally Funded Expenditure	**711**	**818**	**(107)**	**6,284**	**6,399**	**(115)**	**7,450**	**7,466**	**7,440**	**(26)**
Donated										
Other Donations	0	0	0	0	31	(31)	21	21	0	(21)
Chemotherapy Unit Refurbishment	60	0	60	240	316	(76)	459	459	480	21
Sub-Total Planned Donated Expenditure	**60**	**0**	**60**	**240**	**347**	**(107)**	**480**	**480**	**480**	**0**
IFRS 16 Lease Additions										
Warehouse	0	0	0	480	546	(66)	546	546	480	(66)
MSCP Lease remeasurement	0	0	0	1,000	266	734	266	496	1,000	504
CEF Lease remeasurement	0	0	0	600	408	192	408	408	600	192
One Dorset Pathology	0	0	0	0	0	0	0	750	250	(500)
Accommodation & Vehicle Lease Additions	59	20	39	150	220	(70)	220	280	150	(130)
Sub-Total Planned IFRS 16 Expenditure	**59**	**20**	**39**	**2,230**	**1,440**	**790**	**1,440**	**2,480**	**2,480**	**0**
Total Internal & Leased Capital Expenditure	**830**	**838**	**(8)**	**8,754**	**8,186**	**568**	**9,370**	**10,426**	**10,400**	**(26)**
Additional funded schemes										
NHP Development	0	67	(67)	758	1,109	(351)	1,249	1,511	758	(753)
NHP Works	2,000	0	2,000	6,000	0	6,000	0	2,435	12,819	10,384
NHP Enabling	0	496	(496)	4,660	4,684	(24)	4,823	4,837	4,660	(177)
Digital EHR Funding	91	45	46	518	399	119	534	1,093	1,093	0
CDC Funding	0	0	0	16	15	1	16	16	16	0
Mental Health UEC Funding	0	0	0	257	0	257	0	0	257	257
Colposcopy	0	8	(8)	0	88	(88)	103	608	0	(608)
Critical Infrastructure	0	0	0	0	0	0	0	300	0	(300)
Inventory Management System (pending)	0	0	0	0	30	(30)	30	30	0	(30)
Total Externally Funded Capital Expenditure	**2,091**	**616**	**1,475**	**12,209**	**6,325**	**5,884**	**6,755**	**10,830**	**19,603**	**8,773**
Total Capital Expenditure	**2,921**	**1,454**	**1,467**	**20,963**	**14,511**	**6,452**	**16,125**	**21,256**	**30,003**	**8,747**
Expenditure as a % of Plan			50%			69%				71%

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Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meeting held on Monday 27 January 2025

Chair: Dave Underwood	**Executive Lead:** Chris Hearn Rachel Small	**Date of Next Meeting:** Monday 24 March 2025
Quoracy met?	Yes	
Purpose of the report	To assure the Board on the main items discussed by the People and Culture Committee in Common and, if necessary, escalate any matter(s) of concern or urgent business which the Finance and Performance Committee in Common is unable to conclude.	
Recommendation	To receive the report for **assurance**	

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Nil to note
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: **Joint Workforce KPI Dashboard (DCH / DHC)** <u>Dorset County Hospital</u> • Overall agency spend reduced in Month 9; overall WTE reduced in Months 8 and 9 and a reduction of 110.28 WTE is still required by the end of Month 12 to meet the revised WTE plan; Mutually Agreed Resignation Scheme (MARS) in progress with an update to be provided in March 2025. • Overall essential Skills compliance increased to 88% in November and has remained at that level in December. Four subjects below the 80% lower threshold and specific recovery plans in place. • Increase in appraisal rate which occurred in August is being sustained, overall appraisal rate in Month 9 was 76%. • Overall sickness percentage increased in month 7 (October) but decreased again in month 8 to 4.4%. The rolling year figure is 4.2% - encouraging reduction in long term sickness since August but short-term absence has increased during the same period. • The vacancy and turnover rates remain stable, at 3.3% and 9.4% respectively. • Contract costs reducing around Occupational Health <u>Dorset HealthCare</u> • Vacancy factor is 6.3% and has reduced from last month's position (7.1%), moving us to below the lower threshold of process limits.

- Sickness absence rate for December 2024 was 5.8%, which is a marginal increase from the position reported in November 2024 (5.7%). Reducing sickness absence rates remains a key workstream within the Workforce Delivery Framework.
- Slight decrease in completed appraisals this month from 86.7% to 85.4%.
- Mandatory Training compliance had a decrease of 0.1% to 93.13%.

DHC Workforce Delivery Framework (WDF) Update (DHC)

- The workforce delivery framework sets out the priorities and associated actions to enable the delivery of the People Strategy 2020 - 2025.
- Dorset County Hospital do not currently have a comparable report. With the development of the new joint People Plan there will be an aligned update report on the action plan going forward.
- Six key workstreams (reduced from 8 the previous year) - key successes and updates were provided against six key workstreams.
- A new joint People Plan is in development, and it will have an associated action plan. Some of the ongoing actions from current WDF will transfer to the new joint action plan.

Equality Delivery System 2 (DCH / DHC)

- The toolkit comprises eleven outcomes spread across three Domains.
- Agreed that alignment of approach across DCH and DHC going forward, recognising that the actions arising may be different.
- Agreed further informal discussion required on approach across broader EDI and Health Inequalities agenda.

Dorset County Hospital

- The assessed outcomes were overall 'Developing' and by domain:
  - Commissioned or Provided Services – Achieving
  - Workforce and Health and Wellbeing - Developing
  - Inclusive Leadership - Developing
- Received assurance on action plan in place.
- Approved the EDS2 Action Plan for publication with assurance to Board via this report.

Dorset HealthCare

- The assessed outcomes were overall 'Developing' and by domain:
  - Commissioned or Provided Services – Achieving
  - Workforce and Health and Wellbeing – Achieving
  - Inclusive Leadership - Developing
- Received assurance on action plan in place.
- Approved the EDS2 Action Plan for publication with assurance to Board via this report.

Sexual Safety Update (DCH/DHC)

- In September 2023, NHS England launched sexual safety charter. DHC and DCH have signed the charter. Signatories commit to taking and enforcing a zero-tolerance approach and to ten core principles and actions.

- In October 2024, NHS England launched a new policy and supporting assurance framework together with an e-learning resource.
- Report received to provide an update on the collaborative action plans across both Trusts to implement the commitments of the charter and the recommendations from the new national policy, assurance framework and learning resources.
- DCH and DHC reported a RAG rated action plan. Noted some differences in approach to reporting and assessment which will be aligned for next reporting period.

Board Assurance Framework (DCH/DHC)

- Two risks assigned to this Committee:
  - SR2 Culture
  - SR3 Workforce

Dorset County Hospital

- No changes in scores and small number of actions overdue with revised plans in place. No updates were proposed by the Committee.

Dorset HealthCare

- No changes in scores and small number of actions overdue with revised plans in place. No updates were proposed by the Committee.

Corporate Risk Register (DCH/DHC)

- Noted that there is a plan to align the approach to reporting across both Trusts, including the threshold for reporting to Committee.

Dorset County Hospital (reporting risks scoring 15 and above)

- Noted no new risks scoring 20+ and one risk scoring 15+ had been added to the Corporate Risk register (with 1 existing risk scoring 20+ and 15 risks scoring 15-19)
- Noted that risk scoring 20+ related to digital staffing should be raised with the Strategy Transformation and Partnership Committee as it had been open since 2021.

Dorset HealthCare (reporting risks scoring 12 and above)

- Noted no new risks scoring over 12 reported in the period. There are 16 risks scoring 12+ and 6 risks scoring 15+.
- Two relevant risks have been closed in the period.
- Noted that a number of risks were overdue for review and an escalation process has been followed and reminders sent.

CAMHS High Intensity Unit Staffing (DHC)

- Reflected on the original request from Board and noted that it is too early to provide an update on this. Agreed that it will be brought back when recruitment is underway, and this will be added to the PCC workplan and recommend that it is closed as a Board action.

Assurance Reports from Sub-Groups (DCH/DHC)

Dorset County Hospital

	• DCH Partnership Forum Meeting 20 November 2024 • DCH Health and Wellbeing Steering Group 21 November 2024 • DCH Local Negotiating Committee 27 November 2024 <u>Dorset HealthCare</u> • DHC Equality Diversity and Inclusion Steering Group 12 December 2024 • DHC Trade Union Partnership Forum 9 January 2025
Decisions made at the meeting	• Approved the DCH EDS2 Action Plan for publication with assurance to Board via this report. • Approved the DHC EDS2 Action Plan for publication with assurance to Board via this report. •
Issues / actions referred to other committees / groups	• Corporate Risk relating to Digital Staffing (DCH Risk 1152) referred to Strategy, Transformation and Partnership Committee

Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on 29 January 2025

Chair	David Clayton-Smith, Chair
Executive Lead	Nick Johnson, Chief Strategy, Transformation and Partnerships Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework

- Receipt of the **Board Assurance Framework**, noting a reduction in the score for SR7 Collaboration. SR9 Digital Infrastructure score to be reviewed and expected to increase. An update would be provided to each trust's Audit Committee and Board meetings.
- Receipt of the **Corporate Risk Register**, noting that digital risks have been highlighted in a number of recent committee meetings, particularly in relation to the lack of progress on a number of mitigations.
- Broad discussions about the state of **digital capability and capacity** with a number of recommendations identified to address this.
- A number of items approved by the committee, as detailed below.
- Presentation regarding the **Benefits from Adopting a Culture of Continuous Improvement on the Special Care Baby Unit**, demonstrating the benefit that the work that the committee oversaw was making to patients and families, and highlighting the benefits of working with other teams and trusts to make service improvements.

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

- **One Transformation Approach Development Overview and Portfolio Updates**, highlighting:
  - That the approach offered an attempt to ensure that transformation was aligned to the trusts' strategic direction, deploying capacity where it was needed, and tracking benefits of joint working.
  - The opportunities for joint working and developing joined up pathways
  - A recommendation for the committee to endorse the move of frailty programme to be moved in to the Urgent and Emergency Care programme
  - Capacity constraints in the team, and concerns from committee members that there are too many transformational workstreams at present, particularly within the context of limited capacity. A continuous need to manage priorities.

- **Place and Neighbourhoods Portfolio: Integrated Neighbourhood Team Programme Business Case** noting:
  - The ambition to create a multidisciplinary, integrated neighbourhood team comprised of community, mental health and primary care services, with a view to improving the provision of care for patients. The proposal aligned with national policy.
  - Funding for the programme would be sought from the Integrated Care System, not from either trust.
  - Broad support from committee members and staff. Some queries about implementation of the programme, particularly in relation to digital capacity, where financial savings would be made and the involvement of acute trusts in the programme.
  - Business case was approved by the committee.
- **Portfolio Deep Dive: Working Together Portfolio**, highlighting the milestone plan, progress of the enabling plans, the communication and engagement plan, and the roadmap for the joint strategy implementation. The progress of the support services review was also highlighted.
- **Working Together Portfolio: Strategy Dashboard** was not yet ready for presentation as it was still in development. The need to balance mental health, community, and acute, and the importance of getting the metrics right was highlighted. Expected to present to the next committee in common.
- **Patient Carer Race Equality Framework (DHC)**, which was described as a national anti-racism framework developed in recognition of the inequality in access and outcomes of minority communities. A cross-cutting transformation workplan had been developed to meet the requirements of the framework.
- **Equality Delivery System 2 (EDS2)** which was now mandatory and was the only place in which health inequalities and protected characteristics were considered together. The report outlined the progress being made and the rich learning in place but recognised that there were areas for development. The Health Inequalities groups would be utilised to make improvements and to bring health inequalities in to leadership development. Committee members noted the need to more strongly reflect the patient view.
- **New Hospital Programme Update**, noting that the contract for the DCH NHP has been signed with Tilbury Douglas. Work will start on 3rd March and changes to the way the hospital site works would be felt but mitigations to manage this were in place.
- **Digital Capacity and Capability DCH and DHC**, outlining the current position and the historical context that had contributed to that position. In both trusts there were significant 'business as usual' backlogs with demand outstripping supply. The report made a number of recommendations to improve the position, and the committee reflected

	on the need for greater, more strategic investment in to digital and technology.
	• **Impact of contractual issues with Strategic Supplier (Fortrus)**
	• **Assurance Reports** were received from the following:
	  ○ Information Governance (DCH)
	  ○ Sustainability Working Group (DCH)

Decisions made at the meeting	• Approval of the Equality Delivery System (EDS2) • Approval of the Integrated Neighbourhood Team Programme Business Case • Approval of the recommendations in the Quality Governance Committee in Common – Plans for Implementation. DHC Quality Committee to consider whether the Guardian of Safe Working should report in to the Quality Committee or People and Culture Committee.
Issues / actions referred to other committees / groups	• DHC Quality Committee to consider whether the Guardian of Safe Working should report in to the Quality Committee or People and Culture Committee

Quoracy and Attendance						
	24/09/2024	**27/11/2024**	**29/01/2025**			
Quorate?	Y	Y	Y			
David Clayton-Smith	Y	Y	Y			
Andreas Haimboeck-Tichy	N	Y	Y			
Frances West	Y	Y	Y			
Dave Underwood	Y	Apols	Y			
Claire Lehman	Y	Y	Apols			
Chris Hearn	Y	Y	Y			
Nick Johnson	Y	Y	Y			
Dawn Dawson	Y	Y	Y			
Nicola Plumb	Y	Y	Y			
Forbes Watson	N	Y	Y			
Becky Aldridge	Y	Y	Y			

Report to	Dorset County Hospital Board of Directors	
Date of Meeting	11th February 2025	
Report Title	Joint Strategy Implementation Update	
Prepared By	Paul Lewis – Director of Strategy & Improvement	
Approved by Accountable Executive	Nick Johnson - Deputy Chief Executive DCH Joint Chief Strategy, Transformation and Partnerships Officer	
Previously Considered By	Joint Transformation & Improvement Board 20 Jan 25	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	**Yes**	~~No~~
Colleagues	**Yes**	~~No~~
Communities	**Yes**	~~No~~
Sustainability	**Yes**	~~No~~
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	The Joint Strategy implementation is directly linked to the BAF	
Financial	The Sustainabilty strategic objective encompasses finance	
Statutory & Regulatory	The Dashboard metrics will generate a focus in this area	
Equality, Diversity & Inclusion	The Colleagues strategic objective encompasses ED&I	
Co-production & Partnership	Co-production and Partnership are embodied in the strategy and part of the published strategic principles	

Executive Summary

The Joint Strategy and implementation plan was approved in September 2024. It set the strategic direction for Dorset County Hospital and Dorset HealthCare for the next five years and beyond. This report aims to assure the Board that implementation is in progress in line with the approved plan. Risks are understood and being managed, and appropriate oversight and governance is in place.

The Joint Strategy, set the overall direction of the federation and 4 components are in place to embed the strategy. These are, the Culture, Communications and Engagement (CCE) plan, the One Transformation Approach (OTA), the Joint Improvement Framework (JIF) and the Enabling Plans.

The CCE brings the strategy to life to support colleagues across the Federation to understand the impact of the joint strategy on their work and actively contribute to its successful delivery

The OTA is in implementation and consists of 4 portfolios:

- Place & Neighbourhoods – Integrated Neighbourhoods Teams and Frailty
- Mental Health – Access Wellbeing and CYP Mental Health
- Sustainability – Our Dorset Provider Collaborative
- Work Together – implementation of this strategy, Electronic Health Record, Support Services review and New Hospital Programme

When designing the OTA and the associated portfolios, the alignment of portfolios to the strategic objectives was considered (i.e. the portfolios are the strategic objectives). However, as the relationship between transformation programmes and projects and the strategic objectives are not linear, and the purpose of portfolios is not to include all activity related to delivery of the strategic objectives, this is not appropriate.

The JIF aims build on existing good work and support the federation to become a recognised improving organisation. The goal is to Inspire, Empower and Enable our staff, the people we serve and partners to improve in ways that are meaningful to them.

As intended, the Enabling Plans are in development with a view for approval in March 2025. The plans build on the joint strategy and add detail that will allow staff to more easily understand the changes we seek. The Enabling Plans are, Clincial & Quality, Digital, People, Finance and Infrastructure. Currently, it is expected that due to potential developments in the Digital Dorset approach the Digital Plan will be delayed.

To measure progress and impact, a joint strategy dashboard is in development. Good progress has been made, with some measures and metrics being finalised. This is due for approval in February/March 2025. A draft version is attached at Appendix 1.

In addition to the Dashboard, a Strategy Roadmap covering a 3-year period from 25/26, accompanied by a more detailed Strategic Plan for 25/26, is in development and will be presented at the next STP CIC. This will need to also consider recent Planning Guidance, the new NHS Long-term Plan and the changing external environment.

While there was a rigorous process to agree priorities for the OTA, a key risk is the capacity of the federation to carry out so much concurrent change. In an evolving and changing environment ongoing prioritisation is required and an updated plan for 25/26 will be brought to March STP CiC. There is also risk that more staff enagement is needed with the Enabling Plans, particularly the Clinical & Quality plan. The ongoing operational pressures and general volume of work prevent the level of engagement which would ideally be required. Good staff engagement in the development of the plans is directly linked to their appetite and motivation to make the changes necessary. While enagement has been in progress for a while, the time set aside has been limited to meet the March 2025 deadline. To mitigate this risk, some of the plans may need to be reviewed.

To receive updates, set direction, oversee and govern implementation, there is a working group, the Joint Transformation & Improvement Board and the Strategy, Transformation and Partnerships Committee in Common. This structure has been in place for a few months and is bedding in. The implementation of this approach has been hindered by the restriction in recruitment and so benefits realisation and impact reporting are limited.

Recognising the importance of clinically led transformation a Clinical Reference Group is also in place: This is multi-disciplinary and across the Trust. Further discussion on this group, alongside how best to ensure clinically focussed transformation, is required with the new CMO leadership across the Federation.

In summary the Joint Strategy implementation is progressing well. The 4 major delivery initiatives are in progress and in development as planned. Two risks have emerged; clinical engagement and organisational capacity. Appropriate oversight and governance is in place.

Finally, it is recognised that currently the main focus of the strategic updates is on process and structure. This is not unusual at this stage of a strategy cycle. Likewise, key transformation programmes will take time to implement and pay-off. Nevertheless, it is understandable that there are ongoing requests from multiple parties to demonstrate the difference being made. A regular case study item from members of staff is now being presented to the STP CiC. Subject to time being made available a Board Development session will be used to showcase a number of case studies, and the Strategy and

Transformation teams continue to include benefits and impact in reporting albeit this is limited due to resource constraints.
Recommendation
Members are requested to receive the report for **assurance**

Joint Strategy Implementation Update

1. Executive Summary

1.1. The Joint Strategy and Implementation Plan for Dorset County Hospital and Dorset HealthCare was approved in September 2024, setting the strategic direction for the next five years. This report assures the Board that implementation is progressing as planned, with clear governance structures in place and risks being actively managed.

1.2. The strategy is underpinned by four key components: the Culture, Communications, and Engagement (CCE) plan, the One Transformation Approach (OTA), the Joint Improvement Framework (JIF), and the Enabling Plans. These components work together to align and embed the strategic objectives, with a focus on engaging staff and partners in meaningful improvements.

1.3. The OTA is already in implementation and consists of four portfolios: Place & Neighbourhoods, Mental Health, Sustainability, and Work Together, each focused on delivering key transformation goals. The JIF builds on existing work to create a culture of continuous improvement across the Federation. Enabling Plans, including Clinical & Quality, Digital, People, Finance, and Infrastructure, are being developed and are expected for approval in March 2025, though delays are anticipated in the Digital plan due to ongoing changes in the Digital Dorset approach.

1.4. A strategy dashboard is being developed to track progress and impact, with a final version set for approval in early 2025. A Strategy Roadmap and detailed Strategic Plan for 2025/26 are also being developed, aligned with national planning guidance and external factors.

1.5. Two key risks have emerged: the capacity of the organisation to manage concurrent transformation efforts and the need for more staff engagement, particularly in the Clinical & Quality plan. To address these, prioritisation will be ongoing, and some plans may need to be reviewed to ensure adequate staff involvement and successful implementation.

1.6. The implementation process is governed by the Joint Transformation & Improvement Board and the Strategy, Transformation and Partnerships Committee in Common, supported by a Clinical Reference Group to ensure clinically led transformation. While some delays in recruitment have hindered progress, oversight and governance remain strong.

1.7. Given that this is the first joint strategy between the two trusts, implementation is going smoothly despite the challenges. The main risks are clinical engagement and organisational capacity, which are being managed

1.8. with appropriate oversight. While transformation takes time, regular updates and case studies will highlight the ongoing impact of the strategy.

1.9. The Joint Strategy and implementation plan was approved in July 2024. It set the strategic direction for Dorset County Hospital and Dorset HealthCare for the next five

years and beyond. This report aims to assure the Board that implementation is in progress in line with the approved plan. Risks are understood and being managed, and appropriate oversight and governance is in place.

2. Introduction

2.1. After developing the joint strategy, we are now in the implementation phase. The roadmap at Appendix 2 provides an overview of the journey so far, outlining what has been achieved and what lies ahead. The four major initiatives are either in progress or in development, largely in line with the proposed delivery plan approved in September 2024.

2.2. The major initiatives include ongoing staff engagement, prioritised portfolios of structured change, the development of a continuous improvement environment, and more detailed enabling plans to support individuals and teams in connecting their actions to the strategy. Key highlights are outlined in the body of the report.

2.3. Given the breadth, complexity, and scale of the strategic activity, tracking all the moving parts is challenging. To help monitor progress, create focus, celebrate success, and escalate issues quickly, a joint strategy dashboard is being developed. Progress is a little behind due to recruitment restrictions.

2.4. While parts of the strategy are already being implemented, others are still in development. Ideally, all development would be completed before delivery begins, but this is not the environment we are working in. Most risks are being managed effectively, although two key risks—clinical engagement and organisational capacity—have emerged and are being actively assessed and mitigated.

3. The Culture, Communications and Engagement plan

3.1. A central component of the strategy's success is the Culture, Communications and Engagement (CCE) plan. This plan brings the strategy to life to support colleagues across the Federation to understand the impact of the joint strategy on their work and actively contribute to its successful delivery. It also aims to engage a broader range of stakeholders, including local people, by effectively communicating the organisations' collective efforts to improve lives.

3.2. The four key workstreams of the CCE plan focus on embedding the strategy's principles, developing a shared brand, launching a communications campaign, and establishing mechanisms for ongoing engagement. These efforts are crucial in creating a unified approach across both organisations.

3.3. The culture, communications and engagement plan is in place to:

a. Ensure that colleagues at both trusts understand how the joint strategy influences what they do and actively contribute to its successful delivery.

b. Help wider stakeholders (including local people) understand how we are working to improve lives.

3.4. The four workstreams of the plan are to:

a. Embed the principles of the joint strategy across both organisations by proactively engaging colleagues in the ways they prefer

b. Develop and embed a clear shared brand and visual identity, creating a range of assets that clearly demonstrate our joint approach
c. Deliver a communications campaign to launch the strategy, support the OD programme and regularly share information on progress with all stakeholders
d. Establish engagement mechanisms to ensure work to deliver the strategy is constantly informed by a range of views and perspectives.

3.5. Highlight activity so far includes:

a. Running the Our shared vision tour and pop-up events for colleagues, to encourage them to think about their connection to the vision and strategy. There is also a toolkit for teams to use to share views. Outputs are being collated and will be presented when the engagement finishes in March.

b. Developing an interim approach to our branding and graphic identity and launching a range of branded templates giving strong visibility to our shared vision. These are now in wide use across both trusts giving a recognisable reminder across all channels.

c. Launching the communications campaign to raise awareness and encourage buy-in for the strategy using a range of channels and tactics. This includes regular connection to the strategy through the CEO weekly bulletin as well as intranet content and sharing at leadership and other forums. A master slide deck is available to explain the strategy.

d. Mapping where and how the strategy, vision and mission are used in our trusts and starting work to embed the new messaging through these channels. This includes areas like induction, learning and development and staff recognition.

4. One Transformation Approach

4.1. The One Transformation Approach is a set of prioritised portfolios of structured change. A rigorous process was undertaken to prioritise the final list, and it was approved at JTIB. The portfolios are:

- Place & Neighbourhoods – Integrated Neighbourhoods Teams and Frailty
- Mental Health – Access Wellbeing and CYP Mental Health
- Sustainability – Our Dorset Provider Collaborative
- Work Together – implementation of this strategy, Electronic Health Record, Support Services review and New Hospital Programme

4.2. A key risk is the capacity of the federation to carry out so much concurrent change. As the environment evolves and changes quickly, ongoing prioritisation is required. To mitigate the risk a strategy roadmap covering the next 3 years will be produced along with a more detailed plan for 2025/2026. These will be brought to March STP CiC.

4.3. **Portfolio highlights**

4.4. These highlights are designed to demonstrate tangible progress. Comprehensive reports, updates, escalations and decisions are managed through portfolio boards, JTIB and then to the STP CiC.

4.5. Place & Neighbourhoods

Integrated Neighbourhoods Teams.

a. INT Programme Board approved the proposal to roll out across BCP using GP practices as the building block for integration and group them within the existing PCN areas
b. Dorset INTs: Initial meetings starting to identify neighbourhood team areas within the wider footprints
c. Engagement event 15th Jan 2025; Shaping the INTs had overt 150 attendees
d. Business Case is completed and supported by INT Programme Board, JTIB and approved at Dorset System Executive Group

Frailty

a. DHC Frailty Virtual Ward has achieved over 80% occupancy.
b. Frailty SDEC live and patients are being recorded against the new location.
c. Efforts are underway to align frailty developments with the Dorset system UEC programme

4.6. Mental Health

Access Wellbeing

a. Three universal hubs are now operational, offering 1:1 appointment with Wellbeing Coordinators and drop-in services.
b. Additional drop-in locations opened in Somerford, City Gate, and Littlemoor, with further expansions planned for Tricketts Cross and Wimborne.
c. Work is underway to establish a universal offer in Purbeck.
d. Universal partnership boundaries defined, with Dorset Mind (North) and Harmony (West) scoping and developing opportunities for collaboration.

CYP Mental Health

a. Data, workforce capacity, and financial modelling completed.
b. Draft business case for Phase 1 developed, shared with stakeholders, and feedback being incorporated for finalisation.

4.5. Sustainability

Our Dorset Provider Collaborative

a. Programme Director started in December 2024.
b. Informal Steering group established.
c. The Board is reviewing its strategic framework and 2025/26 priorities to align with the Medium-Term Financial Plan, Trust priorities, and the Long-Term Plan.
d. Stocktake of progress and success is underway across 11 clinical networks
e. Dermatology - a joint Collaborative and Commissioning engagement event is planned
f. Procurement and shared services. Agreement among the three Trusts to develop a new Procurement Target Operating Model, with a business case to be presented to the ODPC Leadership Board in January/February 2025 and then to

sovereign Trusts.

4.6. Working Together

Enabling Plans

a. Project leads and Project team identified and working collaboratively
b. Approval route agreed
c. Broad engagement planned to close mid-January
d. Engagement event with Joint SLG January 2025
e. Engagement with Council of Governors planned for February 2025

Joint Improvement Framework (JIF)

a. Special Care Baby Unit presented their improvement and approach to STP CiC January 2025.
b. Discovery phase completed.
c. Now in Define stage. Expected outputs by June 2025 are Vision, aim, scope, principles, benefits, measures of success, maturity model and a common Methodology

Corporate Services Review

a. The People; Finance; Strategy, Transformation, Digital & Partnerships, and Corporate Governance functions are reviewing their services with a view to ensure effective and efficient service provision which optimises existing resources to best meet the needs of service users/customers
b. The outputs are to set out clear performance measures and SLA. To deliver 5% CIP in overall portfolio costs in 24/25 and 25/26, or 10% by 26/27

Dashboard

f. The dashboard is in development and aims to evidence tangible progress towards delivery of the strategic objetives. The plan is to have an initial draft for approval in February 2025.

g. The objectives and ambitions have been agreed. Measures and metrics are being finalised.

5. **Risks**

5.4. Routinely risks are managed within the 4 major initiatives and escalated when required.

5.5. Two risks are emerging that need attention.

Clinical Engagement

a. Time has been devoted for staff engagement and used effectively. However, engaging all staff, particularly clinical staff, meaningfully across the federation in a short time span is challenging. Ongoing operational pressures and general volume of work prevent the level of engagement which would ideally be required. This is most evident with the Clinical & Quality plan where we may not have engaged deep or widely enough with clinical colleagues. Acknowledging a balance is required to reach as many staff and groups as

possible without holding up delivery

b. However, staff engagement is critical to success, particularly the Clinical and Quality plan. To mitigate this risk a Clinical Reference Group has formed with over 20 clinical leads invited. In addition, further discussion with the new CMO leadership will help ensure clinically-led transformation.

Organisational Capacity

a. While there was a rigorous process to agree priorities for the OTA through JTIB and the STP CIC. There is a risk that the federation does not have sufficient capacity to carry out so much concurrent change.

b. Work is required to identify specific areas where capacity is stretched. To mitigate this risk, further prioritisation may be required.

6. Oversight & Governance

6.4. Oversight and governance for the strategy implementation has been in place for a few months.

6.5. The Board Assurance Framework has been updated and since revised to reflect the new strategy and to improve visibility, ease of use and understanding. Risks have been captured and agreed and are reviewed regularly

6.6. Each of the 4 major initiatives have internal management structures that manage the day-to-day running. There is a regular executive-led strategy working group that oversees and manages routine escalations and proactively takes action.

6.7. The JTIB have an overview of all large transformation initiative. It reviews progress, makes decisions, allocates resources and prioritises projects and programmes of work. The STP CiC receives updates for assurance and directs the federation effort.

6.8. Reporting through the Transformation Management Office has been restricted due to recruitment constraints.

7. Conclusion

7.4. It is recognised that currently the main focus of the strategic updates is on process and structure. This is not unusual at this stage of a strategy cycle. While some parts of the strategy are implementing, others are still in development.

7.5. The key programmes are in progress. As with all large-scale transformation initiatives, time is required to implement and expereince the impact and benefits. To demonstrate the difference being made. A regular case study item from members of staff is now being presented to the STP CiC. This is bringing to life staffs' experience improvement, sharing how they were inspired and empowered and the impact it has on the people we serve. Subject to time being made available a Board Development session will be used to showcase a number of case studies.

7.6. In addition, Strategy and Transformation teams continue to include benefits and impact in their highlight reports and regualr updates albeit this is limited due to resource constraints.

8. **Recommendation**

The Board of Directors are recommended to receive the report for **assurance**

Date 30 January 2025

Author
Paul Lewis Joint Director of Strategy & Improvement
With contributions from Sally Northeast, Judith Dean, Lauren Leete and Ciara Darley

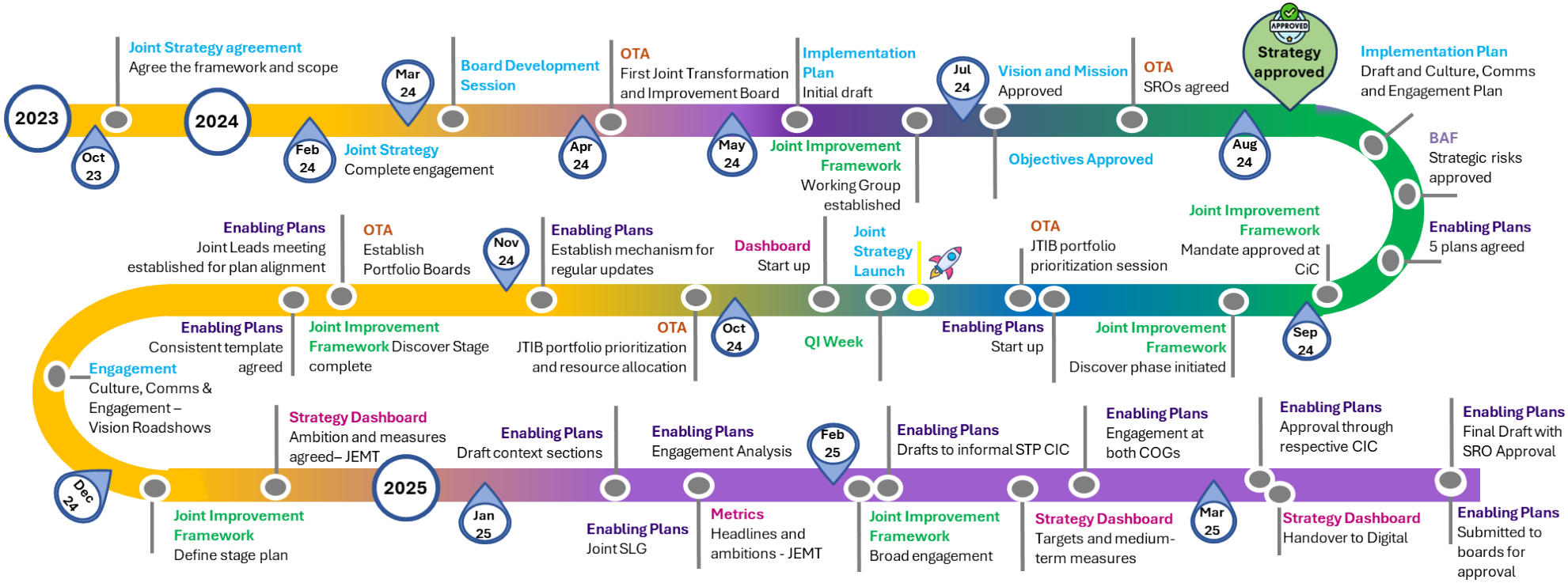
Appendices

1. DRAFT Joint Strategy Dashbaord
2. Strategy development roadmap

Appendix 1 – DRAFT Joint Strategy dashboard

Strategic Objectives	Headline	Ambition	Strategic Goals Medium term 3 – 5 years	Breakthrough Objectives 12 – 18 months (Looking for a few metrics to highlight overall progress)
Care	We provide safe, compassionate care	Improved access to the right care, at the right time in the right place People are equal partners in their care and have a positive experience Patients and service users are always safe in our care	• Patient national constitutional standards for planned and emergency care at met • Patient, family and carer experience is excellent • Hospital acquired infections are in the lowest quartile nationally	• Improved performance against patient national standards for access Mental Health, Planned, Emergency, Community and Children & Young People • Improved annual survey Patient Experience (Focus changes every year) • Patients, families and carers complaints are in the lowest quartile nationally
Community	We help build strong communities where people live well and are healthier	Improved population health and wellbeing through joined-up working across health and care. People staying well through prevention, detection and early intervention, with more control over their own health. People and communities involved in shaping health and care services	• Dorset population is highly activated with their care and wellbeing • Federation spend moved from hospital to neighbourhoods to reduce admissions • Everyone who needs one, has an Anticipatory Care Plan– c40,000 plans (new metric)	• More patients are engaged with their health and wellbeing • More services are co-designed and produced with people and partners • Investment in Integrated Neighbourhood Teams • Increased use of alternatives to avoid admission
Colleagues	We are empowered, skilled, caring colleagues who can thrive at work	Colleagues are positive about their experience at work All colleagues feel they belong and are included A sustainable workforce with the right skills now and for the future	• Staff recommend the Trusts as places to work • Staff have a high sense of wellbeing, belonging and inclusion • Clinical and support services are skilled and staffed appropriately	• Improved staff engagement • More staff are free from abuse, harassment, bullying and physical violence at work • Improved staff turnover • Improved staff wellbeing
Sustainability	Our services are sustainable environmentally and financially and we make best use of our resources	Releasing time to care through improved processes, skill mix and digitally enhanced technology Sustainable models that optimise use of the available resources Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset Minimise our negative impact on public health and the environment	• Digital maturity in top decile of comparable trusts • Delivery of a breakeven position across both Trusts. • Increased utilisation of Trust Estate • Increased Gross Value Add to local economy • Carbon reduction achieved	• Improve recurrency of efficiency schemes • Delivery financial sustainability across our two Trusts • Cost per square foot • Increase our local spend and employment as a % of budget and workforce. Employing local vulnerable groups? • Reduced use of carbon

Appendix 2 – Strategy development roadmap



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Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report
for the meeting held on 17 December 2024

Chair	Stuart Parsons
Executive Lead	Chris Hearn, Joint Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Scheme of Delegation – minor amendment approved (following full review in September 2024) retrospectively (following Board approval 10 December 2024) • Internal Audit Report on System Governance Report – responses provided by ICB and further review of responses requested. Internal Audit to take this forward. • Continued diligence on counter fraud processes

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Audit Committee Annual Workplan – this has been updated to reflect the updated Terms of Reference.
	• Internal Audit Progress and Follow-up Reports
	  ○ Progress report
	  ○ Key financial systems report
	  ○ Maternity Investment Standards (MIS)
	  ○ Internal Audit Benchmarking Report
	  ○ Data Security and Protection Toolkit – highlighted change in approach following publication of new national guidance
	• Counter Fraud
	  ○ NHS CFA National Exercise Report
	  ○ Anti-Crime Progress Report
	• NHS Code of Governance – update on areas for action arising from May 2024 review

Decisions made at the meeting	• None
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance					
	18/06/2024	17/09/2024	17/12/2024	03/02/2025	27/03/2025
Quorate?	Y	Y	Y		
Stuart Parsons	Y	Y	Y		
Claire Lehman	Y	Y	Y		
Stephen Tilton	Y	Y	Y		
Dave Underwood	Y	Y	Y		

Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report
for the meeting held on 03 February 2025

Chair	Stuart Parsons
Executive Lead	Chris Hearn, Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Board Assurance Framework reviewed, noting an increase in SR9 Digital Infrastructure to 16. • Corporate Risk Register noting the key risk of digital, as discussed in recent committee meetings. • Receipt of an Enforcement Notice from the Information Commissioners Officer (ICO) relating to Freedom of Information (FOI) compliance. Significant progress has been made to address the FOI backlog and a response to the enforcement notice will be provided within the required timeframe.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Internal Audit Reports, including:
	  ○ Progress report for 2024/25 audits. Work was underway to develop the internal audit plan for 2025/26.
	  ○ The outcome of the cultural maturity audit. This audit was advisory in nature but produced an overall positive result, with three medium-rated recommendations.
	  ○ Mental Health Act Compliance in Acute Hospital Trusts report for information and discussion. Compliance with the act was the responsibility of Quality Committee, via the Mental Health Steering Group.
	• External Audit Reports
	  ○ Draft audit plan for 2025/26, with work ongoing to finalise the plan. A verbal update would be provided to the next meeting to confirm the final plan. Identified risks in the audit plan include:
	  ▪ Revaluation of Land and Buildings (Risk of Error)
	  ▪ Completeness of Expenditure and year end accruals (Risk of Fraud)
	  ▪ Management Override of Controls (Risk of Fraud)
	• Tender Waiver Report highlighting the number of single tender waivers used between 1st April and 31st December 2024.
	• Freedom of Information Request Compliance and Enforcement Notice from the Information Commissioners Officer, as detailed above.

Decisions made at the meeting	• Approval of the recommendation regarding Charitable Funds Consolidation, to not consolidate charitable funds with the trust's accounts.
Issues / actions referred to other committees / groups	• Cultural Maturity Audit to be shared with People and Culture Committee in Common for oversight. • Mental Health Act Compliance in Acute Hospital Trusts to be shared with Quality Committee for oversight.

Quoracy and Attendance					
	18/06/2024	**17/09/2024**	**17/12/2024**	**03/02/2025**	**27/03/2025**
Quorate?	Y	Y	Y	Y	
Stuart Parsons	Y	Y	Y	Y	
Claire Lehman	Y	Y	Y	Y	
Stephen Tilton	Y	Y	Y	Y	
Dave Underwood	Y	Y	Y	Y	

Report to	Board of Directors – Part 1	
Date of Meeting	11th February 2025	
Report Title	DCH – SFIs and Scheme of Delegation Review	
Prepared By	Mark Lovett, Financial Controller DCH	
Accountable Executive	Chris Hearn, Chief Financial Officer	
Previously Considered By	Senior Finance Team and Chief Financial Officer and Audit Committee 17/12/2024	
Action Required	**Approval**	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR6 – Finance	
Financial	No	
Statutory & Regulatory	Review to ensure in accordance with the laws and government policy.	
Equality, Diversity & Inclusion	No	
Co-production & Partnership	Review and alignment to DHC Standing Financial Instructions re joint working	

Executive Summary

The Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation have been reviewed with updates proposed below. The Standing Financial Instructions of Dorset Healthcare have been reviewed alongside this review to ensure that the two policies are consistent.

A summary of the changes are as follows:

- Update SFIs and Scheme of Delegation with minor formatting amendments throughout and update job titles, committee names, NHS Protect to NHS Counter Fraud Authority, Healthcare Commission to Care Quality Commission and NHS Ligation Authority to NHS Resolution.
- Update for consistency with Dorset Healthcare the terminology to the Regulator replacing NHSI and adding reference to the Health and Social Care Act 2012.
- Tendering and Contract Procedure – Sentence has been added for reference to the replacement of UK Public Contract Regulations 2015 by the Procurement Act 2023.
- Subsidiaries – The new section 26 has been added to cover the financial governance arrangement between the Trust and its subsidiary. This covers the SFIs, reserved matters and the management of the service level agreement.

The implementation of changes to Scheme of Delegation limits which came to the Risk and Audit Committee on the 17th of September 2024 highlighted the limit in Section 8 – Authorisation of Non-Pay Expenditure for department/Ward Delegated Signatory (C) - had been reduced in error to £100. The figure has now been corrected to its intended figure of £5,000 and been presented for approval at the December Board meeting.

Recommendation

The Board of Directors are recommended to:

- APPROVE the proposed updates to the Trust's Standing Financial Instructions and Scheme of Delegation.

Audit Committee – 17th December 2024
DCH – Standing Financial Instructions and Scheme of Delegation review

Executive Summary

The Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation limits have been reviewed with updates proposed below. This review is to ensure the prime financial governance documents remain up to date and reflect national guidelines and are in line with those of Dorset HealthCare to aid collaborative working.

1. Introduction

1.1 The Standing Financial Instructions and Scheme of Delegation have been reviewed and the Audit Committee is asked to approve recommended updates.

1.2 The document is intended to ensure that the Trust's financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

1.3 The document has been reviewed by the senior finance team who have supplied changes to the document.

1.4 This document has also been reviewed alongside both the Standing Financial Instructions and scheme of delegation of Dorset Healthcare to ensure consistency between the two organisations and all areas are covered either in this document or the Trust's Standing Orders.

2. Updates

2.1 The Changes are listed below

Ref	Section heading	Amended Text
All		The document has been updated to reflect the changes to any job titles which have changed since the last update to Directors, Deputy Directors and staff.
All		The document has been updated to reflect any changes to committee names since the last update.
All		Updated for consistency to Dorset Healthcare, the reference to the Regulator in Terminology 1.2 and then throughout the document replacing reference to NHSI
4.5.2	Business Planning, Budgets and Budgetary Control – Performance Information and Monitoring Returns	Organisation name updated to Care Quality Commission from Healthcare Commission

14.2.2	Disposals and Condemnations, Losses and Special Payments – Losses and Special Payments	Organisation name updated to NHS Counter Fraud Authority from NHS Protect
22.10	Risk Management and Insurance	Organisation name updated to NHS Resolution from NHS Litigation Authority
1.2.1.h 1.2.1.p	Introduction – Terminology	Updated for Consistency to Dorset Healthcare, the reference to the Health and Social Care Act 2012
10.2.2	Non Pay Expenditure – Tendering and Contract Procedure	Tendering and Contract Procedure – Add Reference to the replacement of UK Public Contract Regulations 2015 by the Procurement Act 2023.
26	Subsidiaries	Add new section to cover Subsidiaries

2.2 The implementation of changes to Scheme of Delegation limits which came to the Risk and Audit Committee on the 17th of September 2024 highlighted the limit in Section 8 – Authorisation of Non-Pay Expenditure for department/Ward Delegated Signatory (C) - had been reduced in error to £100. The figure has now been corrected to its intended figure of £5,000 and been presented for approval at the December Board meeting.

3. Recommendation

The Risk and Audit Committee are recommended to:

- **APPROVE** the proposed updates to the Trust's Standing Financial Instructions and Scheme of Delegation.

Name and Title of Author: Mark Lovett – Financial Controller
Date: 10/12/2024

Dorset County Hospital
NHS Foundation Trust

PRIME FINANCIAL GOVERNANCE DOCUMENTS PF003

STANDING FINANCIAL INSTRUCTIONS (SFIs)

Policy Title	Standing Financial Instructions (SFIs)		
Policy Number	**1934**	**Policy Version Number**	**1**
Applicable to	All Staff		
Aim of the Policy	To ensure that financial transactions are carried in accordance with the law and government policy		
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Policy Sponsor	Chris Hearn, Joint Chief Financial Officer		
Expert Group	Board of Directors		
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Foreword

1. The Dorset County Hospital NHS Foundation Trust is a public benefit corporation, which was established on 1st June 2007 under the National Health Service Act 2006.

2. As a public benefit corporation, the Trust has specific powers to do anything which appears to be necessary or desirable for the purposes of, or in connection with, its functions. In this respect it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

3. **These Standing Financial Instructions (SFIs), together with the Trust's Standing Orders, provide a business and financial framework within which all executive directors, non-executive directors and officers of the Trust will be expected to work.** All executive and non-executive directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

4. These documents fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

5. In addition to the Standing Orders and SFIs, there is a Scheme of Delegation, a Schedule of Powers Reserved to the Board, Financial Policies and Procedural Notes and locally generated rules and instructions. Existing Financial Policies, Procedure Notes and locally generated rules and instructions shall apply until these are revised (except where specifically overruled by these SFIs). Collectively these must comprehensively cover all aspects of (financial) management and control. In effect, they set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

1.0 Introduction

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust and shall have effect as if incorporated in the Standing Orders (SOs) of the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Powers Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.2. These SFIs identify the financial responsibilities, which apply to everyone working for the Trust. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the Trust's detailed corporate policy documents, financial policies and procedures and any departmental procedure notes. The Joint Chief Financial Officer must approve all financial procedures.

1.1.3. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Joint Chief Financial Officer or delegated officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.4. **FAILURE TO COMPLY WITH SFIs AND SOs IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL**.

1.2. Terminology

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

1.2.1.a. **"Trust"** means the Dorset County Hospital NHS Foundation Trust;
1.2.1.b. **"Board"** means the Board of Directors of the Trust as set out in the Constitution;
1.2.1.c. **"Committee"** means any committee established by the Council of Governors or the Board of Directors for the purposes of fulfilling its functions;
1.2.1.d. **"Council of Governors (CoG)"** means the body of elected and appointed members, authorised to be members of the Council and to act in accordance with the Constitution;
1.2.1.e. **"Constitution"** means the constitution, approved by the Independent Regulator (NHSI), and which describes the operation of the Foundation Trust;
1.2.1.f. **"Joint Chief Executive"** means the chief officer of the Trust and Dorset HealthCare University NHS Foundation Trust;
1.2.1.g. **"Joint Chief Financial Officer"** means the chief financial officer of the Trust and Dorset HealthCare University NHS Foundation Trust;
1.2.1.h. **"2006 Act" and "2012 Act"** refers to the National Health Service Act 2006 and the Health and Social Care Act 2012;
1.2.1.i. **"Authorisation agreement"** refers to the document issued by NHSI at the inception of the Trust authorising it to operate as a Foundation Trust in accordance with section 35 of the National Health Service Act 2006;
1.2.1.j. **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
1.2.1.k. **"Budget Holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

1.2.1.l. **"Funds held on trust"** shall mean those funds, which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept. Such funds may or may not be charitable;
1.2.1.m. **"Legal Adviser"** means the properly qualified person appointed by the Trust to provide legal advice;
1.2.1.n. **"Mandatory services"** are those services which NHSI has deemed it compulsory that the Trust provides, as listed in the Authorisation agreement;
1.2.1.o. **"Protected assets"** refers to those assets of the Trust deemed by NHSI to be essential to the provision of mandatory services (see above) and listed as such in the Authorisation agreement;
1.2.1.p. **"the Regulator"** means the Foundation Trust Independent Regulator for the purposes of the 2006 and 2012 Act;
1.2.1.q. **"SFIs"** means Standing Financial Instructions;
1.2.1.r. **"SOs"** means Standing Orders; and
1.2.1.s. **"Virement"** means the transfer of budgetary provision from one budget head to another.

1.2.2. Wherever the title Joint Chief Executive, Joint Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3. Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control by:

1.3.1.a. Formulating the financial strategy;
1.3.1.b. Requiring the submission and approval of budgets within overall income;
1.3.1.c. Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
1.3.1.d. Defining specific responsibilities placed on directors and employees as indicated in the Reservation of Powers and Scheme of Delegation document.

1.3.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "Reservation of Powers and Scheme of Delegation policy".

1.3.3. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the Joint Chief Executive is accountable to the Board for ensuring that the Trust fulfils the functions and responsibilities set out in the Authorisation agreement within the available financial resources. The Joint Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The Joint Chief Executive and Joint Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.6. It is a duty of the Joint Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.7. The Joint Chief Financial Officer is responsible for:

1.3.7.a. Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
1.3.7.b. Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
1.3.7.c. Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and
1.3.7.d. Ensuring that good financial practice is followed in accordance with accepted professional standards and advice received from internal and external auditors. And, without prejudice to any other functions of Directors and employees to the Trust, the duties of the Joint Chief Financial Officer include the provision of financial advice to the Trust and its Directors and employees:
1.3.7.e. The design, implementation and supervision of systems of internal financial control; and
1.3.7.f. The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.8. All directors and employees, singularly and collectively, are responsible for:

1.3.8.a. The security of the property of the Trust;
1.3.8.b. Avoiding loss;
1.3.8.c. Exercising economy and efficiency in the use of resources;
1.3.8.d. Conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation; and
1.3.8.e. Reporting suspected theft or fraud to the Joint Chief Financial Officer.

1.3.9. Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Joint Chief Executive to ensure that such persons are made aware of this.

1.3.10. For any and all Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Joint Chief Financial Officer.

2.0 Audit

2.1. Audit Committee

2.1.1. In accordance with schedule 7 paragraph 23 (6) of the 2006 Act, the Audit Code for NHS Foundation Trusts issued by the Regulator and both the Trust's Constitution and Standing Orders, the Board shall formally establish an Audit Committee of Non Executive Directors to perform such monitoring, review and other functions as are appropriate. In particular the Audit Committee will provide an independent and objective view of internal control by:

2.1.1.a. Overseeing Internal and External Audit services;
2.1.1.b. Reviewing financial systems;
2.1.1.c. Monitoring compliance with Standing Orders and Standing Financial Instructions; and
2.1.1.d. Reviewing schedules of losses and compensations and making recommendations to the Board.
2.1.1.e. Review the annual financial statements prior to submission to the Board

2.1.2. Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be brought to the attention of the Council of Governors and the Regulator.

2.1.3. It is the responsibility of the Joint Chief Financial Officer to ensure that an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.1.4. The Audit Committee has a responsibility for assessing the external (financial) auditors on an annual basis, both in terms of the quality of their work and the reasonableness of their fees. The Committee is then responsible for making a recommendation to the Council of Governors with regard to their reappointment or otherwise.

2.2. Fraud and Corruption

2.2.1. In line with their responsibilities as set out in HSG(96)12, the Joint Chief Executive and Joint Chief Financial Officer shall monitor and ensure compliance with the Secretary of State's Directions on fraud and corruption.

2.2.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and guidance.

2.2.3. The Local Counter Fraud Specialist shall report to the Joint Chief Financial Officer and shall work with staff in the Counter Fraud and Security Management Service in accordance with NHS Protect guidance.

2.2.4. The Joint Chief Financial Officer is responsible for providing detailed procedures to enable the Trust to minimise and where possible to eliminate fraud and corruption. These procedures are included in the Trust's Anti-Fraud and Bribery Policy and Response Plan, which sets out the actions to be taken by persons detecting a suspected fraud and persons responsible for investigating it.

2.2.5. The measures that are put in place shall be sufficient to satisfy all external bodies to whom the Trust is accountable to, through:

2.2.5.a. Encouraging prevention;
2.2.5.b. Promoting detection; and
2.2.5.c. Ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively.

2.2.6. Fraud and corruption shall be dealt with as gross misconduct.

2.2.7. The Joint Chief People Officer is responsible for ensuring that steps are taken at recruitment stage to establish as far as possible the previous record of potential officers in terms of their propriety and integrity.

2.2.8. Staff are expected to act in accordance with the Trust's Standing Orders and "Code of Business Conduct" following the guidance on the receipt of gifts and hospitality.

2.2.9. Non-Executive Directors are subject to the same high standards of accountability and are required to declare and register any interests which might potentially conflict with those of the Trust.

2.2.10. The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls, and evaluate the implication of fraud for their opinion on the system of risk management, control and governance.

2.2.11. Staff are encouraged to raise any concerns they may have regarding suspected fraud and/or corruption. They can report their suspicions directly, to do this through:

2.2.11.a. The Joint Chief Financial Officer;
2.2.11.b. The Local Counter Fraud Specialist; or
2.2.11.c. The NHS National Fraud Hotline

The preferred route is directly to either local or national counter fraud.

2.2.12. The Joint Chief Financial Officer is responsible for ensuring that action is taken to investigate any allegations of fraud or corruption through the Local Counter Fraud Specialist. The steps to be taken are incorporated in the Trust's Anti-Fraud and Bribery Policy and Response Plan.

2.2.13. Senior Managers are expected to deal firmly and promptly and in accordance with the Trust's disciplinary procedure with anyone who attempts to defraud the Trust or who acts in a corrupt manner.

2.2.14. Any abuse of the procedures, such as unfounded or malicious allegations, is itself subject to full investigation and appropriate disciplinary action.

2.3. Joint Chief Financial Officer

2.3.1. The Joint Chief Financial Officer is responsible for:

2.3.1.a. Ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
2.3.1.b. Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
2.3.1.c. In conjunction with the Counter Fraud and Security Management Service, deciding at what stage to involve the police in cases of misappropriation, and other irregularities;
2.3.1.d. Ensuring that an annual Internal Audit Report is prepared for the consideration of the Audit Committee and the Board. The report must cover:
2.3..d.a. A clear statement on the effectiveness of internal control, in accordance with current controls assurance guidance issued by the Department of Health including for example compliance with control criteria and standards,
2.3..d.b. Major internal control weaknesses discovered,
2.3..d.c. Progress on the implementation of internal audit recommendations,
2.3..d.d. Progress against plan over the previous year;
2.3.1.e. Ensuring that a three year strategic Internal Audit Plan is prepared for the consideration of the Audit Committee and the Board; and
2.3.1.f. Ensuring that an annual Internal Audit Plan is produced for consideration by the Audit Committee and the Board, which sets out the proposed activities for the function for the forthcoming financial year.

2.3.2 The Joint Chief Financial Officer and designated auditors are entitled without necessarily giving prior notice to require and receive:

2.3.2.a. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
2.3.2.b. Access at all reasonable times to any land, premises or employee of the Trust;
2.3.2.c. The production of any cash, stores or other property of the Trust under an employee's control; and
2.3.2.d. Explanations concerning any matter under investigation.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Joint Chief Financial Officer must be notified immediately.

2.4 Role of Internal Audit

2.4.1 In accordance with the requirements of the Audit Code for NHS Foundation Trusts issued by the Regulator, the Trust is required to establish an Internal Audit function. It is the responsibility of the Joint Chief Financial Officer to ensure that this function is in place and operates efficiently and effectively.

2.4.2 Internal Audit will provide assurances about the effectiveness of controls in place across all of the Trust's activities. To fulfil this function, Internal Audit will review the overall arrangements the Board itself has in place for securing adequate assurances and provide an opinion on those arrangements to support the Statement on Internal Control. This will entail reviewing the way in which the Board has identified objectives, risks, controls and sources of assurance on these controls, and assessed the value of assurances obtained.

2.4.3 In addition, Internal Audit will provide specific assurances on the areas covered in the Internal Audit Plan as approved by the Audit Committee, and will work alongside other professionals wherever possible, to advise on systems of control and assurance arrangements. This is a distinct role, which is quite different to reviewing and commenting on the reliance of the assurances themselves, which is the responsibility of the Board.

2.4.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Joint Chief Executive of the Trust.

2.4.5 The Head of Internal Audit shall be accountable to the Joint Chief Financial Officer. The reporting system for Internal Audit shall be agreed between the Joint Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.5 External Audit

2.5.1. The Trust is required to have an external (financial) auditor and is to provide such information and facilities as are necessary for the auditor to fulfil their responsibilities under the 2006 Act.

2.5.2. Under Schedule 7 (paragraph 23) of the 2006 Act and the Trust's Constitution, it is the responsibility of the Council of Governors at a General Meeting to appoint (or remove) the external (financial) auditor on behalf of the Trust. As part of the appointment process, the Trust must ensure that the auditors meet the selection criteria set out in the Audit Code for NHS Foundation Trusts.

2.5.3. Subject to the annual assessment by the Audit Committee, the Council of Governors may reappoint the external (financial) auditors for the following year without the need for a formal selection process. However in accordance with the Audit Code for NHS Foundation Trusts, a market testing exercise will be undertaken as a minimum every 5 years.

2.5.4. The Council of Governors also has the power to appoint (and remove) any external auditor appointed to review and report on any other aspect of the Trust's affairs.

2.6. Audit Code

2.6.1 The Trust has a responsibility, under the terms of its Authorisation agreement, to comply with the Audit Code for NHS Foundation Trusts as approved by the Regulator. The Joint Chief Executive has overall responsibility for ensuring compliance with the Code.

3. Financial Targets

3.1. The Trust is required to meet such financial targets as are specified by the Regulator, either under the terms of the initial Authorisation agreement or subsequently. These specifically include the requirement to:

3.1.1. Contain external borrowing within the Trust's Annual plan and reviewed annually thereafter;

3.1.2. Restrict generated income from 'other purposes' including the provision of private healthcare to be no greater than that to deliver goods and services for the purpose of the health service.

3.2. Whilst there is no specific target regulating overall revenue performance in Foundation Trusts (e.g. a requirement to break-even year on year), The Regulator has the power to intervene in the Trust's affairs and potentially to revoke its Authorisation agreement where financial viability is seriously compromised.

3.3. The Joint Chief Executive has overall executive responsibility for the Trust's activities and in this capacity is responsible for ensuring that the Trust maintains its financial viability and meets any specific financial targets set by the Regulator. In this capacity the Joint Chief Executive is responsible for setting appropriate internal targets in order to ensure financial viability.

3.4. The Joint Chief Financial Officer is responsible for:

3.4.1. Advising the Board and Joint Chief Executive on progress in meeting these targets, recommending corrective action as appropriate;
3.4.2. Ensuring that adequate systems exist internally to monitor financial performance;
3.4.3. Managing the cash flow and external borrowings of the Trust; and
3.4.4. Providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.

4. Business Planning, Budgets and Budgetary Control

4.1. Preparation and Approval of Business Plans and Budgets

4.1.1. Under the terms of Schedule 7 (paragraph 26) of the 2006 Act and its Constitution, the Trust is required to provide the Regulator with information concerning its forward plans for each financial year. In this respect, the Council of Governors is responsible for providing the Board with its views on those forward plans when they are being prepared and the Board correspondingly has a duty to consult them.

4.1.2. The Joint Chief Executive will therefore compile and submit to the Board and the Council of Governors, an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

4.1.2.a. A statement of the significant assumptions on which the plan is based; and
4.1.2.b. Details of major changes in workload, delivery of services or resources required to achieve the plan.

4.1.2.c. The worked whole time equivalent (WTE) numbers by month for the period of the plan.

4.1.3 Once approved, the Joint Chief Executive will be responsible for submitting the Business Plan as required to the Regulator.

4.1.4 The Joint Chief Executive is also responsible for ensuring on behalf of the Board that the Council of Governors is consulted on any significant changes to the Business Plan in year.

4.1.5 At the start of the financial year the Joint Chief Financial Officer will, on behalf of the Joint Chief Executive, prepare and submit revenue and capital budgets for approval by the Board. Such budgets will:

4.1.5.a. Be in accordance with the aims and objectives set out in the annual business plan;
4.1.5.b. Accord with workload and manpower plans;
4.1.5.c. Be produced following discussion with appropriate budget holders/managers;
4.1.5.d. Be prepared within the limits of available and identified funds;
4.1.5.e. Identify all sources of those funds; and
4.1.5.f. Identify potential risks.

4.1.6 The Joint Chief Financial Officer shall monitor financial performance against budget and the business plan, periodically review them, and report to the Board.

4.1.7 All budget holders must provide information as required by the Joint Chief Financial Officer to enable budgets to be compiled.

4.1.8 The Joint Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders to help them manage successfully.

4.1.9 The Joint Chief Financial Officer is responsible for ensuring business cases are produced and authorised in line with delegated responsibilities for all investments.

4.2 Budgetary Delegation

4.2.1 The Joint Chief Financial Officer (on behalf of the Joint Chief Executive) may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

4.2.1.a. The amount of the budget;
4.2.1.b. The staffing levels associated with that budget;
4.2.1.c. The purpose(s) of each budget heading;
4.2.1.d. Individual and group responsibilities;
4.2.1.e. Authority to exercise virement;
4.2.1.f. Achievement of planned levels of service; and
4.2.1.g. The provision of regular reports.

4.2.2 Expenditure authorised by the Joint Chief Executive and delegated budget holders must not exceed the budgetary total or financial virement limits set by the Board.

4.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Joint Chief Executive, subject to any authorised use of virement.

4.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Joint Chief Financial Officer (on behalf of the Joint Chief Executive).

4.2.5 The agreed budgetary delegation limits for the Trust are detailed in the “Scheme of Delegation”.

4.3. Budgetary Control and Reporting

4.3.1 The Joint Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

4.3.1.a. Monthly financial reports to the Board in a form approved by the Board containing:
- 4.3.1.a.a Income and expenditure to date showing trends and forecast year-end position;
- 4.3.1.a.b Explanations of any material variances from plan;
- 4.3.1.a.c Details of any corrective action where necessary and the Joint Chief Executive's and/or Joint Chief Financial Officer's view of whether such actions are sufficient to correct the situation;
- 4.3.1.a.d Approved use of Reserves, both by the Joint Chief Executive under delegated powers and via specific Board decisions; and
- 4.3.1.a.e Capital expenditure to date versus plan.
- 4.3.1.a.f WTE plan and actual together with associated staff costs plan and actual
- 4.3.1.a.g Projected outturn capital expenditure against plan

4.3.1.b. The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible; Investigation and reporting of variances from financial, workload and manpower budgets which needs to specify WTEs both including and excluding Agency staff

4.3.1.c. Monitoring of management action to correct variances; and

4.3.1.d. Arrangements for the authorisation of budget transfers.

4.3.2 Each Budget Holder is responsible for ensuring that:

4.3.2.a. **Any likely overspending is not incurred without the prior consent of the Board**;

4.3.2.b. The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

4.3.2.c. no employees are appointed without the approval of the Joint Chief Executive, other than those provided for in the authorised budgeted establishment.

4.3.3 The Joint Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual Business Plan and a balanced budget.

4.3.4 The Joint Chief Financial Officer is responsible for advising the Joint Chief Executive and the Board on the financial consequences of any changes in policy, pay awards and other events impacting on budgets and will also advise on the financial implications of future plans and developments proposed by the Trust.

4.4. Capital Expenditure

4.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (the particular applications relating to capital are contained in section 12 of these SFIs). The delegation limits for capital expenditure are detailed in the “Scheme of Delegation” and Table B Financial Limits.

4.5. Performance Information and Monitoring Returns

4.5.1 The Joint Chief Executive, on behalf of the Trust, is responsible for providing the Regulator with such information as is necessary to monitor compliance with the terms of the Authorisation agreement.

4.5.2 The Joint Chief Executive, on behalf of the Trust, is also responsible for ensuring that the Trust contributes to standard national NHS data flows, which are required for NHS policy development/ funding decisions as well as performance assessment by the Care Quality Commission.

5. Annual Accounts and Reports

5.1. In accordance with Schedule 7 (paragraph 25) of the 2006 Act and the Trust's Constitution, the Trust must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of the Treasury, direct. These responsibilities will be carried out by the Joint Chief Financial Officer who, on behalf of the Trust, will:

5.1.1. Prepare annual accounts in accordance with the Regulator's FT (ARM FreM) Annual Reporting Manual and any other guidance from the same, the Trust's accounting policies and International Financial Reporting Standards;

5.1.2. Prepare and submit annual accounts to the Board and an audited summary of the Main Financial Statements to an annual members meeting convened by the Council of Governors, certified in accordance with current guidelines;

5.1.3. Lay a copy of the annual accounts, and any report of the external (financial) auditor thereon, before Parliament and subsequently send them to the Regulator.

5.2. The annual accounts should, in accordance with the requirements set out in the Accounts Direction, include a Statement on Internal Control within the financial statements signed by the Joint Chief Executive.

5.3. The Trust's annual accounts must be audited by the external (financial) auditor appointed by the Council of Governors and be presented at the annual members meeting referred to in 1 (b) above.

5.4. In accordance with Schedule 7 (paragraph 26) of the 2006 Act, the Trust will also prepare an annual report, which after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to NHS England. The Annual Report will comply with the Regulator's Annual Report Guidance for NHS Foundation Trusts and will include, inter alia:

5.4.1. Information on the steps taken by the Trust to ensure that the actual membership of the various constituencies (public, patients and staff) is representative of those eligible for such membership;
5.4.2. The Annual Accounts of the Trust in full or summary form;
5.4.3. Details of relevant directorships and other significant interests held by Board members;
5.4.4. Composition of the Audit Committee and of the Remuneration Committee;
5.4.5. Remuneration of the Chair, the Non-Executive Directors and Executive Directors, on the same basis as those specified in the Companies Act;
5.4.6. A statement of assurance by the Joint Chief Executive in respect of organisational controls and risk management within the Trust;
5.4.7. Any other information required by the Regulator.

5.5. The Joint Chief Executive is responsible for signing the Annual Report on behalf of the Board.

5.6. The Trust is to comply with any decision that the Regulator may make as to the form of the Annual Report, the timing of its submission and the period to which it relates.

6. Bank Accounts

6.1. General

6.1.1. The Joint Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued by the Regulator.

6.2. Bank Accounts

6.2.1. The Joint Chief Financial Officer is responsible for:

6.2.1.a. Bank accounts;
6.2.1.b. Establishing separate bank accounts for the Trust's charitable funds;
6.2.1.c. Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made; and
6.2.1.d. Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

6.2.2. No officer other than the Joint Chief Financial Officer will open any bank account in the name of the Trust or relating to any activities of the Trust, or issue instructions to the Trust's bankers.

6.3. Banking Procedures

6.3.1. The Joint Chief Financial Officer will prepare detailed instructions on the operation of bank accounts which must include:

6.3.1.a. The conditions under which each bank account is to be operated;
6.3.1.b. The limit to be applied to any overdraft; and
6.3.1.c. Those authorised to sign cheques or other orders drawn on the Trust's accounts.

6.3.2. The Joint Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

6.4. Tendering and Review

6.4.1. The Joint Chief Financial Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for non-mandatory Trust's banking business.

6.4.2. If required competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board.

7. Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

7.1. Income Systems

7.1.1. The Joint Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2. In this capacity, the Joint Chief Financial Officer will establish systems in order to ensure that timely and appropriate invoices are raised for income due under the terms of contracts with NHS commissioners (see Section 8).

7.1.3. The Joint Chief Financial Officer is also responsible for the prompt banking of all monies received.

7.2. Fees and Charges

7.2.1. The Trust will price its service contracts with NHS healthcare commissioners either according to national tariffs for services under National Payment by Results guidance as published by the Department of Health or through local price negotiation for non-PbR services. In areas where national tariff arrangements do not apply, the Trust will follow the Department of Health's guidance in the "NHS Costing Manual" in costing/pricing NHS service contracts.

7.2.2. The Joint Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3. All employees must inform the Joint Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.3. Debt Recovery

7.3.1. The Joint Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts and in this capacity is responsible for providing the Board with a monthly analysis of debtors profiled by age.

7.3.2. Income not received should be dealt with in accordance with losses procedures.

7.3.3. Overpayments should be detected (or preferably prevented) and recovery initiated.

7.4. Security of Cash, Cheques and Other Negotiable Instruments

7.4.1. The Joint Chief Financial Officer is responsible for:

7.4.1.a. Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

7.4.1.b. Ordering and securely controlling any such stationery;

7.4.1.c The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

7.4.1.d. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.4.2. Official money shall not under any circumstances be used for the encashment of private cheques.

7.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Joint Chief Financial Officer.

7.4.4. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8. NHS Contracts for the Provision of Services

8.1. The Joint Chief Executive, as the accountable officer, is responsible for ensuring that that the Trust enters into suitable legally binding contracts with NHS commissioners both for the mandatory healthcare services specified in the Trust's Authorisation agreement with the Regulator and also other healthcare services. In discharging this responsibility, the Joint Chief Executive should ensure that these contracts take account of:

8.1.1. The standards of healthcare quality expected, including those published by the Secretary of State;
8.1.2. Relevant National Service Frameworks and guidelines published by the National Institute for Clinical Excellence;
8.1.3. Service priorities contained within the Trust's Business Plan and agreed with healthcare commissioners;
8.1.4. National tariffs published by the Department of Health (see 7.2.1) or other agreed local pricing mechanisms where national tariffs do not (yet) apply;
8.1.5. The need to provide ancillary and other supporting services essential to the delivery of the healthcare involved;
8.1.6. The need to ensure the provision of reliable and on-going information on service cost, volume and quality;
8.1.7. Previously agreed developments or investment plans.

8.2. A good contract for health care services will result from a dialogue between clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Joint Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3. The Joint Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing forecast/ budgeted and actual income from contracts with NHS commissioners. This analysis will particularly highlight the impact of differences between planned and actual numbers of patients treated across Healthcare Resource Groups (HRGs) and outline any action required to address such variances. Periodically, at intervals to be agreed with the Board, the Joint Chief Executive will also provide information on the impact of differences between the actual cost to the Trust of treating patients in individual HRGs and the relevant national tariff.

8.4. The Trust will maintain a public and up to date schedule of the authorised goods and services, which are being currently provided, including non-mandatory health services.

9. Terms of Service and Payment of Directors and Employees

9.1. Remuneration and Terms of Service Committee

9.1.1. In accordance with the requirements of the 2006 Act and Standing Orders, the Trust shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2.The Committee will:

9.1.2.a. Advise the Board about appropriate remuneration and terms of service for the Joint Chief Executive and other executive directors (and other senior employees), including:

9.1.2.a.1. All aspects of salary (including any performance related elements/ bonuses);

9.1.2.a.2. Provisions for other benefits, including pensions and cars;

9.1.2.a.3. Arrangements for termination of employment and other contractual terms;

9.1.2.b. Make such recommendations to the Board on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

9.1.2.c. Monitor and evaluate the performance of individual executive directors (and other senior employees); and

9.1.2.d. Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

9.1.3. The Committee shall advise the Board in writing as to the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board's meetings should record such decisions.

9.1.4. The Board will after due consideration and amendment if appropriate approve proposals presented by the Joint Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

9.1.5. The Trust will remunerate the Chair and Non Executive Directors as determined by the Council of Governors.

9.2. Funded Establishment

9.2.1. The manpower plans incorporated within the annual budget will form the funded establishment.

9.2.2. The funded establishment of any department may not be varied without the approval of the Joint Chief Executive.

9.3. Staff Appointments

9.3.1. No director or employee may engage, re-engage, or regrade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

9.3.1.a. Unless authorised to do so by the Joint Chief Executive; and

9.3.1.b. Within the limit of their approved budget and funded establishment.

9.3.2. The Joint Chief Executive will present for Board consideration, procedures for the determination of commencing pay rates, condition of service, etc, for employees.

9.4. Processing of Payroll

9.4.1. The Joint Chief Financial Officer is responsible for:

9.4.1.a. Specifying timetables for submission of properly authorised time records and other notifications;
9.4.1.b. The final determination of pay;
9.4.1.c. Making payment on agreed dates; and
9.4.1.d. Agreeing method of payment.

9.4.2. The Joint Chief Financial Officer will issue instructions regarding:

9.4.2.a. Verification and documentation of data;
9.4.2.b. The timetable for receipt and preparation of payroll data and the payment of employees;
9.4.2.c. Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
9.4.2.d. Security and confidentiality of payroll information;
9.4.2.e. Checks to be applied to completed payroll before and after payment;
9.4.2.f. Authority to release payroll data under the provisions of the Data Protection Act;
9.4.2.g. Methods of payment available to various categories of employee;
9.4.2.h. Procedures for payment by cheque, bank credit, or cash to employees;
9.4.2.i. Procedures for the recall of cheques and bank credits;
9.4.2.j. Pay advances and their recovery;
9.4.2.k. Maintenance of regular and independent reconciliation of pay control accounts;
9.4.2.l. Separation of duties of preparing records and handling cash; and
9.4.2.m. A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

9.4.3. Appropriately nominated managers have delegated responsibility for:

9.4.3.a. Submitting staff attendance returns, time records, and other notifications in accordance with agreed timetables;
9.4.3.b. Completing staff attendance returns, time records and other notifications in accordance with the Joint Chief Financial Officer instructions and in the form prescribed by the Joint Chief Financial Officer; and
9.4.3.c. Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Joint Chief Financial Officer must be informed immediately.

9.4.4. Regardless of the arrangements for providing the payroll service, the Joint Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5. Contracts of Employment

9.5.1. The Board shall delegate responsibility to the Joint Chief People Officer for:

9.5.1.a. Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

9.5.1.b. Dealing with variations to, or termination of, contracts of employment.

10. Non Pay Expenditure

10.1. Delegation of Authority

10.1.1. The Board will approve the level of non-pay expenditure on an annual basis and the Joint Chief Executive will determine the level of delegation to budget managers (including the level of virement between one budget holder and another). The financial limits are laid out in the Scheme of Delegation.

10.1.2. The Joint Chief Executive will set out in the Scheme of Delegation:

10.1.2.a. The list of managers who are authorised to place requisitions for the supply of goods and services; and

10.1.2.b. The maximum level of each requisition and the system for authorisation above that level.

10.1.3. The Joint Chief Executive will also be responsible for ensuring that the Trust has clearly established arrangements for the purchase of goods and services.

10.1.4. The Joint Chief Executive will also be responsible for ensuring that the Trust makes optimum use of corporate, national or regional contracts for the acquisition of goods and services, in order to ensure best value for money.

10.2. Tendering and Contract Procedure

10.2.1. Duty to comply with Standing Orders - The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders (except where SO 3.14 (Suspension of SOs) is applied).

10.2.2. EU Directives Governing Public Procurement - Directives by the Council of the European Union promulgated by the Department of Health (DoH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions. The procurement process for public sector bodies is governed by the UK Public Contract Regulations 2015 which will be replaced by the Procurement Act 2023.

10.2.3. The Trust shall comply with the requirements of the Single Oversight Framework for Capital expenditure. In the case of management consultancy contracts the Trust shall comply with NHS Trust development Authority guidance on 'Consultancy spending controls'.

10.2.4. Formal Competitive Tendering - The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DoH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

10.2.5. Formal tendering or quotation procedures may be waived by officers to whom powers have been delegated by the Joint Chief Executive **without reference** to the Joint Chief Executive **(except in (b) to (g)** below where:

10.2.5.a. The estimated expenditure or income does not, or is not reasonably expected to, exceed the EU limit and one of the following circumstances applies (10.2.5 b to 10.2.5g)

10.2.5.b. Where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with; or

10.2.5.c. The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or

10.2.5.d. Specialist expertise is required and is available from only one source; or

10.2.5.e. The task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

10.2.5.f. There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

10.2.5.g. Where provided for in the Capital Investment Manual.

10.2.5.h. Where the supply of goods or services is covered by an NHS Framework Agreement, and the price is certain (i.e. quoted)

Where it is decided that competitive tendering or quotations are not applicable and should be waived by virtue of (b) to (g) above the fact of the waiver and the reasons should be documented on a Single Tender or Quotation Action Form (STA/SQA) and reported by the Joint Chief Executive to the Executive Operational Committee. All such STA/SQA's should also be reported at the next available meeting of the Audit Committee.

10.2.6. The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

10.2.7. Such STA/SQA Waivers must be numbered, entered onto a register and retained for inspection in the Procurement Department.

10.2.8. It should be noted that the financial limits imposed at the various authorisation levels include VAT and have to be aggregated in the event of a contract covering a given number of months or years, ie "full life commitment".

10.2.9. Except where 10.2.5 or a requirement under 10.2.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

10.2.10. The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of a nominated officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Joint Chief Executive.

10.2.11. For all contracts involving tenders for good and services, a record will be maintained within the Procurement Department and the tender signed off by the Procurement Manager.

10.2.12. Quotations - are always required where formal tendering procedures are waived under 10.2.5 (a) or (c) and as per Table B: Delegated Financial Limits, Section 6 of the Reservation of Powers and Scheme of Delegation. For expenditure on items below the threshold reasonable endeavours should be made to obtain written quotations.

10.2.13. Where quotations are required under 10.2.9 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared for the goods or services required.

10.2.14. Quotations should be in writing unless the Joint Chief Executive or his nominated Officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

10.2.15. All quotations should be treated as confidential and should be retained for inspection.

10.2.16. The Joint Chief Executive or his nominated officer should evaluate the quotations and select the one, which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

10.2.17. Non-competitive quotations in writing may be obtained for the following purposes:

10.2.17.a. The supply of goods/services of a special character for which it is not, in the opinion of the Joint Chief Executive or his nominated officer, possible or desirable to obtain competitive quotations;

10.2.17.b. The goods/services are required urgently.

10.2.18. Where tendering or competitive quotation is not required - because expenditure is below specified limits the Trust shall procure goods and services in accordance with procurement procedures approved by the Board.

10.2.19. The Joint Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

10.2.20. Private Finance - When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

10.2.20.a. The Joint Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

10.2.20.b. Where the sum exceeds delegated limits as per Table B: Delegated Financial Limits, Section 6 of the Reservation of Powers and Scheme of Delegation, a business case must be referred to the Department of Health for approval or treated as per current guidelines.

10.2.20.c. The proposal must be specifically agreed by the Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires.

10.2.20.d. The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

10.2.21. Contracts - The Trust may only enter into contracts within its statutory powers and shall comply with:

10.2.21.a. These Standing Financial Instructions;

10.2.21.b. The Trust's Standing Orders, EU Directives and other statutory provisions;

10.2.21.c. Any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;

10.2.21.d. Such of the NHS Standard Contract Conditions as are applicable.

10.2.22. Where appropriate contracts shall be in or embody the same terms and conditions of contract, as was the basis on which tenders or quotations were invited.

10.2.23. In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Joint Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

10.2.24. Personnel and Agency or Temporary Staff Contracts - The Joint Chief Executive shall nominate officers with delegated authority to enter into contracts for the employment of other officers, to authorise regrading of staff, and enter into contracts for the employment of agency staff or temporary staff.

10.2.25. Where the Trust elects to invite tenders for the supply of healthcare services these Standing Financial Instructions and the Standing Orders shall apply as far as they are applicable to the tendering procedure.

10.2.26. The Joint Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

10.2.27. Cancellation of Contracts - Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the National Health Service and in accordance with 10.2.2 and 10.2.3, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 and other appropriate legislation.

10.2.28. Determination of Contracts for Failure to Deliver Goods or Material - There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

10.2.29. Contracts Involving Funds Held on Trust - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts.

10.3. Choice, Requisitioning, Ordering, Receipt and Payments for Goods and Services

10.3.1. The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement Team shall be sought. Requisitions must therefore be directed through the Trust's official contracts negotiated by or on behalf of the Trust, where available. Where such official contracts are not available, the procurement department must obtain quotations or tenders from an approved list of suppliers, in accordance with Standing Orders.

10.3.2. The Joint Chief Financial Officer will:

10.3.2.a. Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

10.3.2.b. Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

10.3.2.c. Be responsible for the prompt payment of all properly authorised accounts and claims and for advising the Board performance against targets set under the Government's Better Payments Practice Code;

10.3.2.d. Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

10.3.2.d.a. A list of directors/employees (including specimens of their signatures) authorised to requisition, receipt and certify invoices for payment in respect of goods/services provided to the Trust.

10.3.2.d.b. Certification that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

10.3.2.d.c. A timetable and system for submission to the Finance Department of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.3.2.d.d. Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.3.2.e. Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.3.3. Prepayments are only permitted where exceptional circumstances apply. In such instances:

10.3.3.a. The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value) and the intention is not to circumvent cash management arrangements;

10.3.3.b. The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

10.3.3.c. The Joint Chief Financial Officer must authorise the proposed arrangements before contractual arrangements proceed; and

10.3.3.d. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Joint Chief Executive if problems are encountered.

10.3.4. Official Orders must:

10.3.4.a. Be consecutively numbered;
10.3.4.b. Be in a form approved by the Joint Chief Financial Officer;
10.3.4.c. State the Trust's terms and conditions of trade; and
10.3.4.c.a Used only by those duly authorised.

10.3.5. Managers must ensure that they comply fully with the guidance and limits specified by the Joint Chief Financial Officer and that:

10.3.5.a. All contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Joint Chief Financial Officer in advance of any commitment being made;
10.3.5.b. Contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);
10.3.5.c. Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;
10.3.5.d. No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
10.3.5.d.1. Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
10.3.5.d.2. Conventional hospitality, such as lunches in the course of working visits;
10.3.5.d.3. Drugs company hospitality
10.3.5.d.4. Education Events
10.3.5.d.5. All gifts and hospitality must be reported in accordance with the Trust policy of reporting gifts and hospitality. Failure to report such gifts or hospitality may invalidate the supplying company from competing for Trust Business.
10.3.5.e. No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Joint Chief Financial Officer on behalf of the Joint Chief Executive;
10.3.5.f. All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash and any other specific areas agreed by the Joint Chief Financial Officer;
10.3.5.g. Verbal orders must only be issued very exceptionally by an employee designated by the Joint Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
10.3.5.h. Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
10.3.5.i. Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
10.3.5.j. Changes to the list of directors/employees authorised to certify invoices are notified to the Joint Chief Financial Officer;
10.3.5.k. Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Joint Chief Financial Officer; and
10.3.5.l. Petty cash records are maintained in a form as determined by the Joint Chief Financial Officer.

10.3.6. The Joint Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.4. Grants to Local Authorities and Voluntary Bodies

10.4.1. Grants to local authorities and voluntary organisations made under the powers of section 75 of the 2006 Act shall comply with procedures laid down by the Joint Chief Financial Officer which shall be in accordance with these Acts.

11. Treasury Management

11.1. External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The Trust operates within the framework and guidance provided by the Regulator and total amount of the Trust's borrowing must be affordable within the framework.

11.1.3 The Board must approve any application for a loan or overdraft facility and applications will be made by the Joint Chief Financial Officer or a person with specific delegated powers from the Joint Chief Financial Officer.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position and requirement in excess of one month must be authorised by the Joint Chief Financial Officer.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.2. Investments

11.2.1. Under the terms of the 2006 Act and its Constitution, the Trust may invest money (other than money held by it as a Trustee) for the purposes of or in connection with its functions. This may include investment by forming or participating in forming bodies corporate or by otherwise acquiring membership of bodies corporate.

11.2.2. The Joint Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held, other than short-term temporary cash surpluses.

11.2.3. The Joint Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.2.4. In the case of temporary cash surpluses, these may only be held in such form and with such public or private sector organisations, as are approved by the Board. In giving approval to the mechanisms for short-term investment, the Board will take account of instructions or guidelines issued by the Regulator to Foundation Trusts.

11.2.5. For other longer-term forms of investment, the approval of the Board will be obtained before proceeding.

11.3. Cash Flow Monitoring

11.3.1. The Joint Chief Financial Officer is responsible for managing and monitoring the overall cash flow of the Trust and for providing reports thereon to the Board. These reports will include:

11.3.1.a. A comparison of month end outturn with the plan (monthly); and
11.3.1.b. A rolling 12 month projection of month end cash balances (quarterly)

12. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

12.1. Capital Investment

12.1.1. The Joint Chief Executive:

12.1.1.a. Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
12.1.1.b. Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost ; and
12.1.1.c. Shall ensure that the capital investment is not undertaken without consideration of the availability of resources to finance all revenue consequences, including capital charges.

12.1.2. For every capital expenditure proposal the Joint Chief Executive shall ensure:

12.1.2.a. That a business case is produced setting out:
12.1.2.b. An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
12.1.2.c. Appropriate project management and control arrangements.
12.1.2.d. That the Joint Chief Financial Officer has certified professionally to the capital costs and revenue consequences detailed in the business case.

12.1.3. For capital schemes where the contracts stipulate stage payments, the Joint Chief Executive will issue procedures for their management, incorporating the recommendations of “The efficient management of healthcare estates and facilities”. The Joint Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4. The approval of a capital programme shall not constitute approval for the expenditure on any scheme. The Joint Chief Executive shall issue to the manager responsible for any scheme:

12.1.4.a. Specific authority to commit expenditure;
12.1.4.b. Authority to proceed to tender; and
12.1.4.c. Approval to accept a successful tender.

12.1.5. The Joint Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

12.1.6. The Joint Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

12.2. Private Finance

12.2.1. When the Trust proposes to access finance under the Private Finance Initiative, the following procedures shall apply:

12.2.1.a. The Joint Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;
12.2.1.b. Where the sum involved exceeds delegated limits, the business case must be treated as per current guidelines; and
12.2.1.c. The Board of Directors must specifically agree the proposal.

12.2.1.d. The effect of correct treatment of the proposed scheme in accordance with International Accounting Standards (especially IAS 16, IFRC 4, and IFRIC 12) shall be fully considered before a decision is reached on whether or not to proceed.

12.3. Asset Registers

12.3.1. The Joint Chief Executive is responsible for the maintenance of the registers of assets, taking account of the advice of the Joint Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.3.2. The Trust shall maintain an asset register recording fixed assets.

12.3.3. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

12.3.3.a. Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
12.3.3.b. Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
12.3.3.c. Lease agreements in respect of assets held under a finance lease and capitalised.

12.3.4. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.3.5. The Joint Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6. The value of assets shall be indexed to current values in accordance with methods specified in the Regulator's Financial Reporting Manual.

12.3.7. The value of each asset shall be depreciated using methods and rates as determined by the Joint Chief Financial Officer.

12.4. Security of Assets

12.4.1. The overall control of fixed assets is the responsibility of the Joint Chief Executive.

12.4.2. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Joint Chief Financial Officer. This procedure shall make provision for:

12.4.2.a. Recording managerial responsibility for each asset;
12.4.2.b. Identification of additions and disposals;
12.4.2.c. Identification of all repairs and maintenance expenses;
12.4.2.d. Physical security of assets;
12.4.2.e. Periodic verification of the existence of, condition of, and title to, assets recorded;
12.4.2.f. Identification and reporting of all costs associated with the retention of an asset; and
12.4.2.g. Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
12.4.2.h. All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Joint Chief Financial Officer.
12.4.2.i. Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines

to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

12.4.2.j. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.3. Where practical, assets should be marked as Trust property.

13. Stores and Receipt of Goods

13.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

13.1.1. Kept to a minimum;
13.1.2. Subjected to annual stock take; and
13.1.3. Valued at the lower of cost and net realisable value.

13.2. Subject to the responsibility of the Joint Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Joint Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Joint Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated estates manager.

13.3. The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager or Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

13.4. The Joint Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

13.5. Stocktaking arrangements shall be agreed with the Joint Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

13.6. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Joint Chief Financial Officer.

13.7. The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Joint Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The Designated Officer shall report to the Joint Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also 14, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.8. For goods supplied via the NHS Supplychain central warehouses, the Joint Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorized person shall check receipt against the delivery note before forwarding this to the Joint Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.

14. Disposals and Condemnations, Losses and Special Payments

14.1. Disposals and Condemnations

14.1.1. Under the terms of the Authorisation agreement, the approval of the Regulator is required prior to the disposal of any protected assets (above any "de minimis" limit where specified). There are no external restrictions on the disposal of other assets provided that the proceeds are used to further the Trust's public interest objectives.

14.1.2. The Joint Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. These procedures should take account of the requirements set out in (1) above.

14.1.3. When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Joint Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.4. All unserviceable articles shall be:

14.1.4.a. Condemned or otherwise disposed of by an employee authorised for that purpose by the Joint Chief Financial Officer; and

14.1.4.b. Recorded by the Condemning Officer in a form approved by the Joint Chief Financial Officer, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Joint Chief Financial Officer.

14.1.5. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Joint Chief Financial Officer who will take the appropriate action.

14.1.6. Competitive Tendering or Quotation procedures shall not apply to the disposal of:

14.1.6.a. Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Joint Chief Executive or his nominated Officer;

14.1.6.b. Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

14.1.6.c. Items to be disposed of with an estimated sale value of less than the figure of £50,000, this figure is to be reviewed annually;

14.1.6.d. Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

14.1.6.e. Land or buildings concerning which DoH guidance has been issued but subject to compliance with such guidance.

14.2. Losses and Special Payments

14.2.1. The Joint Chief Financial Officer shall prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

14.2.2. Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Joint Chief Executive and the Joint Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss, including through theft, criminal damage or fraud confidentially. This officer will then appropriately inform the Joint Chief Financial Officer and/or Joint Chief Executive. Where a criminal offence is suspected, the Joint Chief Financial Officer must immediately inform the police and NHS Counter Fraud Authority. The Joint Chief Financial Officer should also comply with any requirements to report fraud as determined by NHSI/Secretary of State.

14.2.3. For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial, the Joint Chief Financial Officer (or the Local Counter Fraud Specialist on the Director's behalf) must notify the Audit Committee, which will consider approval of write off on behalf of the Board.

14.2.4. The Joint Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.5. For any loss, the Joint Chief Financial Officer should consider whether any insurance claim could be made.

14.2.6. The Joint Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded and presented to the Audit Committee.

15. Information Technology

15.1. The Trust, under the terms of its Authorisation agreement, is required to participate in the national programme for information technology, in accordance with any guidance issued by the Regulator. This requirement extends to the Joint Chief Financial Officer in fulfilling his/her responsibilities for the computerised financial data of the Trust as set out below.

15.2. The Joint Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

15.2.1. Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

15.2.2. Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

15.2.3. Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

15.2.4. Ensure that an adequate management (audit) trail exists through the computerized system and that such computer audit reviews as he/she may consider necessary are being carried out.

15.3. Where a new financial system or significant amendment to a current financial system is proposed, the Joint Chief Financial Officer will ensure that an appropriate Business Case is prepared and approved in advance at the appropriate level. The Joint Chief Financial Officer will also ensure that such systems are developed in a controlled manner, with appropriate project planning mechanisms, and are thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.4. In the case of new financial systems which are sponsored jointly by a number of healthcare or other organisations, including the Trust, the Joint Chief Financial Officer will seek to ensure that the same approval/ planning requirements as set out in paragraph 3 above are complied with and that the Trust is fully signed up to the development.

15.5. The Joint Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.6. Where another health organisation or any other agency provides a computer service for financial applications, the Joint Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

15.7. Where computer systems have an impact on corporate financial systems the Joint Chief Financial Officer shall satisfy him/her self that:

15.7.1. Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
15.7.2. Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
15.7.3. Joint Chief Financial Officer staff have access to such data; and
15.7.4. Such computer audit reviews as are considered necessary are being carried out.

16. Patients' Property

16.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

16.2. The Joint Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

16.2.1. Notices and information booklets;
16.2.2. Hospital admission documentation and property records; and
16.2.3. The oral advice of administrative and nursing staff responsible for admissions; that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. The sole exception to this requirement is where patients are admitted in the circumstances outlined in paragraph 1 above.

16.3. The Joint Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to safeguard the interests of the patient.

16.4. Where good practice guidance (e.g. Department of Health instructions to non Foundation Trusts) suggests the need to open separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Joint Chief Financial Officer.

16.5. In all cases where property of a deceased patient is of a total value as may be prescribed by any amendment to the Law of Property Act 1994, Small Payments Act 1965, the production of Probate or Letters of Administration shall be required before any of the property is released or forms of indemnity.

16.6. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7. Where patients' property or income is received for specific purposes and held for safe keeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17. Funds Held on Trust

17.1. Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the guidance and regulation as determined by the Charity Commission.

17.2. The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.3. As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust.

17.4. The over riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18. Acceptance of Gifts and Hospitality

18.1. The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The Trust's Managing Conflicts of Interest in the NHS Policy(copy available from the Corporate Governance Manager/Human Resources), must be followed, and if appropriate the Joint Chief Executive and Joint Chief Financial Officer notified immediately so that the appropriate action can be taken.

18.2. Officers should follow the 'Managing Conflicts of Interest in the NHS Policy', it covers the accepting of inexpensive articles such as calendars or diaries and registering of gifts and hospitality. If gifts arrive unsolicited, the advice of the Joint Chief Financial Officer should be sought.

19. Private Transactions

19.1. Officers having official dealings with contractors or other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

20. Declaration of Interests

20.1. In accordance with Standing Orders, the Trust Secretary or other person as agreed from time to time shall be advised of declared pecuniary interests of members of the Board of Directors or officers, for recording in the register to be maintained for that purpose. This shall be updated every twelve months.

21. Retention of Documents

21.1. The Joint Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Department of Health guidelines for best practice.

21.2. The documents held in archives shall be capable of retrieval by authorised persons.

21.3. Documents so held shall only be destroyed at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

22. Risk Management & Insurance

22.1. The Joint Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current controls assurance guidance, which must be approved and monitored by the Board of Directors.

22.2. The programme of risk management shall include:

22.2.1. A process for identifying and quantifying risks and potential liabilities;
22.2.2. Engendering among all levels of staff a positive attitude towards the control of risk;
22.2.3. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
22.2.4. Contingency plans to offset the impact of adverse events;
22.2.5. Audit arrangements including; internal audit, clinical audit, health and safety review;
22.2.6. Decision on which risks shall be insured through arrangements with either the NHS Litigation Authorities Pooling Schemes or commercial insurers; and
22.2.7. Arrangements to review the risk management programme.

22.3. The existence, integration and evaluation of the above elements will provide the basis on which to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required in the Accounts Direction.

22.4. The Joint Chief Executive in consultation with his/her designated officer(s) shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board of Directors.

22.5. Each officer shall promptly notify the designated officer of all new risks or property under his/her control, which require to be insured and of any alterations affecting existing risks or insurances.

22.6. The designated officer shall ascertain the amount of cover required and shall affect such insurances as are necessary to protect the interests of the Trust.

22.7. The Joint Chief Executive or his/her designated officer shall make all claims arising out of policies of insurance and each officer shall furnish the Joint Chief Financial Officer immediate with full particulars of any occurrence involving actual or potential loss to the Trust and shall furnish an estimate of the probable cost involved.

22.8. The Joint Chief Financial Officer shall ensure that all engineering plant under his/her control is inspected by the relevant Insurance Companies within the periods prescribed by legislation.

22.9. The value of all assets and risks insured shall be reviewed or index linked on an annual basis by the designated officer.

22.10. The Joint Chief Financial Officer /Joint Chief Nursing Officer shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or enter into arrangements with commercial insurers.

22.11. Where the risk pooling schemes are used, the Joint Chief Financial Officer / Joint Chief Nursing Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Joint Chief Financial Officer / Joint Chief Nursing Officer shall ensure that documented procedures cover these arrangements.

22.12. The Risk Pooling Scheme for Trusts requires members to contribute to the settlement of claims (the 'deductible'). The Joint Chief Financial Officer /Joint Chief Nursing Officer shall

ensure documented procedures also cover the management of claims and payments below the deductible in each case.

22.13. The Joint Chief Financial Officer / Joint Chief Nursing Officer shall ensure documented procedures cover the management of claims and payments in respect of the arrangements with commercial insurers.

23. Custody of Seal and Sealing of Documents

23.1. Custody of Seal - The Common Seal of the Trust shall be kept by the Secretary in a secure place.

23.2. Sealing of Documents - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a Committee, thereof or where the Board has delegated its powers.

23.3. Before any building, engineering, property or capital document is sealed it must be approved and signed by the Joint Chief Executive (or an Officer nominated by him/her) and authorised and countersigned by the Chairman (or an Officer nominated by him/her who shall not be within the originating directorate).

23.4. Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

24. Signature of Documents

24.1. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Joint Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

24.2. The Joint Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or Committee or Sub-Committee to which the Board has delegated appropriate authority.

25. Miscellaneous

25.1. Standing Orders to be given to Directors and Officers - It is the duty of the Joint Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Joint Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

25.2. Documents having the standing of Standing Orders - Standing Financial Instructions and Reservation of Powers to the Board and Scheme of Delegation shall have the effect as if incorporated into SOs.

26. Subsidiaries

26.1 Subsidiaries

26.1.1 Subsidiary companies where the Trust are the shareholder (e.g. DCH Subco Ltd) are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries are subject to their own governance arrangements, and therefore these Standing Financial Instructions do not have to apply, except for where the group position is directly impacted (e.g. Group CDEL limit for capital). The subsidiary's during set-up broadly adopt the Trust's Standing Financial Instructions.

26.1.2 Whilst subsidiaries operate independently, their directors on appointment agree to the Reserved Matters, this is a schedule of changes where prior written approval of the Shareholder is required. This includes alteration of any constitutional documents of the company. Any changes to the schedule of prior Shareholder approval will require approval of Trust Board, following review and recommendation by the Audit and Risk Committee.

26.1.3 Subsidiaries for which the Trust provide services under a service level agreement (SLA). The arrangements for administration of the SLA are managed by the Commercial Development Team.

26.1.4 Dependent on the terms of the SLA, memorandum of understanding or equivalent, these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding or equivalent should be referred to on a case by case basis.

POLICY AUTHORISATION AND APPROVAL FORM

POLICY TITLE:	**STANDING FINANCIAL INSTRUCTIONS**
APPROVED BY:	**TRUST BOARD**
DATE APPROVED: NO OF MINUTE (IF APPLICABLE:)	
CONFIRMED BY:	**Chris Hearn**
DESIGNATION:	**Joint Chief Financial Officer**
Policy Lead:	**Chris Hearn**
Policy Author:	**Mark Lovett**
Date & Version:	**December 2024**
Review Date:	**December 2027**

RESERVATION OF POWERS

&

SCHEME OF DELEGATION

December 2024

The up to date version of this document can be found on the Intranet

SCHEME OF DELEGATION

Standing Orders (SOs), Standing Financial Instructions (SFIs) and Accountable Officer Memorandum set out in some detail the financial responsibilities of the Joint Chief Executive, the Joint Chief Financial Officer and other Directors.

The Scheme of Delagation covers matters delegated by the Board to the Joint Chief Executive and Directors, and certain other specific matters referred to in SFIs. It also details where approval is required by the Board or Board Sub-Committee

Further delegation may be approved.

Each Director will need to consider the arrangements for authorisation of expenditure against delegated budgets and further delegation of management/professional responsibilities.

FINANCIAL CONTROL ENVIRONMENT

In accordance with Standing Financial Instruction 1.3 "Audit Committee", the board exercises financial supervision and control by:

a) Authorising the financial strategy;

b) Requiring the submission and approval of budgets within approved allocations / overall income;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

d) Defining specific responsibilities placed on members of the Board, Committees / Sub-Committee members and employees as indicated in the Scheme of Delegation

e) Approving provision of shared services

To support this SFI 4, “Business Planning, Budgets and Budgetary Control” set out the main aspects of budgetary and resource management within the Trust.

Once the Board has reviewed and approved the Operating Plan and any supporting financial plan / budget the Board will delegate approval to the Joint Chief Executive, Joint Chief Financial Officer, Executive Directors and employees to commit these resources for the purpose set out in the plan subject to the financial thresholds set out in this scheme of delegation.

For the avoidance of doubt this delegation (subject to the limits approved by the Board in the Scheme of Delegation) include:

- Awarding of Contracts including the signing of appropriate contract documentation;
- Payment of sums due against approved contracts;
- Agreement of contract variations and subsequent amendments to contract payments;
- Operation of appropriate procurement processes within agreed financial thresholds;
- Budgetary delegation icluding approval of non-pay single orders, payroll expenditure and authorisation for the raising of invoices to debtors;

- Approval to vire (transfer) budgets within overall available financial resources and in line with the Operating Plan;
- Approval of capital expenditure
- Approval of disposal, condemnations, losses and special payments
- Business development and investments

These delegated authorities set out the maximum authorised delegated authority for the Trust. All delegated authority, except where otherwise indicated applies only to the Divisons or cost centre for which the delegated authority has been given. Delegated authority only applies up to budgeted levels.

Those with delegated limits are responsible for ensuring that Standing Orders and Standing Financial Instructions are followed and that commitments are only made using the Trust formal processes which requires that goods and services must be ordered utilising the Trust Purchasing processes as issued from time to time by the Chief Financial Officer or Head of Procurement & Logistics and that the formal tendering process, where applicable, has been followed in accordance with Standing Orders and Standing Financial Instructions.

All delegated authority, except where otherwise indicated, applies only to the Divisons or cost centre for which the delegated authority has been given as described on the Delegated Authority Form.

Delegated authority may be exercised only the amounts up to budget limits and no higher, and carries no discretionary freedom to overspend against budgets.
Delegated authority may be exercised only on amounts up to budget limits and no higher, and carries no discretionary freedom to overspend against budgets.

Officers with delegated authority are responsible for ensuring that Standing Orders and Standing Financial Instructions are followed and that commitments to purchase goods and services are made using the Trust Purchasing Procedures as issued from time to time by the Joint Chief Financial Officer, Deputy Chief Financial Officer or Head of Procurement & Logistics.

Purchase requisitions for authorisation must be routed via the organisational structure.

The delegation of authority is a formal process and each person to whom authority is delegated within this process is required to sign a Delegated Authority Form in a format to be determined by the Joint Chief Financial Officer. The Deputy Chief Financial Officer is to maintain a register of delegated authorities and retain the signed Delegated Authority Forms.

The Joint Chief Executive will issue delegated authority to Directors who may delegate to deputies.

In the absence of the delegated officer, authority reverts to the higher level of authority. The only exceptions are the Joint Chief Executive and Joint Chief Financial Officer whose nominated Deputies will assume their level of Authority during planned and unplanned absences.

In the absence of the Joint Chief Executive's nominated Deputy the authority will revert to the Board of Directors.

SCHEME OF RESERVATION AND DELEGATION

The following decisions are reserved to the Board, i.e. these decisions may only be made by the Board under the arrangements outlined within the Standing Orders.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
A SO 2.5	The Board	***General Enabling Provision*** 1. The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
B Statutory Framework SO 4.9 SO 4.10 SO 4.5 SO 7.1 SO 7 SO SO 5 SO 5 SO 2.4 SO 4.4 Statutory Framework SO 8.2 SO 3.19 SO 5.3	The Board	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Approve a scheme of delegation of powers from the Board to the Chief Executive and other committees**.** 5. Require and receive the declaration of Board members' interests which may conflict with those of the Trust and, taking account of any waiver which the Secretary of State for Health may have made in any case, determining the extent to which that member may remain involved with the matter under consideration. 6. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 7. Approve arrangements for dealing with complaints. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 9. Receive reports from Committees including those that the Trust is required by the Secretary of State or Monitor to establish and to action appropriately. 10. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 14. Authorise use of the seal. 15. Discipline members of the Board or employees who are in breach of statutory requirements 16. Approve any urgent decisions taken by the Chairman of the Trust and Chief Executive for ratification by the Trust in public session
C SO 3.2 SO 4.1 SO 2.1 SO 4.7 SO 4.8	The Board	***Appointments/ Dismissal*** 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss officer members 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 5. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the CE for staff not covered by the Remuneration Committee.
		Strategy, Operational Plan and Budgets 1. Define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored.

		3. Approve plans in respect of the application of available financial resources to support the agreed Annual Plan.

Statutory Framework & NHS Framework	The Board	4. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State and/or Monitor. 5. Approve (with any necessary appropriate modification) the Trust annual plan. 6. Approve annually (with any necessary appropriate modification) the Trust Acute Services Contract. 7. Approve the Trust's policies and procedures for the management of risk. 8. Approve Outline and Final Business Cases for Capital Investment if this represents a variation from the Plan. 9. Approve budgets 10. Advise on the introduction or discontinuance of any significant activity or operation. An activity of operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £250,000. 11. Approve annually Trust's proposed organisational development proposals. 12. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 13. Approve PFI proposals. 14. Approve the opening of bank accounts. 15. Approve Executive proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 per annum. 16. Approve Executive proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Joint Chief Executive and Joint Chief Financial Officer (for losses and special payments) previously approved by the Board. 17. Approve individual compensation payments. 18. Approve proposals for action on litigation against or on behalf of the Trust. 19. Approve revenue investments greater than £500,000.
E	The Board	**Policy Determination** 1. The approval of Trust corporate management policies where not specifically delegated to Committee(s) to approve. Policies so adopted shall be listed and appended to this document.
F	Council of Governors	**Audit** 1. Approve the appointment (and where necessary dismissal) of External Auditors and advise the Monitor on the appointment (and where necessary change/removal) of External Auditors including arrangements for the separate audit of funds held on trust, and to receive reports of the Audit Committee meetings and take appropriate action.
	The Board	2. Receive the annual management letter received from the External Auditor and agreement of Executive's proposed action, taking account of the advice, where appropriate, of the Audit Committee.
G	The Board	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts.
H	The Board	**Monitoring** 1. Receipt of such reports as the Board sees fit from the Executive in respect of its exercise of powers delegated.

SCHEME OF RESERVATION AND DELEGATION

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEE

The following decisions and duties have been delegated by the Board to the Sub Committees detailed below.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 2.1.1.a SFI 2.1.1 SFI 2.1.1.c SFI 2.1.1.d SFI 2.1.1.e	Audit Committee	The Committee will: 1. Advise the Board on internal and external audit services; 2. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives; 3. Monitor compliance with Standing Orders and Standing Financial Instructions; 4. Review schedules of losses and compensations and agree write offs; 5. Review the annual financial statements prior to submission to the Board.
SFI 9.1.2.a SFI 9.1.2.a.1 SFI 9.1.2.a.2 SFI 9.1.2.a.3 SFI 9.1.2.b SFI 9.1.2.d SFI 9.1.3	Remuneration Committee	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other executive directors and other senior employees including: • all aspects of salary (including any performance-related elements/bonuses); • provisions for other benefits, including pensions and cars; • arrangements for termination of employment and other contractual terms; 2. Make recommendations to the Board on the remuneration and terms of service of senior employees to ensure they are fairly rewarded for their individual contribution to the Trust having proper regard to the Trusts's circumstances and performance and to the provisions of any national arrangements for such staff; 3. Ensure proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 4. Report in writing to the Board the basis for its recommendations.
	People and Culture Committee	The Committee will advise the Board: - for full details refer to Terms of Reference
	Finance & Performance Committee	The Committee will advise the Board: - for full details refer to Terms of Reference
	Strategy, Transformation and Partnership Committee	The Committee will advise the Board: - for full details refer to Terms of Reference
	Quality Committee	The Committee will advise the Board: - for full details refer to Terms of Reference

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

The following duties are delegated by the Board to the Chairman and Executive officers.

REF	DELEGATED TO	DUTIES DELEGATED
AOM 3	Joint Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources.
AOM 3 AOM 3	Joint Chief Executive & Joint Chief Financial Officer	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Monitor/Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
AOM 3 AOM 3	Joint Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
AOM 10	Joint Chief Executive	Ensure effective management systems that safeguard public funds and assist Trust Chairman to implement requirements of corporate governance including ensuring managers: • have a clear view of their objectives and the means to assess achievements in relation to those objectives; • be assigned well defined responsibilities for making best use of resources; • have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
SO 2.1	Joint Chair	Implement requirements of corporate governance
AOM 8	Joint Chief Executive	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office (NAO). Use to best effect the funds available for providing healthcare, developing services and promoting health to meet the needs of the local population.
AOM 7	Joint Chief Financial Officer	Operational responsibility for effective and sound financial management and information.
AOM 7	Joint Chief Executive	Primary duty to see that JCFO discharges the function above.
AOM 3	Joint Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements
	Joint Chief Executive	The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Boards by the Secretary of State are fundamental in exercising your responsibilities for regularity and probity. As a Board member you have explicitly subscribed to the Codes; you should promote their observance by all staff.
AOM 12	Joint Chief Executive & Joint Chief Financial Officer	Chief Executive, supported by Joint Chief Financial Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
AOM 13	Joint Chief Executive	If Joint Chief Executive considers the Board or Joint Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Joint Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary Monitor.
AOM 13	Joint Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Joint Chief Executive's responsibility for value for money, the Joint Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Joint Chief Executive should inform the Regulator. In such cases, and in those described in paragraph 24, the Joint Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

The following duties and decisions are either reserved to the Board or delegated to the stated Committees, Non Executive members or Executive officers.

REF	DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
SFI 18.1	Board	Approve procedure for declaration of hospitality and sponsorship
	Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of Code of Conduct, and other ethical concerns.
	All Board members	Subscribe to Code of Conduct
SFI 9	Board	Board members share corporate responsibility for all decisions of the Board.
	Chair and Non Executive Directors	Chair and non Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Board of Governors for the discharge of those responsibilities.
	Board	The Board has six key functions for which it is held accountable by Monitor of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure that the Executive leads an effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
	Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. establish the Executive; 3. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these; 4. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 5. establish performance and quality measures that maintain the effective use of resources and provide value for money; 6. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 7. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference which set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the Board.

	Chair	It is the Chairman's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner; 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead non-executive Board members through a formally - appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other executive Board members; 6. appoint non-executive Board members to an Audit Committee of the main Board; 7. advise the Board of Governors on the performance of non-executive Board members.
	Chief Executive	The Chief Executive is accountable to the Chairman and non-executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
	Non Executive Directors	Non Executive Board members are appointed by or on behalf of the Board of Governors to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through Monitor to Ministers and to the local community.
	Chair and Board Members	Declaration of conflict of interests.
	Board	NHS Boards must comply with legislation and guidance issued by the Monitor on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

Table A – Delegated Authority

The individual, who has the delegated matter delegated to them, retains responsibility for this matter. The individual who has operational responsibility delegated to them is responsible for undertaking the actual delivery of the matter.

REF	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
	1. Standing Orders/Standing Financial Instructions/Constitution		
SFI 1.1.3	a) Final authority in interpretation of Standing Orders	Chairman	Chairman
SFI 1.3.6	b) Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Joint Chief Executive	Directors/Heads of Department
SFI 1.3.8	c) Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial instructions and financial procedures	Joint Chief Executive	All Directors and Employees
	d) Suspension of Standing Orders	Board of Directors	Board of Directors
SO 3.14	e) Review suspension of Standing Orders	Audit Committee	Audit Committee
SO 3.15	f) Variation or amendment to Standing Orders	Board of Directors	Board of Directors
SO 5.2	g) Emergency powers relating to the authorities retained by the Board of Directors.	Joint Chair and Joint Chief Executive with two non-executives	Joint Chair and Joint Chief Executive with two non-executives
SFI 1.3.8.d	h) Disclosure of non-compliance with Standing Orders to the Joint Chief Executive (report to the Board of Directors)	All	All
	i) Disclosure of non-compliance with SFIs to the Chief Financial Officer (report to the Audit Committee)	All	All
SFI 1.1.3	j) Advice on interpretation or application of SFIs	Joint Chief Financial Officer	Joint Chief Financial Officer / Internal Audit
	2. Meetings		
SO 3.1	a) Calling meetings of the Foundation Trust	Joint Chairman	Joint Chairman
SO 3.10	b) Chair all Foundation Board of Directors and Board of Governors meetings and associated responsibilities	Joint Chairman	Joint Chairman
	3. Financial Planning/Budgetary Responsibility		
	a) Setting:		
SFI 4.1.5	• Submit budgets to the Board of Directors	Joint Chief Financial Officer	Joint Chief Financial Officer
SFI 4.1.2	• Submit to Board of Directors financial estimates and forecasts	Joint Chief Financial Officer	Joint Chief Financial Officer
	b) Monitoring:		
SFI 4.2.1	• Delegate budget to budget holders	Joint Chief Executive	Joint Chief Financial Officer
SFI 4.3.1	• Monitor performance against budget	Joint Chief Financial Officer	Budget Holders with support from Finance Manager
	• Preparation of a business case for investment over £50,000.		
	• Identify and implement cost improvements and income generation activities in line with the Service Development Strategy.	Joint Chief Executive	Project Sponsors and Leads supported by Programme Office
	• Submit monitoring returns	Joint Chief Financial Officer	Deputy Chief Financial Officer
	• Preparation of annual accounts	Joint Chief Financial Officer	Deputy Chief Financial Officer
	• Preparation of annual report	Joint Chief Executive	Joint Chief Financial Officer
	c) Authorisation of Virement	Joint Chief Executive	
	It is not possible for any officer to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders requires the agreement of both parties.	Joint Chief Executive	Refer to Table B Delegated Limits
	d) Provision of budget holder guidance instructions and ensuring adequate training is delivered on an ongoing basis to budget holders	Joint Chief Financial Officer	Deputy Chief Financial Officer
	4. Bank/OPG Accounts (Excluding Charitable Fund Accounts)		
	a) Operation:		
SFI 6.1.1	• Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 6.2.2	• Opening bank accounts	Joint Chief Financial Officer	Joint Chief Financial Officer
SFI 6.3.1	• Authorisation of transfers between Foundation Trust bank accounts	Joint Chief Financial Officer	To be completed in accordance with bank mandate/internal procedures
	• Authorisation of:	Joint Chief Financial Officer	To be completed in accordance with bank mandate/internal procedures
	• Investment of surplus funds in accordance with the Foundation Trust's Operating Cash Management Policy.	Joint Chief Financial Officer	Deputy Chief Financial Officer
	• Approval and Monitoring of Operating Cash Management Policy.	Board of Directors	Joint Chief Financial Officer
	c) Petty Cash	Joint Chief Financial Officer	Refer To Table B Delegated Limits

	5. External Borrowing		
SFI 11.1	a) Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital.	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 11.1	b) Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.	Joint Chief Financial Officer	In accordance with relevant mandate
SFI 11.1	c) Authorisation of drawing of working capital financing facilities up to principal sum of £10,000,000 at any one time	Joint Chief Financial Officer	In accordance with relevant mandate
SFI 11.1	d) Preparation of procedural instructions	Joint Chief Financial Officer	Deputy Chief Financial Officer
	6. Non Pay Expenditure		
SFI 10.3.1	b) Obtain the best value for money when requisitioning goods / services	Joint Chief Financial Officer	Head of Procurement & Logistics
SFI 10.1.1	c) Financial Limits for Budgetary Expenditure (including invoice authorisation without orders)	Joint Chief Executive	Refer to Table B Delegated Limits
SFI 10.3.5.e	d) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement.	Joint Chief Executive	Joint Chief Financial Officer
SFI 10.3.2.e	e) Payment of accounts in accordance with terms and conditions of purchase	Joint Chief Financial Officer	Deputy Chief Financial Officer
	7. Supplies, Systems and Receipt of Goods		
SFI 13.2	a) Responsibility for purchasing systems, stock control systems and ensuring procedures are in place for the control over stores and receipt of goods, issues and returns	Joint Chief Financial Officer	Deputy Chief Financial Officer / Head of Procurement & Logistics
SFI 13.2	b) Responsibility for control of Pharmaceutical stocks	Chief Operating Officer	Chief Pharmacist
SFI 13.5	c) Stocktaking arrangements	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 13.7	d) Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.	Joint Chief Financial Officer	Deputy Chief Financial Officer / Head of Procurement & Logistics
	8. Capital Investment		
	a) Requirement Setting:		
SFI 12.1	• Ensure that there is a robust requirement setting process for capital investment	Joint Chief Executive	Joint Chief Financial Officer
	b) Programme:		
SFI 12.1.1.a	• Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans	Joint Chief Executive	Joint Chief Financial Officer
SFI 4.1.5	• Preparation of Capital Investment Programme	Joint Chief Financial Officer	Capital Planning & Space Utilisation Group
SFI 12.1.2	• Preparation of a business case for expenditure over £50,000	Joint Chief Financial Officer	All Directors
SFI 12.1.6	• Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Joint Chief Executive	Refer to Table B Delegated Limits
SFI 12.1.5	• Authorisation of capital requisitions	Joint Chief Executive	Capital Planning & Space Utilisation Group
SFI 12.1.1.b	• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Joint Chief Executive	Joint Chief Financial Officer
SFI 12.1.1.c	• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Joint Chief Executive	Joint Chief Financial Officer
SFI 12.1.6	• Issue procedures to support capital investment	Joint Chief Financial Officer	Deputy Chief Financial Officer
	c) Private Finance:		
SFI 12.2.1.a	• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Joint Chief Executive	Joint Chief Financial Officer
	d) Leases;		
SFI 12.2.1.d	• Granting and termination of leases with annual rent <= £50k	Joint Chief Financial Officer	Joint Chief Financial Officer
SFI 12.2.1.d	• Granting and termination of leases with annual rent < £100k	Joint Chief Executive	Joint Chief Financial Officer
SFI 12.2.1.d	• Granting and termination of leases with annual rent >= £100k	Board of Directors	Joint Chief Executive
	9. Quotation, Tendering & Contract Procedures		
	a) Services:		
SFI 10..2.19	• Best value for money is demonstrated for all services provided under contract or in-house	Joint Chief Executive	Joint Chief Financial Officer, supported by Head of Procurement & Logistics.
SFI 10.2.23	• Nominate officers to oversee and manage the technical and, or qualitative and, or operational aspects of contract on behalf of the Foundation Trust.	Joint Chief Executive	As nominated by Joint Chief Executive.
SFI 10.2.23	• Oversee the commercial aspects of the contract on behalf of the Foundation Trust, including contract management and amendments and pricing.	Joint Chief Financial Officer	Head of Procurement & Logistics
SFI 10.2.12	b) Quotations	Joint Chief Executive	Refer to Table B Delegated Limits
	c) Competitive Tenders:		
SFI 10.1.1	• Authorisation limits	Joint Chief Executive	Refer to Table B Delegated Limits
SO 14	• Receipt and custody of tenders prior to opening	Joint Chief Executive	Joint Chief Executive
SO 14	• Opening of tenders	Joint Chief Executive	Two Senior Officers, one of whom should be a senior manager, not from the originating department or the officer receiving the tenders. Consisting of a Board member or Deputy/Associate Director.

SO 14	• Decide if late tenders should be considered	Joint Chief Executive	Joint Chief Financial Officer
SFI 10.2.5	d) Waiving the requirement to request quotes or tenders - subject to SOs	Joint Chief Executive	Refer to Table B Delegated Limits
SO 14	e) Where the lowest tender or quotation is not accepted the details are to be permanently documented using a quotation or tender acceptance form	Joint Chief Executive	Joint Chief Financial Officer
SO 14.8	f) Reporting of waivers for tenders and quotations to the Audit Committee	Joint Chief Financial Officer	Joint Chief Financial Officer
	10. Fixed Assets		
SFI 12.3.2	a) Maintenance of asset register	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 12.3.5	b) Approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset register	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 12.1.1.c	c) Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 12.4	d) Responsibility for security of Foundation Trust assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with Foundation Trust procedures.	Joint Chief Executive	All staff
	11. Personnel & Pay		
SFI 9.3.1	a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Joint Chief Executive	Refer to Table C Establishment & Pay Control
SFI 9.3.1	b) Authority to fill funded post on the establishment with permanent staff.	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.3.2	c) The granting of additional increments to staff within budget (other than automatic increments) as per Agenda for Change and Medical staff terms and conditions	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.3.2	d) All requests for upgrading/regrading major skill mix changes shall be dealt with in accordance with Foundation Trust Procedures and Agenda for Change and Medical Staff terms and conditions	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.2	e) Establishments		
	• Additional staff to the agreed establishment with specifically allocated finance	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
	• Additional staff to the agreed establishment without specifically allocated finance	Joint Chief Executive	Refer to Table C Establishment & Pay Control
SFI 9.4.3	f) Pay		
	• Authority to complete standing data forms effecting pay, new starters, variations and leavers • Authority to authorise overtime • Authority to authorise travel & subsistence expenses	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.4.3	g) Leave (To be applied in accordance with Agenda for Change and Medical Staff terms and conditions of service)		
	• Approval of annual leave • Annual leave – approval of carry forward up to a maximum of 5 days as per Agenda for Change and Medical Staff terms and conditions of service • Annual leave – approval of carry forward of 6-10 days (to occur in exceptional circumstances) • Annual leave - approval of carry forward in excess of 10 days.	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.4.3	h) Family & Special Leave as per Foundation Trust Policy covering:-		
	• Bereavement Leave • Special Leave for Family and Domestic Reasons • Adoption Leave • Paternity Leave • Parental Leave • Maternity Leave	Joint Chief Executive	Refer to Table C Establishment & Pay Control
SFI 9.4.3	i) Special Leave as per Foundation Trust Policy covering:-		
	• Jury Service • Armed Services • Short Term Unpaid Leave • Employment Break Leave • Medical Staff Leave of Absence – paid and unpaid • Time off in lieu	Joint Chief Executive	Refer to Table C Establishment & Pay Control
SFI 9.4.3	j) Sick Leave on half pay as per Attendance Management Policy		
	• Phased return to work part-time on full pay to assist recovery • Extension of sick leave on full or half pay	Joint Chief Executive	Refer to Table C Establishment & Pay Control
SFI 9.4.3	k) Study Leave		
	• Medical staff study & professional leave		
	- Career Grade	Chief Medical Officer	As policy
	- Non Career Grade	Post Graduate Tutor	Clinical Director
	• All other study leave as per policy	Joint Chief People Officer	Line Managers
SFI 9.4.3	l) Removal Expenses (Authorisation of payment of removal expenses incurred by officers taking up new appointments as per policy)	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.3.2	m) Grievance Procedure (All grievances cases must be dealt with strictly in accordance with the Grievance Policy)	Joint Chief People Officer	Directors and Head of Department in conjunction with Deputy Chief People Officer
SFI 9.3.2	n) Authorised Car & Mobile Phone Users		
	• Publicise policy for authorised car user and mobile phone user	Joint Chief Financial Officer	Deputy Head of Estates and Facilities

	• Requests for new posts to be authorised as car users	Joint Chief Financial Officer	All Directors, Heads of Department
	• Requests for new posts to be authorised as mobile telephone users	Joint Chief Financial Officer	All Directors, Heads of Department
SFI 9.3.2	o) Renewal of Fixed Term Contracts	Joint Chief People Officer	Refer to Table C Establishment & Pay Control
SFI 9.3.2	p) Staff Retirement Policy		
	• Authorisation of extensions of contract beyond normal retirement age	Joint Chief People Officer	Directors
	• Authorisation of return to work in part time capacity under the flexible retirement scheme	Joint Chief People Officer	Directors
	• Redundancy	Joint Chief Executive	Joint Chief People Officer
	• Ill Health Retirement	Joint Chief People Officer	Directors, Head of Department in association with Deputy Chief People Officer
SFI 9.3.2	q) Disciplinary Procedure (excluding Executive Directors) as per Disciplinary Policy and Medical Staffing Policy	Joint Chief People Officer	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
SFI 9.5.1	r) Ensure all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Joint Chief People Officer	Deputy Chief People Officer
	12. Engagement of Staff Not On the Establishment		
SFI 9.3.1	a) Non Medical Consultancy Staff.		
	• Where aggregate commitment in any one year (or total commitment) is less than £20,000 and is within directorate budget	Joint Chief Executive	Directors
	• Where aggregate commitment in any one year is more than £20,000	Joint Chief Executive	Director of Finance & Resources
SFI 9.3.1	b) Booking of Bank Staff		
	• Nursing	Joint Chief Nursing Officer	Matron, Budget Holder
	• Medical	Chief Medical Officer	Clinical Directors
SFI 9.3.1	c) Booking of Agency Staff		
	• Nursing	Joint Chief Nursing Officer	Matron
	• Medical	Chief Medical Officer	General Managers
	13. Funds Held on Trust		
SFI 17.1	a) Management: • Funds held on trust are managed appropriately.	Joint Chief Financial Officer	Nominated fund holder
SFI 17.2	b) Maintenance of authorised signatory list of nominated fund holders.	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 17.2	c) Expenditure Limit		Refer to Table B Delegated Limits
	• Fundraising Appeals: • Preparation and monitoring of budget • Reporting progress and performance against budget • Operation of Bank Accounts:	Joint Chief Financial Officer	Fundraising Manager with advice from the Deputy Chief Financial Officer
SFI 6.1	d) Managing banking arrangements and operation of bank accounts	Joint Chief Financial Officer in conjunction with trustees	Deputy Chief Financial Officer
SFI 6.2.1.b	e) Opening bank accounts	Joint Chief Financial Officer	Joint Chief Financial Officer
SFI 11.2	f) Investments:	Joint Chief Financial Officer	Refer to Table B Delegated Limits
	• Nominated deposit taker	Board of Trustees	Joint Chief Financial Officer
	• Placing transactions	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 17.1	g) Registration of Funds with Charities Commission	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 17.1	h) Approval of the annual charitable funds accounts	Board of Directors acting on behalf of the Corporate Trustee	Charitable Funds Committee

	14. Patient Services Agreements		
SFI 8.1	a) Negotiation of:		
	• Main Commissioning Contracts for Acute services	Joint Chief Executive	Joint Chief Financial Officer
	• Contracts	Joint Chief Financial Officer	Directors
SFI 8.3	b) Quantifying and monitoring Non-contract activity	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 8.3	c) Reporting actual and forecast income including payment by results	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 4.3.4	d) Costing Foundation Trust Agency Purchase Contract and Non Commercial Contracts	Joint Chief Financial Officer	Deputy Chief Financial Officer

SFI 4.3.4	e) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Joint Chief Financial Officer	Deputy Chief Financial Officer / Head of Management Accountants
	15. Setting of Fees and Charges		
SFI 7.2.2.	a) Overseas Visitors, Income Generation and other patient related services.	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 7.2.2.	b) Private Patients	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 7.2.2.	c) Non patient care income	Joint Chief Financial Officer	Directors, Head of Department
SFI 7.2.3	d) Informing the Director of Finance of monies due to the Foundation Trust	Joint Chief Financial Officer	All Staff
SFI 7.3	e) Recovery of debt	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 7.4	f) Security of cash and other negotiable instruments	Joint Chief Financial Officer	Deputy Chief Financial Officer
	16. Disposal and Condemnations		
SFI 14.1.6.b	Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Joint Chief Financial Officer	Refer to Table B Delegated Limits
	17. Losses, Write-off & Compensation		
SFI 14.2	a) Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing the Counter Fraud and Security Management Service of frauds	Joint Chief Executive	Deputy Chief Financial Officer
SFI 14.2	b) Financial Limits	Joint Chief Executive	For Financial Limits Refer to Table B
	Ex-Gratia Payments:		
SFI 14.2	a) Financial Limits	Joint Chief Financial Officer	For Financial Limits Refer to Table B
SFI 14.2	b) Other, except cases of maladministration where there was no financial loss by claimant £50,000	Joint Chief Executive	Joint Chief Financial Officer
	18. Reporting of Incidents to the Police		
	a) Where a criminal offence is suspected • criminal offence of a violent nature • arson or theft • other	Joint Chief People Officer	Senior Manager On-call, Directors, Director of Operatial Planning and Performance
	b) Where a fraud is involved (Counter Fraud and Security Management Service and External Audit)	Joint Chief Financial Officer	Local Counter Fraud Officer
	19. Financial Procedures		
SFI 1.1.2	a) Maintenance & Update on Foundation Trust Financial Procedures	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 1.3.4	b) Accountable for Financial Control	Joint Chief Executive / Joint Chief Financial Officer	All budget holders with support from Finance Manager
SFI 1.3.7	c) Responsibilities:- • Implement Foundation Trust's financial policies and co-ordinate corrective action. • Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented • Ensuring that sufficient records are maintained to explain Foundation Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff. • Maintaining such accounts, certificates etc to meet statutory requirements.	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 1.3.7	d) Financial Systems • Responsible for the accuracy and security of computerised financial data. • Ensure that contracts for computer services clearly define responsibilities for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. • Ensure that new and upgraded systems are developed in a controlled manner and tested.	Joint Chief Financial Officer	Deputy Chief Financial Officer
	20. Audit Arrangements		
SFI 2.3.1.b	a) Ensure an adequate internal audit service, for which he / she is accountable, is provided (and involve the Audit Committee in the selection process when / if an internal audit service provider is changed.)	Board of Directors	Joint Chief Financial Officer
SFI 2.3.1.d	b) Review, appraise and report in accordance with Government Internal Audit Manual (GIAM) and best practice.	Audit Committee	Internal Audit
SFI 2.4.2	c) Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
SFI 2.5.3	d) Ensure cost-effective external audit.	Audit Committee	Joint Chief Financial Officer
SFI 2.3.1.d	e) Implement recommendations	Joint Chief Executive	Relevant Officers
	21. Legal Proceedings		
SFI 24.1	a) Engagement of Foundation Trust's Solicitors	Joint Chief Executive	Joint Chief Financial Officer
SFI 24.1	b) Approve and sign all documents which will be necessary in legal proceedings	Joint Chief Executive	Joint Chief Financial Officer
SFI 24.2	c) Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed	Joint Chief Executive	Joint Chief Financial Officer
	22. Clinical Audit	Chief Medical Officer	Clinical Directors / Clinical Managers/ Department Heads / Clinical Governance Department
	23. Commercial Sponsorship		

	a) Agreement to proposal	Joint Chief Executive	Joint Chief Financial Officer
	24. Patients' Property (in conjunction with financial advice)		
SFI 16.2.3	a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Joint Chief Executive	Joint Chief Nursing Officer
SFI 16.3	b) Prepare detailed written instructions for the administration of patients' property	Joint Chief Nursing Officer	Deputy Chief Nurse
SFI 16.2	c) Informing staff of their duties in respect of patients' property	Joint Chief Nursing Officer	Deputy Chief Financial Officer
SFI 16.5	d) Issuing property valued >£5,000 only on production of a probate letter of administration	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 16.5	e) Deceased Patients Property	Joint Chief Nursing Officer	Deputy Chief Nurse
	25. Patients & Relatives Complaints		
	a) Overall responsibility for ensuring that all complaints are dealt with effectively	Joint Chief Executive	Joint Chief Nursing Officer
	b) Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly.	Joint Chief Nursing Officer	Respective Director
	26. Seal		
SO 8.1	a) The keeping of a register of seal and safekeeping of the seal	Joint Chief Executive	Joint Director of Corporate Affairs
SO 8.4	b) Attestation of seal in accordance with Standing Orders	Joint Chairman	Joint Chief Executive
SFI 18	**27. Hospitality**		
	a) Keeping of hospitality register	Joint Chief Executive	Joint Director of Corporate Affairs
	b) Applies to both individual and collective hospitality receipt items in excess of £100.00 per item received	Joint Chief Executive	All staff declaration required in Foundation Trust's Hospitality Register
SFI 20	**28. Declaration of Interest**		
SO 7.0	a) Declare relevant and material interest	Joint Chief Executive	Board of Directors, Joint Executive Management Team, Consultants, Head of Department
SO 7.2	b) Maintaining a register	Joint Chief Executive	Joint Director of Corporate Affairs
SFI 21	**29. Data Protection Act**		
	a) Review of Foundation Trust's compliance	Joint Chief Executive	Joint Director of Corporate Affairs
SFI 21	**30. Records**		
	a) Review Foundation Trust's compliance with the Retention of Records Act	Joint Chief Executive	Executive Directors
	b) Retention of records held under Records Management Code of Practice for Health and Social Care	Joint Chief Executive	Executive Directors, Heads of Department
	c) Ensuring the form and adequacy of the financial records of all departments	Joint Chief Financial Officer	Deputy Chief Financial Officer
SFI 21	**31. Confidential Information**		
	a) Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS.	Joint Chief Executive	Joint Chief Nursing Officer
	b) Freedom Of Information Act Compliance Code	Joint Chief Executive	Joint Director of Corporate Affairs
SFI 22	**32. Authorisation of New Drugs**	Joint Chief Executive	Medicines Committee
SFI 22	**33. Authorisation of Research Projects**	Joint Chief Executive	R & D Committee
SFI 22	**34. Authorisation of Clinical Trials**	Joint Chief Executive	R & D Committee
SFI 22	**35. Authorisation of Product Trials**	Joint Chief Executive	Head of Department with Head of Procurement & Logistics
SFI 22	**36. Infectious Diseases & Notifiable Outbreaks**	Joint Chief Nursing Officer	Clinical Directors
SFI 22	**37. Review of Fire Precautions**	Joint Chief Executive	Joint Chief People Officer
	38. Health and Safety		
SFI 22	a) Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Joint Chief Executive	Joint Chief People Officer
	39. Medicines Inspectorate Regulations		
SFI 22	a) Review Regulations	Joint Chief Executive	Chief Pharmacist
	40. Environmental Regulations		
SFI 22	a) Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Joint Chief Financial Officer	Joint Director of Estates & Facilities
	41. Relationships with Press		
	a) Non-Emergency General Enquiries	Joint Chief Executive	On call Director

	b) Emergency Enquiries	Joint Chief Executive	Head of Communications

Table B – Delegated Financial Limits

	DELEGATED FINANCIAL LIMITS (£) (unless otherwise stated, all figures are inclusive of VAT irrespective of recovery arrangements.)												
	Board of Directors	Finance and Performance Committee	Senior Leadership Group	Capital Planning & Space	Chief Executive Officer	Chief Financial Officer	Other Executive Officer	Deputy Director of Finance	Delegated Budget Holders (A)	Delegated Budget Managers (B)	Department/ Ward Delegated	Head of Financial Management	Senior Finance Management
1. Approval Process and Delegated Limits													
Initial Revenue and Capital Budget - approval	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Capital approval outside of initial budget													
Approval of new capital business case proposals (within approved total capital budget but subject to critical patient need)	Yes	£500,000	No	£250,000	£50,000	£50,000	No	£50,000	No	No	No	£25,000	£25,000
Revenue approval process outside of initial budget													
Authorisation to Proceed to Bid for new business	Yes	£500,000	No	No	£250,000	£50,000	No	No	No	No	No	No	No
New Revenue Business cases - Approval outside planning cycle	Yes	£500,000	£250,000	No	£50,000	£50,000	No	No	No	No	No	No	No
2. Budget Virement													
Authorisation of Virement (adjustments to budgets) from Reserves/Additional Income	Yes	No	No	No	£2,000,000	£1,000,000	No	£500,000	No	No	No	£250,000	£25,000
Authorisation of Virement (adjustments to budgets) within Divisions	Yes	No	No	No	£2,000,000	£1,000,000	No	£500,000	£20,000	No	No	£250,000	£30,000
3. Cash and Banking													
Investment of Surplus Operating Cash	Yes	No	No	No	£25,000,000	£25,000,000	No	£5,000,000	No	No	No	£2,500,000	No
Petty Cash Disbursements	No	No	No	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes
4. Capital Assets													
Disposal and Condemnations of Capital Assets - Items obsolete, unserviceable, irreparable or cannot be cost-effectively repaired	Yes	No	No	No	Yes	£50,000	No	£25,000	No	No	No	£15,000	No
All leases and ALL property purchase contracts and Termination: Where Board approval to the business case has been given and procurement process has been followed: For leases authorisation level relates to cost over total contract period.	Yes	No	No	No	250000	£250,000	No	No	No	No	No	No	No
5. Losses and Special Payments (reported to Audit Committee)													
Losses													
Fruitless payments (including abandoned Capital Schemes) and constructive losses	Yes	No	No	No	Yes	Yes	£5,000	No	No	No	No	No	No
Other Losses													
Losses of cash due to theft, fraud, overpayment & others.	Yes	No	No	No	Yes	Yes	£5,000	£5,000	No	No	No	£500	No
Bad debts and claims abandoned.	Yes	No	No	No	Yes	Yes	£5,000	£5,000	No	No	No	£500	No
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Yes	No	No	No	Yes	Yes	£20,000	No	No	No	No	No	No
Culpable causes (eg fraud, theft, arson).	Yes	No	No	No	Yes	Yes	£5,000	£5,000	No	No	No	£500	No
Special Payments													
Compensation payments by Court Order	Yes	No	No	No	Yes	Yes	£5,000	No	No	No	No	No	No
Extra contractual payments to contractors	Yes	No	No	No	Yes	Yes	£5,000	No	No	No	No	No	No
Ex-gratia Payments:-													
To patients / staff for loss of personal effects	Yes	No	No	No	£10,000	£5,000	£1,000	£1,000	No	No	No	£100	No
Other ex-gratia payments	Yes	No	No	No	£10,000	£5,000	£1,000	£1,000	No	No	No	£100	No
6. Patients Property (Release of property of a deceased patient)													
Up to £5,000	Production of Probate or Letters of Administration shall be required before any of the property is released												
Over £5,000	Forms of indemnity shall be obtained												
7. Income	**Threshold limits represent the contract's lifetime value**												
Renewal of existing contracts and new contracts with business case approval	Yes	No	No	No	£10,000,000	£1,000,000	One approval - £1,000,000 Two approvals - £3,000,000	£1,000,000	£250,000	No	No	£500,000	No
Debtor Request Forms	N/A	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes

Authorisation of credit notes/Cancellation of invoices	N/A	No	No	No	Yes	Yes	No	Yes	No	No	No	Yes	Yes
8. Non-Pay Expenditure inc Capital	**Threshold limits represent the contract's lifetime value**												
Authorisation of Non-Pay Expenditure - including invoice approval, award, signing of contract, contract variations, change notices and requisitioning etc *(In addition to approval, all Purchase orders need agreement and sign off from either a member of the Procurement team or a senior Finance colleague (8b and above).)*	Yes	No	No	No	£5,000,000	£1,000,000	One approval - £1,000,000 Two approvals - £3,000,000	£1,000,000	£250,000	£30,000	£5,000	£50,000	£30,000
Authorisation of Purchase credit notes	N/A	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Waiving procurement requirements detailed in Section 11 (Ex VAT)	Yes	£500,000	No	No	£250,000	£150,000	No	£75,000	No	No	No	£50,000	No

9. Sections 9a and 9b are ex VAT unless otherwise specified.	**Threshold limits represent the contract's lifetime value e.g. a 5-year contract of £25,000 per year requires £125,000 method and authorisation.**
9.a Procurement Process for Products & Services	
Quotations for all purchases : 1 written quote	under £10,000
Quotations - where possible, obtain a minimum of 3 written quotations	£10,000 to <£25,000
Formal quotation process run by procurement - Minimum number invited to quote -3	£25,000 to <£75,000
Formal Local Tender- Minimum number invited to tender -4	£75,001 to Procurement Regulation Thresholds including VAT
The Procurement Regulation processes apply	over Procurement Regulation Thresholds including VAT
9.b Procurement Process for Building & Estates Engineering Procurement	
Quotations for all purchases : 1 written quote	under £10,000
Quotations - where possible, obtain a minimum of 3 written quotations	£10,000 to <£25,000
Formal quotation process run by procurement - Minimum number invited to quote -3	£25,000 to <£100,000
Formal Local Tender- Minimum number invited to tender -4	£100,001 to Procurement Regulation Thresholds including VAT
The Procurement Regulation processes apply	over Procurement Regulation Thresholds including VAT

	Charitable Funds Committee	Chair plus Chief Financial Officer	Deputy Director of Finance	Nominated Fund Manager
10. Funds Held on Trust				
Expenditure authorisation (per request)	Yes	£10,000	£2,000	£500

Table C – Establishment and Pay Control

Establishment delegation

	Approve Increases to Establishment (new post or unfunded change) incremental	Approve Changes to Structure within existing establishment & within level of financial authority	New Post(s) matched by Post(s) disestablished for skill mix changes - cost neutral or delivering a financial saving in year	Appointing to Posts in Establishment
Joint Chief Executive	Yes	Yes	Yes	Yes
Joint Chief Financial Officer	No	Yes	Yes	Yes
Other Director	No	Yes	Functional Director plus Joint Chief Financial Officer	Yes
Deputy Director / Associate Director / Head of Service	No	Yes	No	Yes
Budget Holder/Manager	No	Yes	No	Yes

Pay delegation

Officer	Joint Chief Executive	Joint Chief Financial Officer	Other Director	Deputy Director / Associate Director / Head of Service	Budget Holder	Budget Manager
Certify Time Sheets - completion and authorisation of positive reporting forms	Yes	Yes	Yes	Yes	Yes	Yes
Agency & Temporary Staff*	Yes	Yes	Yes	Yes	No	No
Increase of Consultant Pas in excess of Whole-time (10pas)	Yes	Yes	Yes	Yes	Yes	No
Additional recurring allowances excluding Consultant PA's and Contractual Payments	Yes	Yes	Yes	Yes	Yes	No
Termination Forms	Yes	Yes	Yes	Yes	Yes	Yes
Lease Cars approvals;	Yes	Yes	No	No	No	No
Staff Appointment forms*	Yes	Yes	Yes	Yes	Yes	Yes
Annual leave buy back (rostered staff only)	Yes	Yes	Yes	Yes	Yes	Yes
Annual Leave C/ Fwd	Yes	Yes	Yes	Up to 1 week of basic contracted hours		
Compassionate and special leave	Yes	Yes	Yes	Up to 6 days		
Unpaid leave	Yes	Yes	Yes	Up to 5 days		
Approval of business travel and subsistence expenses (per claim) maximum limit	£5,000	£5,000	£1,500	£1,500	£500	£500
Salary Changes	Yes	Yes	Yes	No	No	No
Salary Advances	Yes	Yes	Yes	No	No	No
Salary arrears of Pay authorisation	Yes	Yes	£10,000	No	No	No
Overtime and On Call within T&Cs of Service	Yes	Yes	Yes	Yes	Yes	Yes
Overtime and On Call outside T&Cs of Service	Yes	Yes	Yes	No	No	No
Relocation Expenses (In accordance with policy)	£6,000	£6,000	£6,000	No	No	No
Voluntary Severance terms & payments	Yes	Yes	No	No	No	No
Redundancy	£50,000	£50,000	No	No	No	No
Premium Payments (Medical Staff)	Yes	Yes	Yes	No	No	No

Officer	Change Forms which do not affect pay – eg ESR Personal Data Changes	Increase in Hours	Increase in Banding	Acting Up Arrangements	Extension to Fixed Term Contract	Commencement Forms* (these are forms which notify payroll of the start of a new employee to an established post)
		Within Authorised Financial Limits				
		Within Establishment				
Joint Chief Executive	Yes	Yes	Yes	Yes	Yes	Yes
Joint Chief Financial Officer	Yes	Yes	Yes	Yes	Yes	Yes
Other Director	Yes	Yes	No	Yes	Yes	Yes
Deputy Director / Associate Director / Head of Service	Yes	Yes	No	Yes	Yes	Yes
Budget Holder	Yes	Yes	No	Yes	Yes	Yes
Budget Manager	Yes	Yes	No	Yes	Yes	Yes

In exceptional circumstances the Joint Chief Executive may authorise other employees than those listed to authorise those items on the previous page

New posts include changes which are entered ESR where a new post is added, even where this is on the basis od deleting existing posts to support the change

* Note that additional requirements apply in respect of engagement of consultants and non clinical agency staff

Definitions:

Staff Appointment Form – approval to employ a particular individual

Staff Commencement Form – provision of details to payroll regarding a new employee, including salary, cost centre and personal data

These relate to appointments / commencements to approved posts only – they do not confer authority to approve new or changed posts.

Table D – Summary of Minimum Retention Periods for Records

No.	Class of Document	Retention Period
	FINANCIAL	
	Salaries and Wages Records	10 Years after the end of the financial year to which they relate.
	Pay sheets and records of unpaid salaries and wages.	6 years after the end of the financial year to which they relate.
1	Principal ledger records including cashbook, ledgers and journals.	6 Years after the end of the financial year to which they relate.
2	Bills, Receipts and Cleared Cheques.	6 Years after the end of the financial year to which they relate.
	Debtors Records.	2 years after the end of the financial year in which they are paid or are written off, but at least 6 years in respect of any unpaid account which has not yet been written off.
1	Creditor Payments Records	6 Years after the end of the financial year to which they relate.
2	Requisitions	6 Years after the end of the financial year to which they relate.
3	Minor accounting records; pass-books, bank statements, deposit slips, cheques; petty cash expenditure accounts, travel and subsistence records, minor vouchers, duplicate receipt books etc.	2 years after the end of the financial year to which they relate.
4	Cost accounts prepared in accordance with the directions of the Secretary Of State or at the request of the department.	6 years after the end of the financial year to which they relate.
	Tax Forms	6 years after the end of the financial year to which they relate.
1	V.A.T Records	6 years after the end of the financial year to which they relate.
2	Budgets	6 years after the end of the financial year to which they relate.
3	Major establishment records including personal files, letters or appointments, contract references and related correspondence and records of leave.	6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, which ever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destroyed after the officer leaves the hospital's service.
1	Stores Records - Major (Stores Ledger Etc.)	6 years after the end of the financial year to which they relate.
2	Stores Records – Minor (requisitions, issue notes, transfer vouchers, goods received books, delivery notes etc)	2 years after the end of the financial year to which they relate.
3	Audit Reports.	6 years after the formal clearance by the appointed auditor.
4	Accounts – Annual (Final - One set only)	20 years after the end of the financial year to which they relate.
5	Accounts – Working Papers	6 years after the end of the financial year to which they relate.
6	Documents other than those of permanent relevance in relation to trust funds and the terms of any trusts administered by health authorities.	6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted.
	NON-FINANCIAL	
1	Property Acquisitions / Disposal Records	Permanent
2	Buildings and engineering works, inclusive of projects abandoned or deferred - key records (e.g. final accounts, surveys, site plans, bills of quantities)	Permanent
3	Contracts – non sealed (other) on termination	6 years after the end of the financial year to which they relate.
4	Contracts – sealed and associated records	6 years after the end of the financial year to which they relate.
5	Tenders - Unsuccessful	6 years after the end of the financial year to which they relate.
6	Inventories (not in current use) of items having a life of less than 5 years	2 years after the end of the financial year to which they relate
7	Records of custody and transfer of keys.	3 years after the end of the financial year to which they relate.
8	Patient activity data	3 years after the end of the financial year to which they relate.

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors Meeting, part 1	
Date of Meeting	11 February 2025	
Report Title	Freedom of Information Requests Compliance and Service of Enforcement Notice from Information Commissioners Officer	
Prepared By	Dave Way, Data Protection Officer and Information Governance Manager, Dorset Health Care.	
Approved by Accountable Executive	Nick Johnson Deputy Chief Executive DCH	
Previously Considered By	Audit Committee, 03/02/2025	
Action Required	**Approval**	
	Assurance	Y
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care		No
Colleagues	Yes	
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR4: Capacity and Demand	
Financial	Additional 2 x band 3 staff employed by DHC	
Statutory & Regulatory	Compliance with the Freedom of Information Act 2000	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	DHC providing the resources and management of the DCH FOI process.	

Executive Summary

Freedom of Information Requests Compliance.
The report states the current position of the DCH FOI Backlog, Enforcement Notice and future plans
Background: The FOI back log came about due to DCH having of resource issues. DHC has established a team to resolve the issue. The Information Commissioners Office has issued an Enforcement Notice to DCH.
Status: Initial Backlog, 976 Reduced to 299 of which as of the 28/01/25 only 29 are outstanding. There have been 212 new FOIs. There are currently 59 open FOIs
Risks: Financial currently the budget for staff is being covered by the DHC Medical Records budget putting a budget pressure on DHC Med Records budget. Future resilience of the FOI team when it reduces to 1 WTE band 3
What Options are being considered. DHC will build resilience into its FOI team to cover leave and sickness in the DCH FOI team. The finances between both Trusts need to be resolved.
We recommend the Trust accepts the Enforcement Notice and DHC will use its team to support the DCH FOI "team" going forward as BAU.
Asking the Committee to note the report and accept the Enforcement Notice and approve the plan to include DCH FOI resilience into the DHC FOI & SARS team capability.

Recommendation

Members are requested to:

- Receive the report for **assurance**

Freedom of Information Requests Compliance

1. Executive Summary

1.1. DCH found that due to resource issues it had not been able to respond to Freedom of Information (FOI) requests as required by the FOI Act 2000. A backlog of 976 unanswered FOIs had built up making a compliance risk for the Trust. The Information Commissioners Office (ICO) has issued an Enforcement Notice to DCH for noncompliance in failing to respond to FOI requests which is a statutory requirement.

1.2. As part of federated working, a plan was put in place to utilise the resources and management of the Dorset HealthCare IG and Medical Records Team to address the backlog and create a team to manage future requests. Two Band 3 WTE were recruited with one on a permanent contract and one on a fixed term contract due to end June 25. The team is to be based at Sentinel House and managed by the DHC Data Protection Officer and the Med Records Manager

1.3. Since starting the service on 22nd October 24 the team has processed and ratified the outstanding back log of 976 FOIs. In an agreed plan with the ICO we were able to reduce the backlog to 299 still requiring a response and as of the 28/01/25 we had 29 outstanding backlog FOI requests which we anticipate will be cleared by the 21st February 25. DHC is building resilience for the DCH FOI team by including a resource from within its Med Records Team to provide cover for the DCH FOI Team. The financials still need to be resolved with the cost of the additional resources being absorbed by the DHC Med Records Team budget putting a pressure on that budget.

2. Introduction

2.1. The DHC Data Protection Office Dave Way and Clare Taylor DHC Medical Records Manager as requested by DCH has established an FOI team to process DCH's FOIs. Currently 2 x FOI administrators reducing to 1 by the 13th of June 25. The team has also set up and introduced the FOI system purchased by DCH as the system of choice to process the DCH FOIs. Clare Taylor is working with the supplier AMS to introduce system improvements to make it easier to use by Trust staff and so that we can produce useful reports.

2.2. The work undertaken to identify the back log numbers included identifying repeat requests required an analytical approach and a decision endorsed by the ICO was taken to write to all of the outstanding FOI requestors and ask them if they still needed an answer and give them a timeline of 10 working days to respond or the request will not be responded to. This reduced the numbers 976 to 299.

2.3. Add to this is the need to process new FOI requests and the team have received 212 new requests since starting the service.

3. Main narrative

3.1. The Team is on course with the support of the various contributors at DCH to clear the backlog by the end of February ahead of the expectations of the ICO.

3.2. The Trust will need to acknowledge the Enforcement Notice from the ICO and the FOI team are confident that once the backlog is cleared that we will be able

to keep on top of the FOIs and respond to >80% of requests within the required 20 days and as we build our relationships within DCH that should increase and improve response time to >90%

3.3. The Team resilience issue is best managed by DHC having a DCH trained member of staff in it's wider DHC Med Records team who can step in and cover for holidays and sickness.

4. Figures from the DCH FOI System (as at 29/01/2025):

	October	November	December	January	February	March	Total
Backlog	75	91	131	2	0	0	**299**
New	57	55	46	54	0	0	**212**
Total	**132**	**146**	**177**	**56**	**0**	**0**	**511**

ALL FOI's – Overall Figures (both New and Backlog):

Complete	451
In Progress	60
Total	511

Of the **backlog FOI's only**, 270 have been completed, and 29 are currently open, and being processed.

Backlog Only	Total	Notes
Completed	270	(Completed/Revoked)
In Progress	29	(In Progress – awaiting information from contributors)
Total	299	(Backlog – total number of FOI's from backlog spreadsheets – entered)

5. Conclusion

5.1. The ICO Enforcement Notice needs to be acknowledged and an DHC/DCH FOI plan incorporated into the response.

5.2. The backlog is under control and was to be cleared by the 31st January at the current rate we should be cleared by mid-February 25.

5.3. The FOI Team will be established with resilience in place to stay in control the requirement to respond to FOIs

Baker,Abi 04/02/2025 15:47:21

6. Recommendations

6.1. The Board is recommended to:

a. Receive the report for **assurance**

Name and Title of Author: Dave Way Data Protection Officer Dorset HealthCare University NHS Foundation Trust
Date 27/01/25

7. Appendices

7.1. Appendix 1 ICO Enforcement Notice

FREEDOM OF INFORMATION ACT 2000 (SECTION 52)
ENFORCEMENT POWERS OF THE INFORMATION COMMISSIONER
ENFORCEMENT NOTICE

DATED: 6 January 2025

To: Dorset County Hospital NHS Trust

Of: Dorset County Hospital
Williams Avenue
Dorchester
Dorset
DT1 2JY

1. Dorset County Hospital NHS Trust ("DCHT") is a "public authority" listed in Schedule 1 and defined by [section 3(1)(a)(i)] of the Freedom of Information Act 2000 ("FOIA"). FOIA provides public access to information held by public authorities.

2. DCHT's obligations as a public authority under FOIA include –

    a. Being obliged to publish certain information about its activities;
    b. Responding to requests for information from members of the public.

3. The Information Commissioner (the "**Commissioner**") hereby issues DCHT with an Enforcement Notice (the "**Notice**") under section 52 FOIA. The Notice is in relation to DCHT's:

    a. Continuing non-compliance with section 1(1) FOIA; and
    b. Continuing breach of section 10(1) FOIA.

4. This Notice explains the Commissioner's decision to take enforcement action. The specific steps that DCHT is required to take are set out in **Annex 1**.

Legal Framework for this Notice

5. A person requesting information from a public authority has a right, subject to exemptions, to be informed by the public authority in writing whether it holds the information, and to have that communicated to him, if the public authority holds it. This is set out in section 1(1) FOIA–

> "(1) Any person making a request for information to a public authority is entitled –
> (a) to be informed in writing by the public authority whether it holds information of the description specified in the request, and
> (b) if that is the case, to have that information communicated to him."

6. Section 10(1) FOIA specifies that public authorities must respond to requests within 20 working days:

> "… a public authority must comply with section 1(1) promptly and in any event not later than the twentieth working day following receipt."

7. There is provision under FOIA for a public authority to claim a reasonable extension to this limit in certain circumstances but in all cases, the public authority must give the requestor a written response within the standard time limit for compliance.

8. The Commissioner has various powers under FOIA. One of these is the issuing of an Enforcement Notice. Section 52(1) of FOIA states –

> "If the Commissioner is satisfied that a public authority has failed to comply with any of the requirements of Part I, the Commissioner may serve the authority with a notice (in this Act referred to as an "enforcement notice") requiring the authority to take within such time as may be specified in the notice, such steps as may be so specified for complying with those requirements."

9. Section 52 FOIA has effect subject to section 53 FOIA, which provides details of the exceptions from the duty to comply with a decision notice or enforcement notice.

Background

10. In October 2024, the Chief Executive of DCHT wrote to the Commissioner to advise that DCHT was experiencing issues with its ability to comply with its FOI obligations.

11. In November 2024, the Commissioner met with representatives from DCHT and Dorset Healthcare University NHS Foundation Trust ('DHUT'), and was informed that due to staffing challenges, DCHT's compliance had dropped to an all-time low resulting in a backlog of around 1000 cases.

12. DCHT explained that, following the COVID pandemic, it has experienced increased demand for its frontline services and has not had the funding available to finance its Corporate Governance Team. Due to the lack of resource for its FOI function and an increase in the number of FOI requests, DCHT saw its compliance drastically decline, forming a significant backlog.

13. DCHT explained that a joint leadership team was set up with DHCT and DHUT in 2022. In 2023 a joint chair and chairman were appointed. This is a federated model and not a merger and remain two separate organisations with their own Board. In June 2024, DHUT agreed to provide support to DCHT's FOI function, and began this work in mid-October 2024. DHUT has advised that two members of staff have been recruited to support the FOI compliance work.

14. DHUT began by working through the outstanding cases and removing duplicates. This brought the backlog total to 897. It then contacted requesters to check if they still wanted to proceed with their requests. As a result of this work, the backlog of requests for DCHT was reduced to 220.

15. As at 20 December 2024, DHUT reported that the number of open requests were 183 and that it had further reduced the backlog to 75 requests. DHUT has advised the Commissioner that it is aiming to clear DCHT's backlog by the end of January 2025.

16. Recent data provided by DHUT on behalf of DCHT indicates that its timeliness has, in respect of new requests, remained poor for at least the last 12 months with an overall compliance rate of just 15.15%. As DHUT has only recently taken over handling FOI requests on behalf of DCHT, it has not been able to provide the Commissioner with compliance figures per quarter.

17. Of the overdue requests that form DCHT's backlog, 45 requests are over three months old, 8 are over six months old and 5 requests are over a year old. The oldest request was received in September 2023.

The Contravention and Reasons for this Notice

18. FOIA requires a public authority to inform people whether it holds information they have requested and to communicate it to them within 20 working days of receipt of their request.

19. DCHT has explained that its FOI compliance was good prior to the pandemic but since then it has struggled with increased demand on its service and the lack of funding available for resourcing its teams that would usually handle FOI requests. DHCT had acquired software to process FOI request more efficiently but has not had the resources to put it in place. DCHT explained that it has had to prioritise its front-line health services.

20. The Commissioner recognises that funding, prioritising services, and staff recruitment and retention are issues experienced across the public sector. However, DCHT still has a statutory duty to respond to requests for information in a timely manner. It is important that it has proper plans in place to reach, and then maintain, high levels of compliance with FOIA.

21. DCHT has tried to assure the Commissioner that, with support from DHUT, it is focusing on reducing the backlog and improving compliance for recent requests. The Commissioner welcomes the proactive approach DCHT has taken in alerting him to its issues with FOI compliance and the engagement he has had recently from DCHT and DHUT. The Commissioner also recognises the good progress DHUT has already made in clearing the backlog of requests.

22. Responding to requests for information is a statutory duty. It is imperative that DCHT recognises the importance of clearing its backlog and the legal implications of failing to do so. Imposing a legally

enforceable deadline makes clear the priority that the Commissioner considers this task should be given. It also provides a definitive backstop to assist DCHT in ensuring that backlog figures do not slip any further. He has taken into account the scale of the backlog and the timing of this notice when setting the timeframe by which he expects compliance.

23. Taking into account the significant volume of unanswered FOI requests, their age profile including many requests subject to considerable delay, and the need for significant and sustained improvement in timely FOI responses, the Commissioner considers it a proportionate regulatory step to issue an Enforcement Notice requiring DCHT to comply with section 1(1) of FOIA in respect of all of its outstanding requests. It is essential that the improvements described in **Annex 1** are implemented which compliance with this Notice will support.

24. The Commissioner also considers it a proportionate regulatory step to require DCHT to devise and publish an action plan, which formalises measures to mitigate delays. This action plan should be supported by a 'lessons learned' exercise, which examines the root cause of delays in request handling, from allocation through to clearance at different stages, with mitigations for any recurring problems addressed specifically in the plan.

Other Matters

25. The Commissioner considers that DCHT may benefit from using his self-assessment toolkit which is designed to help public authorities assess their current FOI performance and provide indicators of where efforts should be focused in order to improve. The first topic is particularly relevant as it deals with timeliness.

26. The Commissioner notes that DCHT does not publish timeliness statistics. The Commissioner cannot require this as part of an enforcement notice under FOIA, but reiterates that DHCT should do this in line with the section 45 Code of Practice. He would also recommend that DCHT publishes, on a monthly basis, its progress in clearing its FOIA backlog in line with the updates it gives the Commissioner about its compliance with this notice.

27. The Commissioner would draw DCHT's attention to his recent guidance on publishing FOI compliance data and recommends this approach is taken.

28. In complying with this Notice, the Commissioner reminds DCHT that it should continue to ensure that appropriate resources are available so that it meets the requirements of all information rights legislation to which it is subject. This includes handling new information requests under FOIA in a timely manner, and its duties under the Data Protection Act 2018 and UK General Data Protection Regulation, including responding to subject access requests promptly.

Terms of this Notice

29. The Commissioner therefore exercises his powers under section 52 of FOIA to serve an Enforcement Notice requiring DCHT to take specified steps to comply with FOIA. The specified steps are set out in **Annex 1** of this Notice.

30. The consequence of failing to comply with an Enforcement Notice is that the Commissioner may make written certification of this fact to the High Court pursuant to section 54 of FOIA. Upon consideration and inquiry by the High Court, DCHT may be dealt with as if it had committed a contempt of court.

Right of Appeal

31. By virtue of section 57 of FOIA there is a right of appeal against this Notice to the First-tier Tribunal (Information Rights). If an appeal is brought against this Notice, it need not be complied with pending determination or withdrawal of that appeal.

32. Information about the appeals process may be obtained from:

First-tier Tribunal (Information Rights)
GRC & GRP Tribunals,
PO Box 9300,
LEICESTER,
LE1 8DJ

Tel: 0203 9368963
Email: GRC@justice.gov.uk
Website: www.justice.gov.uk/tribunals/general-regulatory-chamber

33. Any Notice of Appeal should be served on the Tribunal within 28 (calendar) days of the date on which this Enforcement Notice is sent.

Phillip Angell
Head of Freedom of Information Casework
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Annex 1

TERMS OF THE ENFORCEMENT NOTICE

THIS NOTICE REQUIRES DCHT TO TAKE THE FOLLOWING STEPS BY THE DATES SPECIFIED BELOW::

By 28 February 2025, DCHT shall:

(i) in respect of each information request where the response is outside of 20 working days as at the date of this notice, and where a permitted extension has not been applied, comply with section 1(1)(a) of FOIA and, if information of the description specified in the request is held, either:
(ii) communicate that information pursuant to section 1(1)(b) FOIA; or issue a valid refusal notice under section 17 FOIA, unless section 17(6) FOIA applies.

Within 35 calendar days of this notice, DCHT shall:

(iii) devise and publish an action plan formalising the measures it will take to ensure it complies with its legal duties under Part 1 of FOIA to respond to information requests in a timely fashion, while also clearing its backlog of late requests by 28 February 2025 as required by this notice.

Dorset County Hospital
NHS Foundation Trust

DCH Charitable Funds Committee Assurance Report for the meeting held on 20.1.2025

Chair	Dave Underwood
Executive Lead	Nicholas Johnson
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• **DCH Charity Business 25/26** – DCH Charity Business Plan 25/26 reviewed by committee and recommended to DCH Board (Corporate Trustee) for approval at 11th February 2025 Board meeting.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (19.11.24)** – approved as an accurate record. • **CFC Actions (19.11.24)** – All actions completed or in progress. **DCH Charity Financial Reports 24/25 (M9)** – reports were received. Total income as of end Dec 2024 £426,965. Unrestricted funds were £274,294 providing a surplus of £34,294 against the reserves target of £240,000. • **DCH Charity Business 25/26** – DCH Charity Business Plan 25/26 reviewed by committee and recommended to DCH Board (Corporate Trustee) for approval at 11th February 2025 Board meeting. • **£2.5M Capital Appeal (ED/CrCU) report (Jan 2025)** – first £500K milestone achieved and announced in media and displayed on new Appeal totaliser at DCH. • **Fundraising & Communications report** – overview of current key fundraising activities and communications. • **Lillian Martin legacy** – committee agreed to accept the £250,000 offer from Wessex Water to purchase the specific portion of land occupied by the company. This amount will be received for the six benefitting charities.
Decisions made at the meeting	• **DCH Charity Business 25/26** – DCH Charity Business Plan 25/26 reviewed by committee and recommended to DCH Board (Corporate Trustee) for approval at 11th February 2025 Board meeting. • **Lillian Martin legacy** – committee agreed to accept the £250,000 offer from Wessex Water to purchase the specific portion of land

	occupied by the company. This amount will be received for the six benefitting charities.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	Date 19.11.24	**Date 20.1.25**	**Date**			
Quorate?	Y	Y				
Dave Underwood	Y	Y				
Chris Hearn	Y	Y				
Jo Howarth	Y	Y				
Anita Thomas	Y	Y				
Margaret Blankson	Y	Y				
Stephen Tilton	Y	N				

ICB Board Report

Reporting Committee:	ICB Board
Date of Meeting:	7 November 2024
Meeting Chair:	Jenni Douglas Todd, ICB Chair

Decisions made by the Board	• The Board approved the revised terms of reference for the ICB Board committees which had been updated following the ICB executive team restructure.
Key Messages agreed by the Board	• Welcomed the Board story and the need to be more ambitious around defining and tracking productivity, wider system involvement and the need to look at the prevention/out of hospital work and how to connect this with improving productivity. • Board Assurance Framework (BAF) – noted the further work to understand the use of the BAF with the need to focus on controls and assurance. • CEO report – noted the requirement to build on the response to the Darzi report which would be the basis for current 10 Year Health Plan work. A positive workshop had been held with system colleagues on Medium Term Plan with consensus over next three years to deliver what was needed. There was recognition that Integrated Neighbourhood Teams were a key transformation programme of work with the requirement for acceleration of local conversations. • Integrated Performance Reporting: Committee Escalation Reports – noted the requirement for better forecasting to enable more effective mitigation of risks earlier, and the impactful cardiovascular disease presentation at the ICB Strategic Objectives Committee, particularly in relation to the focus on outcomes. • The Board approved the ICB committee terms of reference noting the revised executive membership and the conversations to revisit provider representation on the committees. • Winter plan – noted the continued challenges around No Criteria to Reside and the need to deliver the plan by this winter, with recognition that there would be no financial flexibility over the winter. Admission prevention and consideration of how to manage risk appetite and risk sharing ahead of escalation to senior colleagues was required. An update to the Board on the Newton work programme was required. The work undertaken by the Communications and Engagement Team for prevention awareness was recognised. Parity on mental and physical health was required as part of the winter plan. • Noted the good progress in terms of the Primary Care Access Recovery Plan. • Noted the proposed approach in response to the Care Quality Commission Dorset ICS Pilot Assessment which included the oversight and assurance role of the ICB Quality, Experience and Safety Committee.

	• Intensive and Assertive Community Mental Health Review - noted the development of an action plan which would be monitored through the ICB Quality, Experience and Safety Committee. There was recognition of the complexity around service provision and an update would be brought to a future Board meeting. There was a requirement to create right environment to enable people to engage with health and care. • Dorset ICS engagement plans - noted the co-ordinated approach being taken to support engagement with the government's 10 Year Health Plan and the importance of comprehensive engagement to ensure inclusivity. A collective response would be considered at a future Board meeting. • The Teams nominated for awards for the Check Before You Order, structured medications review and Dorset hydration programme were congratulated and would be invited to the next business meeting for lunch. • Further details on the accelerator pilot for coastal navigator work to address deprivation would be brought back to the Board.
Summary of items received by the Board	• Board Story and Deep Dive on Enhancing Productivity and Value for Money • Board Assurance Framework • Chief Executive Officer's Report • Committee Escalation Reports • Committee Terms of Reference and Governance Update • Winter Plan • Delivery Plan for Recovering Access to Primary Care • Dorset ICS Care Quality Commission Pilot Assessment Report • Intensive and Assertive Community Mental Health Services Review • Dorset ICS Engagement Plans to Support the 10 Year Health Plan

Report to	Board of Directors, part 1	
Date of Meeting	11th February 2025	
Report Title	Equality Delivery System (EDS2) 2024 Report and Action Plan	
Prepared By	Jan Wagner (Equity, Diversity, Inclusion & Belonging Lead)	
Approved by Accountable Executive	Nicola Plumb Joint Chief People Officer	
Previously Considered By	People and Culture Committee in Common (PCCiC)	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	This paper relates to both current BAF workforce risks as it links to engagement, belonging and retention. *SR2: Culture* *If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.* *SR3: Workforce Capacity* *If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources*	
Financial	Failure to comply with the EDS2 and the Public Sector Equality Duty (PSED) could pose significant risks to the organisation, including reputational damage and the possibility of financial penalties.	
Statutory & Regulatory	The general equality duty is outlined in Section 149 of the Equality Act 2010. Public organisations, including NHS Trusts, are bound by this duty and must give due consideration to the need to eliminate unlawful discrimination, harassment, and victimisation. The Public Sector Equality Duty (PSED) obliges public bodies to have due regard to the need to eliminate discrimination, promote equality of opportunity, and foster harmonious relations between diverse groups in the course of their work.	
Equality, Diversity & Inclusion	The development of fair and inclusive leadership, practices, and organisational culture supports the 'Well-Led' domain of the CQC framework. Inclusive workplaces are associated with improved staff health and wellbeing, which in turn is strongly linked to higher levels of patient satisfaction and improved clinical outcomes. Consequently, advancements in Equality, Diversity, and Inclusion (EDI) initiatives have the potential to positively impact all CQC domains.	

Co-production & Partnership	The EDS2 report demonstrates our commitment to acknowledging areas where improvement is needed, while reinforcing our intention to value our people, monitor performance more effectively, and enhance the experiences of staff and patients. Despite this year's rating indicating that there is still significant progress to be made, we remain focused on fostering an environment where everyone feels valued, welcomed, and respected, with a genuine sense of belonging. We recognise that improving staff satisfaction is key to driving better patient experiences and outcomes, and we are determined to make meaningful improvements in the coming year.

Executive Summary

This Equality Delivery System (EDS2) 2024 Report outlines the key activities undertaken during the review process. It highlights the current organisational rating, identifies areas for improvement, and presents a clear action plan to address identified gaps. The report also demonstrates how EDS aligns with the Trust's strategic priorities, operational plans, and its ongoing commitment to fostering an inclusive environment for staff and patients alike.

While this year's review reflects a rating of **Developing Activity**, the Trust is committed to learning from this process and implementing targeted actions to enhance equality, diversity, and inclusion across all areas of its services, workforce, and leadership.

The Report was approved by the People and Culture Committee in Common (PCCiC) on the 27th of January 2025.

Recommendation

The Board is recommended to receive the EDS2 2024 report and the accompanying action plan for **assurance**, noting the Trust's continued commitment to making tangible improvements in EDI.

EQUALITY DELIVERY SYSTEM (EDS2) 2024 REPORT AND ACTION PLAN

1. Introduction

The EDS2 2024 report builds on previous efforts, serving as a critical improvement tool for NHS commissioning and provider organisations. It continues to support Dorset County Hospital (DCH) in fostering active dialogue with staff, patients, and partners to address health inequalities across the three key domains: Services, Workforce, and Leadership. Despite the challenges encountered this year, the Trust remains committed to enhancing equality, diversity, and inclusion (EDI) in every aspect of its operations.

While this year's overall rating indicates areas requiring significant improvement, the Trust views it as an opportunity to refocus efforts and deepen its commitment to fostering an inclusive environment for all. The EDS framework has been instrumental in identifying key areas for action, and a comprehensive improvement plan is now in place to drive progress.

The toolkit comprises eleven outcomes spread across three Domains:

1. Commissioned or Provided Services
2. Workforce and Health and Wellbeing
3. Inclusive Leadership

The outcomes are evaluated, scored and rated giving an organisational outcome of:

- 0 - Undeveloped Activity
- 1 - Developing Activity
- 2 - Achieving Activity
- 3 - Excelling Activity

2. Narrative

The EDS2 report assessed 11 outcomes across three domains, with each outcome evaluated and rated by stakeholders. The scores reflect ongoing challenges, but they also highlight progress in several key areas. Below is a brief overview of the ratings:

Domain One	Outcome	Rating
Commissioned or Provided Service	Patients (service users) have required levels of access to the service	**2**
	Individual patients (service users) health needs are met	**2 (1.66)**
	When patients (service users) use the service, they are free from harm	**2 (1.66)**
	Patients (service users) report positive experiences of the service	**1**

Total Score Domain One		**7**
Domain Two	**Outcome**	**Rating**
Workforce and Health and Wellbeing	When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	**1**
	When at work, staff are free from abuse, harassment, bullying and physical violence from any source	**1**
	Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	**2**
	Staff recommend the organisation as a place to work and receive treatment	**1**
Total Score Domain Two		**5**
Domain Three	**Outcome**	**Rating**
Inclusive Leadership	Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**1**
	Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**2**
	Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**1**
Total Score Domain Three		**4**
Total Scores – all domains		**16**

Domain 1: Commissioned or Provided Services

The Trust achieved an average rating of **Achieving** Activity, reflecting a solid foundation in providing accessible services and addressing patient needs. However, efforts are required to improve data collection processes and ensure equitable service delivery across all patient groups. Targeted initiatives, such as enhanced access to health data and ongoing work on personalised care, show promise for future improvement.

Domain 2: Workforce Health and Wellbeing

The Trust received an average of **Developing** Activity for this domain. While there has been some progress in supporting staff wellbeing and fostering a positive work environment,

feedback indicates the need for a more robust approach to tackling issues such as bullying, harassment, and discrimination. New initiatives, including the introduction of a Sexual Misconduct Policy and enhanced reporting systems, are expected to drive improvements in staff experience and wellbeing.

Domain 3: Inclusive Leadership

The Trust's rating for this domain was **Developing** Activity, indicating room for growth in inclusive leadership practices. While senior leaders have demonstrated a commitment to EDI through Board development, engagement and governance structures, greater consistency in leadership engagement and more visible support for staff networks are key areas for improvement. Plans are in place continue the roll out of Inclusive Leadership Training and embed EDI objectives into annual appraisals for senior leaders.

There has been a slight decrease of 2 points (in Domain One 1 point & in Domain three 1 point) since the last EDS2 review was conducted at DCH in 2022, No EDS2 review was undertaken in 2023 as the EDI Lead role was vacant and it was not a contractual requirement at that time.

3. Methodology

For Domains 2 and 3, data from the 2023 staff survey and an additional anonymous EDS2 survey conducted in October 2024, which was provided to 587 members of staff, were used to address key questions. The results were compared and discussed in a workshop held in November 2024, attended by 35 invitees representing a diverse range of roles and responsibilities across various services within DCH, as outlined in the EDS2 framework. This included staff network chairs and co-chairs. The attendees reviewed the survey outcomes and aligned them with the rating guidance narratives. All decisions were made unanimously.

4. Conclusion

The EDS 2024 review highlights important areas for development while acknowledging the positive steps already taken. The Trust recognises that improving its EDI performance requires a sustained, organisation-wide effort. With a comprehensive action plan aligned with the Joint Inclusion and Belonging Strategy, there is a clear path forward to address identified gaps, enhance staff and patient experiences, and strengthen the Trust's culture of inclusion.

Despite the challenges, DCH remains optimistic about its future. By introducing the Joint Inclusion and Belonging Strategy and action plan in 2024, the Trust aims to embed EDI principles into everyday practices and continue to engage meaningfully with stakeholders. It is expected that the Trust will make significant progress in the coming year.

5. Recommendation

Following on from review & approval by PCCiC on 27th January, the Board is recommended to receive the EDS2 2024 report and the accompanying action plan for **assurance**, noting the Trust's continued commitment to making tangible improvements in EDI.

Name and Title of Author: Jan Wagner, Equity, Diversity, Inclusion & Belonging Lead
Date: January 2025

Appendices

Appendix 1 – Equality Delivery System (EDS2) Report and Action Plan

NHS Equality Delivery System EDS2
2024

EDS Report and Action Plan

Dorset County Hospital

Contents

Introduction to the Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	**Dorset County Hospital**	**Organisation Board Sponsor/Lead**
		Nicola Plumb (Joint Chief People Officer)
Name of Integrated Care System	NHS Dorset	

EDS Lead	Jo Howarth Director of Nursing DCH (Domain 1) Jan Wagner Equity, Diversity, Inclusion & Belonging Lead (Domain 2 and 3)		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	July 2024 – Dec. 2024		**Individual organisation**	Dorset County Hospital
			Partnership* (two or more organisations)	Not for this reporting cycle
			Integrated Care System-wide*	Not for this reporting cycle

Date completed	09/01/2025	**Month and year published**	02/2025
Date authorised	27/01/2025 (TBC)	**Revision date**	01/02/2026

Completed actions from previous year	
Action/activity	**Related equality objectives**
N/A as EDS not previously carried out in 2023	

EDS Rating and Score Card

The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure.

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Ethnicity Reporting:** Ethnicity Recording has been assessed as a collaborative priority with commissioners and providers across the system. Dorset has implemented several initiatives to enhance access to population-level health data. Notably, quantitative data on demographic factors such as age, gender, and ethnicity are readily available through the Dorset Intelligence Information System (DiiS). Additionally, a comprehensive assessment of data quality has been undertaken by the Dorset System Intelligence Function, which has identified the need for a greater focus on ethnicity recording and made corresponding recommendations. This initiative is further supported by the Dorset Annual Report 23/24 and the governance framework of the Health Inequalities' Unwarranted Variation programme. Quantitative demographic data, including ethnicity, age, and gender, is accessible via the DiiS and is instrumental in supporting case-finding methodologies. This data facilitates targeted interventions and enhances the capacity for monitoring health disparities at a population level. In some service areas, ethnicity data recording exceeds national benchmarks, with certain services achieving 100% adherence to recommended standards. However, where discrepancies in ethnicity data recording exist within DCH, targeted efforts are in place to address	Average: Achieving activity-2	Director of Nursing

		these gaps. These efforts aim to standardise data capture processes, improve staff training, and engage service users in ensuring the accuracy and completeness of ethnicity information. Continuous work is ongoing to further improve these systems and reduce variations in data collection practices. *Rating: achieving activity-2* **Targeted Lung Health Checks:** Similarly, DCH have undertaken a joint approach with NHS Dorset and UHD on assessment of TLHCs as a system wide service. Dorset was an early adopter of TLHCs ahead of the National screening programme, prioritising local areas of highest deprivation, where the most minority communities live. The service is delivered by DCH from Weymouth Community Hospital, which is well placed to meet population needs including reasonable adjustments. Any alternative mobile service would be challenged by rural accessibility and digital network access. From the data available on uptake and experience, people with protected characteristics report good experiences and uptake is in line with expected cohort data, the exception is working-age people, for whom additional engagement is proposed. There is provision for people who move into Dorset to continue accessing services; a safety net, invites are repeated every two-years, and opt-in anytime or opt-out options. A gap identified is access for people in prison (there are three adult prisons in Dorset) and homeless people, as individuals at higher risk of experiencing health inequalities.		

		Rating: achieving activity-2 **Learning Disability Alerts:** Improving access, meeting needs, safety and engagement (DCH only) There has been a long history of working collaboratively with colleagues within the Community Learning Disability teams, driven by a succession of national reports highlighting the inequalities faced by people with a Learning Disability when accessing healthcare services. In recent times joint working has been further strengthened by the *Federation* with Dorset Healthcare NHS Foundation Trust. As part of the 'Working Together Programme' we have expanded the alert so that the Community Learning Disability Clinical Lead also receives the email alert and can follow up on any care requirements accordingly. The presentation and short film below, describes this in more detail, highlighting some of the benefits for the person with a learning disability Presentation Video Rating: achieving activity - 2		
	1B: Individual patients (service users) health needs are met	**Ethnicity Reporting:** A range of options have been adopted to include both cultural to technical solutions to improve ethnicity information across a range of protected characteristics.	Average: Achieving activity-2 (1.66)	Director of Nursing

		Reviewing these initiatives are suggestive of the possibilities that protected characteristics such as pregnancy, maternity, age, and gender will be captured and recorded. Some interventions are: (1) University Hospitals Dorset is working with GPs to pull ethnicity data from patient GP records to update their hospital records, particularly for patients without a Dorset GP. (2) Dorset County Hospital has completed the same and is focusing on training staff in the Emergency Department, Same Day Emergency Care unit, and Admission wards to improve ethnicity and protected characteristics recording. (3) Additionally, work on establishing a direct HL7 feed from DiiS into the Trust's data warehouse is underway, (though technical challenges remain). (4) Dorset Healthcare is convening ongoing discussions to address workforce data improvements that could provide opportunities for collaboration, and enhanced service delivery through learning. Previous DHC directed efforts to improve ethnicity recording, such as sending letters to patients lacking ethnicity data, however the approach was ineffective due to low response rates (relative to cost). *Rating: achieving activity-2* **Targeted Lung Health Checks:** Individual needs are collected as part of a risk-scoring profile for the TLHC and LDCT scan, including questions on reasonable adjustments. The TLHC is a first contact digital/telephone offer, however, where requested this can be facilitated face-to-face to meet needs. Impact is demonstrated in Portland where Late-Stage diagnoses in 23/24 dropped to 21.4% - meeting the national 25% target		

		and significantly below Dorset average of 65% for Lung Cancers. As with all screening activity, there are 'incidental findings' from LDCT scans and the local policy ensures identified health needs are met by GP's and allied specialities. Patient records document signposting to local services e.g. Community Smoke Stop, however, end to end data on uptake is poor. *Rating: achieving activity-2* **Learning Disabilities:** '**Was not brought/ did not attend' pilot project** As mentioned in the video, this work has led to a further project looking the 'did not attend/ was not brought' for people with a learning disability. The aim of the project was to explore the reasons why some people missed appointments, did not come in for their appointments or were not brought to their appointments. We know people with a learning disability experience many barriers when accessing healthcare which further adds to missed or late diagnosis/ treatment resulting in poorer health outcomes. It was also important to explore if the person had care and support, why they were not brought, as there may be potential safeguarding concerns if the person is not supported to attend their health appointments. The DCH business intelligence team were able to create a report for those people who are flagged as having a Learning Disability and who were recorded as 'did not		

		attend' for outpatient appointments. This included people on GP registers as well as those on the DCH PAS flagging system. This report is refreshed each month and is used to inform targeted intervention/communication with individuals and their carers. Further improvements are required to refine the approach and reduce DNA rates. *Rating: developing activity- 1*		
	1C: When patients (service users) use the service, they are free from harm	**Ethnicity Reporting:** DiiS provides quantitative data by age, gender and ethnic background. The system is useful for proactive case finding. However, some ethnic groups have opted out for using their data. A preliminary analysis indicates no substantial disparities in opt-out rates by ethnicity. The use of DiiS for case finding and evaluating service outcomes is unlikely to increase inequalities from an ethnicity perspective. However, periodic reviews and targeted analyses will be essential to maintain equitable practices. *Rating: achieving activity-2* **Targeted Lung Health Checks:** TLHCs in a national screening programme, which has met all clinical safety requirements, based on the results of robust clinical trials. The programme has 15 quality standards B1647-quality-assurance-standards-targeted-lung-health-checks-programme-v2.pdf. In Dorset the service providers have robust policies and procedures for managing adverse incidents and monitoring quality, which can be interrogated at TLHC level. TLHC is on the Trust risk register as data is managed locally until a National data	Average: Achieving activity-2 (1.66)	Director of Nursing

		system is implemented. There is a policy and strong pathways for supporting patients where 'incidental findings' are made for non-lung cancer investigations or care. Patient information ensures participants are aware of the risks and benefits of the TLHC, LDCT scans and management of incidental findings. There is a risk from harm, where patients who are referred for LDCT scans Did Not Attend, and it is proposed a deep dive is undertaken to identify areas of focus and improvement, including where there are differences by protected characteristics e.g. Gender and Age. *Rating: achieving activity-2* **Learning Disabilities:** The aim of the 'Did not attend/'Was not brought' project is to reduce the risk of harm to patients by identifying and addressing any safeguarding concerns, improving health surveillance and timeliness of interventions, and improving long term outcomes for those with a registered Learning Disability Further analysis of the data and outcomes of the Patient Experience questionnaire will be undertaken to identify wider determinants affecting attendance rates and to inform actions for improvement. *Rating: developing activity 1*		
	1D: Patients (service users) report positive	**Ethnicity Reporting:** To address the barriers to accurate ethnicity data recording and access to care, Dorset NHS organisations are undertaking a series of targeted initiatives designed to	Average: Developing activity-1	Director of Nursing

	experiences of the service	enhance the collection of ethnicity and other protected characteristic data. These efforts focus on engaging both staff and service users to improve data accuracy and inclusivity. Engagement strategies include collaboration with key staff networks, particularly within Maternity and Neonatal Services, as well as outreach to migrant health contacts and responses to inquiries from the Patient Experience Team. These activities aim better understanding and communication regarding the importance of recording ethnicity and other protected characteristics. Additional avenues for engagement are being explored through the Integrated Care Board, which includes health inequalities-focused initiatives, Primary Care Networks, and Health and Wellbeing Events. These efforts aim to expand the reach of data collection and address potential inequities in healthcare delivery. One notable initiative is the Conversation Café, launched by Dorset County Hospital, which is specifically designed to reduce variations in ethnicity data recording. The Conversation Café applies innovative, trauma-informed approaches to engage patients and service users in a supportive environment, where sensitive data collection is prioritised. This initiative is closely aligned with NHS Dorset's organisational objectives, focusing on improving both the quality of data and the delivery of patient care. Central to these efforts is the collection of feedback from both patients and service users. This feedback provides critical insights into barriers to data collection and informs the development of interventions.		

		Furthermore, guide cards are being developed, based on input from individuals with lived experience, to help facilitate more accurate and sensitive data collection. These guide cards will be trialled in specific departments within Dorset County Hospital and, if successful, will be expanded across other areas to standardise and improve ethnicity data collection processes. *Rating: Developing activity-1* **Targeted Lung Health Checks:** Patient experience data is available through National and local surveys, however, the results are not analysed by protected characteristics. National surveys are limited without TLHC as route of diagnosis as a presentation. National surveys are presented at ICB and Trust level, for the ICB there were no scores below the expected range and there were no significant differences for respondents' experience of care by tumour type, age, sex or ethnicity, all reporting 9.0+ as the average rating. A Dorset patient survey and recent Friends and Family test results reflect positively on their experience of care; however, additional qualitative feedback would provide insights for improvement and better inform commissioning decisions, including plans for the TLHC programme to roll out countywide. Improving communication and engagement is a key recommendation. *Rating: Developing activity-1* **Learning Disabilities:** The Community Learning Disability created a questionnaire aimed at exploring why people may not attend		

		appointments. This was checked by people with lived experience to ensure it was easy to understand. We expect that issues such as poor health literacy, inaccessible appointment letters, transport issues may be some of the reasons for non-attendance but this has yet to be substantiated. We know anecdotally that attendance at health appointments can be a low priority for people As a consequence of patient feedback, Hospital charitable funds supported the creation of 4 virtual tours aimed primarily at people with a learning disability although we hope many other people may find these useful. The production company co-created and reviewed the film series as part of a film club for people with a learning disability. Some of the actors were also people with lived experience. Links below: Virtual tours *Rating: Developing activity- 1*		
Domain 1: Commissioned or provided services overall rating			7 (6.32)	

Domain 2: Workforce health and well-being

Domain	Outcome	Data Sources	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions		The Trust offers a wide range of support with physical and psychological health & wellbeing through Vivup our Employee Assistance Programme (EAP) including: - telephone counselling and referral to on-side counselling - financial & debt advice - diabetes, dementia and cancer information Vivup is a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues	Developing activity-1 To reach Achieving: Health monitoring data is collated and the organisation would use sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment. And the organisation would provide support to staff who have protected characteristics	Joint Chief People Officer

			The Trust offers also information on the intranet page about: - Trust-wide staff vaccination programmes - Menopause support service Additionally, the Trust signposts via the intranet page to support: - For Men & Women - Against domestic abuse - for LGBTQ+ staff	for all mentioned conditions.	
		NSS Question 9d “My immediate manager takes a positive interest in my health & wellbeing”	72% of staff think this is true reflection and has gone up by 2% but has gone down since 2019 by 2%.		
		NSS question 11a “My organisation take positive action on health and well-being.”	59% of staff agreed on this statement which is a similar percentage to 2021 when the question was first asked.		
		Anonymous EDS2 survey carried out in OCT-2024 Q1 “ Do you know where to go to find out information that would	50% of staff said they agreed with this statement.		

		support you to manage obesity, diabetes, asthma, COPD and mental health conditions?" Workshop on the 4th of November 2024, with 35 invitees representing a good variety of roles and responsibilities across various services within DCH as requested in the EDS2 framework. The attendees discussed the outcomes of the surveys and put them against the narratives of the rating guidance.	The members of the workshop discussed openly the difficulty of this question as it included 5 main topics. Considering the results of the 2 surveys and that the Trust provides support for one of the conditions and signposts the others to independent publicly accessible services, the members rated it a score of 1 – as per the following definition; "The organisation targets reading materials about the mentioned health conditions to staff about the mentioned conditions. The organisation promotes work-life balance. The organisation signposts to national support." They were not able to elevate it to a score of 2 as that would have been: "The organisation monitors the health of staff with protected characteristics. The organisation promotes		

			self-management of conditions to all staff. The organisation uses sickness and absence data to support staff to self-manage long term conditions and to reduce negative impacts of the working environment. The organisation provides support to staff who have protected characteristics for all mentioned conditions.”		
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	NSS combined Q14b & Q14c In the last 12	The Trust signed the Sexual Safety Charter and is in the process of developing a Sexual Misconduct Policy. The Trust will also implement a new staff reporting system with an option to report concerns anonymously to encourage staff to report their concerns. This is in response to the recommendations in the “To-Hot-Too-Handle” Report from 2024 outlining why staff are not reporting their concerns.	Developing activity-1 To reach Achieving: The organisation has a zero-tolerance policy for verbal and physical abuse towards staff. The organisation penalises staff who abuse, harass or bully other members of staff and takes action to	Chief People Officer

		months how many times have you personally experienced harassment, bullying or abuse at work from managers & other colleagues NSS Q16c 1-7 On what grounds have you experienced discrimination? Sexual Safety in Healthcare Survey at Dorset County Hospital from July 2024. Q5 “Have you ever been subjected to or witnessed sexual harassment or sexual assault in the workplace?” Anonymous EDS2 survey carried out in OCT-2024 Q2 “When at work, staff are free from abuse, harassment, bullying and physical violence from any source?”	30% of staff experienced harassment, bullying or abuse in the last 12 months. This has remained at a similar level since 2019 and it is slightly under the NHS average. Ethnicity seems to be the highest basis for discrimination with 35% followed by “other” with 31% and gender by 22% 31% answered this question with yes with 43% stating it had occurred on 3 or more occasions 31% of participants answered this question with “no”.	address and prevent bullying behaviour and closed cultures, recognising the link between staff and patient experience With the new approach on Sexual Safety including the Sexual Misconduct Policy and the new reporting system that includes bullying & harassment the Trust will achieve level 2.	

		Workshop on the 4th of November 2024, with 35 invitees representing a good variety of roles and responsibilities across various services within DCH as requested in the EDS2 framework. The attendees discussed the outcomes of the surveys and put them against the narratives of the ratings guidance.	The members of the workshop appreciated this includes many variations and any source. With consideration of the 3 surveys they rated the organisation with the score of 1: " The organisation acts and supports staff who have been verbally and physically abused. The organisation acts to penalise staff who abuse or bully other members of staff. Staff are supported to report patients who verbally or physically abuse them." It was decided not to elevate it to a score 2 as this would need a Zero-Tolerance-Policy and the Trust "… takes action to address and prevent bullying behaviour and closed cultures, recognising the link between staff and patient experience."		

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source		The Trust staff have access to a number of Speaking Up functions, which includes the Freedom To Speak Up Guardian, who is a major source of advice and support. Staff are given confidential support and provided with guidance and opportunities to resolving their issues. The Union reps from BMA, HCSA RCN and Unison are on hand to offer independent advice and support as well. The four Staff Network chairs and their committee provide support to their members at their respective meetings and networking events. The networks meet monthly. Equality impact assessments are applied when amending or creating policy and procedures for reporting abuse, harassment, bullying and physical violence, as they are with all HR and other policies and procedures across	Achieving activity-2 To reach Excelling: The organisation facilitates pooling union representatives with partner organisations, to encourage independence and impartiality. Relevant staff networks are … "provided protected time to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source." Appropriate resourcing to be in place.	Chief People Officer

			the Trust. Support is provided for staff outside of their line management structure through all of the above sources, and in addition, the Employee Assistance Programme (EAP) is available 24/7, free of charge, in complete confidence for support, advice and counselling. It is provided by an external provider, Vivup.		
		NSS Q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?	55% “yes” with a 3% decrease from the year before.		
		NSS Q11c During the last 12 months have you felt unwell as a result of work-related stress?	41% with a decrease by 5% from previous year.		
		NSS Q13a – Q13c In the last 12 months how many times have you personally experienced physical violence at	a) 11% decrease by 4% b) 0.67% with a slight increase c) 1.27% with a slight decrease		

		work from...? Patients / service users, their relatives or other members of the public, Managers, Other colleagues. Anonymous EDS2 survey carried out in OCT-2024 Q3 “Do you know where to go to access independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source?” Workshop on the 4th of November 2024, with 35 invitees representing a good variety of roles and responsibilities across various services within DCH as requested in the EDS2 framework. The attendees discussed the outcomes of the surveys and put them against the narratives of the ratings guidance.	Yes 72%. With the main answer “FTSUG” The groups had a lively discussion to score between 1 and 2 as they do not see the FTSUG as an appropriate resource on this topic and it is not guardian**s** (plural) at DCH but decided for the score 2 as the narrative is more suitable: “The organisation supports union representatives to be independent and impartial. Freedom to Speak Up guardians are embedded.		

			Relevant staff networks are active, accessible and staff led. Equality impact assessments are applied when amending or creating policy and procedures for reporting abuse, harassment, bullying and physical violence. Support is provided for staff outside of their line management structure.”		
	2D: Staff recommend the organisation as a place to work and receive treatment	NSS Q25c I would recommend my organisation as a place to work NSS Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. Anonymous EDS2 survey carried out in OCT-2024 Q4 “Staff recommend the organisation as a	66% would recommend the organisation as a place to work which is an increase by 5% in comparison to 2022 but a decrease of 3% in comparison to 2019. 72% are happy with the standard what is an increase of 6% in comparison to 2022 but a decrease of 6% in comparison to 2019 61% would recommend as a place to work and receive treatment.	Developing activity-1 To reach Achieving: The organisation should compare the experiences of LGBT+ staff against other staff members and reach an average recommendation rate over 70% (85% for Excelling)	Chief People Officer

		place to work and receive treatment?” Workshop on the 4th of November 2024, with 35 invitees representing a good variety of roles and responsibilities across various services within DCH as requested in the EDS2 framework. The attendees discussed the outcomes of the surveys and put them against the narratives of the ratings guidance.	The group discussed this topic and appreciated these are two very different question in one. As most people are very proud of their work a recommendation as a place of treatment was expected but with other results in the NSS they may have reservations about the recommendation as a place to work. The result might be mixed up for these reasons. They also discussed that the organisation is comparing experiences from BAME and Disabled staff but not from LGBTQ+ staff. They still decided to rate for a score of 1 as the main reason is the percentage of recommendation: “Over 50% of staff who live locally to services provided by the organisation do/would choose to use those services. Over 50% of staff who live locally are happy and regularly recommend the organisation as a place to work. Over 50% of		

			staff who live locally to services provided by the organisation would recommend them to family and friends. The organisation collates and compares the experiences of BAME, LGBT+ and Disabled staff against other staff members. The decision against a higher rating was on the basis that the combined question in the EDS2 survey was 61% and the NSS scoring was just in 1 category slightly over 70% and there is no comparison of LGBT+ staff experiences.		
Domain 2: Workforce health and well-being overall rating				5	

Domain 3: Inclusive leadership

Domain	Outcome	Data Sources	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line	Staff Networks The rating narratives are including staff networks. In the workshop on the 4th of November 2024 all		Developing activity-1 To achieve Excelling:	Trust Board

	management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	staff networks rated these narratives. Engagement with staff networks. For a score of 1: “Board members and senior leaders have at least yearly/twice yearly engagement with staff networks.” For a score of 2: “ Board members and senior leaders meet staff networks at least 3 or more times a year.” For a score of 1: “Board members and senior leaders acknowledge religious, cultural or local events and/or celebrations.” For a score of 2: “Board members and senior leaders **engage** in religious, cultural or local	Board members: 1 of 4 networks responded with yes. All networks responded with no. Within the CEO brief religious, cultural or local events and/or celebrations are mentioned on a regular basis. All staff networks declared they can’t remember any active engagement on any of these occasions.	**All** board members and senior leaders meet staff networks at least 3 or more times a year. **All** board members and senior leaders **engage** in religious, cultural or local events and celebrations. **All** board members and senior leaders attend Conscious Inclusion & Inclusive Leadership Training. Every board member and executive leader to have an EDI-	

		events and/or celebrations. --- General information	The Board received the WRES, WDES, Gender Pay Gap, and Staff Survey Reports for review and approval and therefore have oversight of the Trusts current progress and challenges. The Trust has defined executive leads for EDI and health inequalities, being the Chief People Officer and Director of Nursing respectively. The Trust does not have a defined non-Executive Director for EDI matters – the Board aims to retain collective ownership and responsibility for this area. The Trust has a non-executive director (NED) Wellbeing Guardian and a NED Freedom to Speak Up champion, both of which incorporate inequalities in the scope of their role.	related workstream.	

			The Chief People Officer is the Chair of the EDI steering group and is accountable for EDI at Board Level. EDI related issues are discussed through EDI Steering Group, People & Culture Committee in Common and Board. EDI content is embedded within the Trust's Future Hospital strategy and within the People Plan - including more staff and teams being empowered in a compassionate, inclusive and open culture, and improved equality, diversity and inclusion and wellbeing for all.		
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed		The Board and People and Culture Committee in Common annual workplans have all of the EDI frameworks such as WRES, WDES, Gender Pay Gap and EDS2 listed and discussed at times of compliance and implementation.	Achieving activity-2 To achieve Excelling: Both equality and health inequalities	Trust Board

			The annual EDI report as well as the recent design and implementation of the Joint Inclusion and Belonging Strategy has been fully discussed and approved at PCCiC and Board.	are standing agenda items in **all** board and committee meetings. Equality and health inequalities impact assessments are completed for all projects and policies and are signed off at the appropriate level where required. BME staff risk assessments are completed. Staff risk assessments, specific to those with any protected characteristics, are completed	

				and monitored where relevant	
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Workshop on the 4th of November 2024, with 35 invitees representing a good variety of roles and responsibilities across various services within DCH as requested in the EDS2 framework. The attendees discussed the outcomes of the surveys and put them against the narratives of the ratings guidance. EDIB dashboard (18/12/24) Narrative for the score of 2: “Those holding roles at AFC Band 8C and above are reflective of the population served”	34 people cover 8C and above BME: 1 (3%) Disabilities: 2 (6%) In average people in Dorset: BME: 12% (Census 2021) Disabilities: 18% (Census 2021) The annual cycles for People Committee and Quality and Safety Committees ensure that	Developing activity-1 To reach Achieving: Those holding roles at AFC Band 8C and above are reflective of the population served.	Trust Board

			staff EDI and public health inequalities are considered as part of the annual cycles by the respective lead committees. Annual Staff Survey results are produced and published. These are broken down by ethnicity, sexuality, gender, age, religion and disability, which impact internal action plans in relation to changes in data as a result of staff demographics and opinion. WRES/WDES and Gender Pay Gap report and action plans agreed prior to submission and considered by the People and Culture Committee in Common.		
		Domain 3: Inclusive leadership overall rating		4	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Not within this reporting cycle.	**Independent Evaluator(s)/Peer Reviewer(s):** Not within this reporting cycle.

EDS Organisation Rating (overall rating): 16 - Developing
Organisation name(s): Dorset County Hospital
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Jan Wagner, Equity, Diversity, Inclusion & Belonging Lead	March 2025-March 2026
EDS Sponsor	**Authorisation date**
Nicola Plumb (Joint Chief People Officer)	27/01/2025

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Targeted Lung Health Checks**: Address access for people in prison (there are three adult prisons in Dorset) and homeless people, as individuals at higher risk of experiencing health inequalities.	Liaise with ICB and NHSE Health and Justice Colleagues to implement mechanisms to ensure residents at The Verne and Portland Prisons are invited and able to attend for screening.	Quarter 2 25/26
	1B: Individual patients (service users) health needs are met	**Learning Disabilities:** Continued refinement of the LD dashboard and develop targeted interventions to reduce DNA rates.	Refine dashboard using wider determinants to identify any inequity and inequality of access markers; develop interventions to address.	Quarter 1 25/26

	1C: When patients (service users) use the service, they are free from harm	**Targeted Lung Health Checks:** Risk of harm is mitigated by achieving a reduction in DNA rates and widening screening and uptake opportunities	Undertake a deep dive to identify areas of focus and improvement, including where there are differences by protected characteristics e.g. Gender and Age.	Quarter 2 25/26
	1D: Patients (service users) report positive experiences of the service	**Ethnicity Recording:** Standardise data capture processes, improve staff training, and engage service users in ensuring the accuracy and completeness of ethnicity information.	Host Conversation Café with Staff and Community Network partners to better understand barriers to recording and develop a set of visual cues for use in receptions and booking areas	Quarter 2 25/26

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	The Trust will be an employer of choice which recruits and develops staff fairly, taking appropriate action whenever necessary so that talented people choose to join, remain and develop within the Trust.	Updating intranet page and Health & Wellbeing Folders with all relevant information about obesity, diabetes, asthma, COPD and mental health conditions.	Q2 25/26

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Dignity and respect will underpin our civility agenda.	Joint Inclusion and Belonging Strategy, Action Plan **Action 2 & 5** Full implementation of the WorkInConfidence reporting system, offering transparent anonymised statistics about cases of incivility, implementing a Sexual Misconduct Policy with a Zero-Tolerance approach, updating Bullying & Harassment Policy to a Zero-Tolerance approach. **Action 3** Set up Task and Finish Group to ensure incidents of harassment, bullying or abuse are reported and staff are supported **Action 14** Ensure all staff-on-staff reporting is handled fast, fair, transparent and is recorded in an (EDIB) measurable way with all staff handling cases trained to identify harassment, bullying or abuse in a multidisciplinary way	Q1 25/26

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source		Staff Network Charter to be signed off by SLG (EDS2: Relevant staff networks are staff led, funded and provided protected time to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source.)	Q2 25/26
	2D: Staff recommend the organisation as a place to work and receive treatment		Joint Inclusion & Belonging Strategy **All Actions**	2025/26

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**Joint Inclusion and Belonging Strategy** Leaders set the tone and culture for their organisation. The actions under this pillar focus on encouraging our leaders and line managers to demonstrate compassion and conscious inclusion. These behaviours are vital in creating an inclusive culture at Dorset HealthCare and Dorset County Hospital. For us, Inclusive Leadership means actively seeking out and embracing diverse viewpoints as we recognise this will empower our staff to deliver great care and patient experience. As highlighted in the Messenger Review, we agree that principles of EDI should be embedded as the personal responsibility of every leader and every member of staff. We will encourage our leaders and line managers to actively challenge bias and discrimination to reduce inequitable experiences and to	Joint Inclusion and Belonging Strategy, Action Plan **Action 38** All leaders to take part in Conscious Inclusion & Inclusive Leadership Training *(EDS2: Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity and inclusion.)* **Action 41** Include an EDIB objective in yearly appraisals to ensure every leader demonstrates their commitment to inclusion and fairness *(EDS2: Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity and inclusion.)* **Action 43** Senior management team and Board to engage with all staff networks – sponsors understand their role and commitment and including it as essential objective.	2025/26

		actively listen, learn and role-model inclusive behaviours.	*(EDS2: All board members and senior leaders meet staff networks at least 3 or more times a year.* *All board members and senior leaders engage in religious, cultural or local events and celebrations.)*	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed		Joint Inclusion and Belonging Strategy, Action Plan **Action 37:** Review and revise existing Equality Impact Assessment framework to ensure EIAs are fully embedded as a decision-making tool for processes impacting staff and patients *(EDS":Equality and health inequalities impact assessments are always completed for **all projects and policies** and are checked by an SME and signed off at the appropriate level.* *BME staff risk assessments are completed.)*	2025/26
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients		Joint Inclusion and Belonging Strategy, Action Plan **Action 16:** Improve diverse panel compositions and interview questions through collaboration with staff networks *(EDS2: Those holding roles at AFC*	2025/26

			Band 8C and above are reflective of the population served.) **Action 19:** Increase in staffing levels more reflective of diversity of local communication and regional/national labour markets *(EDS2: Those holding roles at AFC Band 8C and above are reflective of the population served.)* **Action 21:** Design and implement mandatory EDIB questions for every interview *(EDS2: Those holding roles at AFC Band 8C and above are reflective of the population served.)* **Action 26:** We will review our on-boarding data 'shortlisting to interview to appointment' and explore any inequalities regarding to protected characteristics *(EDS2: Those holding roles at AFC Band 8C and above are reflective of the population served.)*	