

**Minutes of a meeting of the
of Dorset County Hospital NHS Foundation Trust
held on the 9th December at 2 pm
in Trust HQ Board Room and online**

Present:		
David Clayton-Smith	DCS	Trust Chair
Simon Bishop	SB	East Dorset
Mike Byatt	MBy	Weymouth and Portland
Judy Crabb	JC	West Dorset
Alan Clark	AC	Weymouth and Portland
Max Deighton	MD	Staff Governor
Kathryn Harrison	KH	West Dorset (Lead Governor)
Jean- Pierre Lambert	JPL	Weymouth and Portland
Tim Limbach	TL	West Dorset
Anne Link	AL	Weymouth and Portland
Carol Manton	CM	North Dorset
Paul Midhun	PM	Saff Governor
Rory Major	RM	Appointed Governor Dorset Council
Jack Welsh	JW	Staff Governor
In Attendance:		
Sarah Anton	SA	Governor and Membership Manager
Abi Baker	AB	Corporate Governance Manager
Dawn Dawson	DD	Joint Chief Nursing Officer
Mandy Ford	MF	Deputy Director of Corporate Affairs
Jenny Horrabin	JH	Joint Director of Corporate Affairs
Nick Johnson	NJ	Joint Director of Strategy, Transformation & Partnerships
Claire Lehman	CL	Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
Lynn Taylor	LT	Member of the Public
Anita Thomas	AT	Chief Operating Officer
Apologies:		
Matthew Bryant	MB	Joint Chief Executive
Maurice Perks	MPe	North Dorset

CoG24/071	Formalities	Action
	The Chair declared the meeting open and quorate. Apologies for absence were received from MB and MPe.	
CoG24/072	Conflicts of Interest	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
CoG24/073	Minutes of the Meeting held on the 14th October 2024.	
	The minutes of the meeting held on 14 October 2024 were agreed as an accurate record on condition of the below amendment. SB stated in the previous minutes it was unclear if his question about South walks house meant patients or staff are. SB clarified he was referring to patient area and his specific example was the Xray department.	

	Resolved: that the minutes of the meeting held on the 14 October 2024 be approved.	
CoG24/074	Matters Arising: No current Actions	
	The Action Log was considered, and approval was given for the removal of completed items.	
	Resolved: that the action log be received, updates noted, and approval be given for the removal of completed actions.	
CoG24/0075	Chairs Update	
	<p>DCS presented his update, circulated previously and highlighted the following -</p> <ul style="list-style-type: none"> • DCS has been catching up on visits around the wards. • Attended the first Annual thanksgiving at Dorford Centre, a remembrance for relatives that had passed away in hospital. This was a lovely evening run by the hospital Chaplin. There were readings and hymns that all sang. CQC require us to do this on an annual basis. • Hospital Charity raising money for the A & E dept. Attended by Kate Adie for a Q and A session. • DCS informed the council of the many council activities across both trusts, including a Joint Board Workshop. There was a NED Digital meeting and there will be item coming up on the agenda for both councils in the new year around digital. • Meeting with the new MPs Lloyd Hatton and Edward Morello. • DSC attended the ICP Board that he is a member of. Here there is a focus of creative Health which is of special interest to the Chair. • Bi-monthly CEO/Chair meeting for NHS Dorset/DCH and DHC/UHD with good work being developed for the provider collaborative, building improved working relationships between the acute hospitals. • BCP culture led Health & Wellbeing conversations. This is more relevant to DHC and UHD, however the relationships developed here for UHD, community and mental health helpful as on the BCP side of the county. • Attended the melting pot meeting here in Dorchester, another meeting planned in Feb 25 to include nursing staff to begin discussion around a Creative Health strategy. A combination of getting governance bodies to work together in joint activities where appropriate and connecting into systems and the local 	

	<p>authorities to help us on the journey of being integrated and joined up.</p> <p>KH asked can the thanksgiving service at the Dorford Centre be attended by people who have no faith or are of differing faiths?</p> <p>DCS added it was not particularly religious and was multi-faith. Poems and readings were not all religious.</p> <p>NP confirmed that the Chaplin has tried to cater for multi-faith from the position of being Chaplin.</p> <p>KH added someone of no faith may be put off by something of any faith.</p>	
	Resolved: that the Chairs Update be received for information.	
CoG24/076	CEO Report	
	<p>DD introduces herself as Joint Chief Nursing Officer and cover the CEO report today.</p> <p>DD talked to the previously circulated slides and highlighted some good news about DCH and some national updates.</p> <ul style="list-style-type: none"> • New chemotherapy unit is going well. Funded by the DCH Hospital charity that has raised 2 million pounds. • Work around theatres and the special care dentistry that we offer provided by Somerset NHS Foundation Trust (FT). The new suite is up and running. • External survey of people that have used our services from April to July 2024. DCH scored very well in comparison to other trusts in areas such as patient experience. Areas of improvement highlighted from this survey were - further information being provided to patient when they leave hospital to care for their condition at home. Also ensuring that patients understand the explanation given by a doctor or nurse on their condition, treatment and more explanation for why tests are needed. • DD then moved onto update about the system and the direction of travel. Moving from digital to analogue. The focus moving away from bedded care to community care. Encouraging patients to have care locally. Moving from illness to prevention. • There are a range of things happening across the system that mean we need to work collaboratively for good outcomes for patients. • GPs are thinking of taking action across the country. We are planning how to manage and mitigate this as an organisation, but we would hope that a resolution will be sought locally with our local ICB so there is a much-reduced impact. • Supporting people with MH needs to get access and wellbeing, including children and young people. This impacts acute care as well as out in the community. Jo Howarth has been leading on work within the Emergency Department (ED) to support children. • Ongoing all age neurodiversity review with system partners to ensure we adequately meet the need of people with for 	

example, autism or ADHD. The ICB will be commissioning a new service, which is different from what we currently have.

- Work around length of stay to enable medically fit people to get home as soon as possible. Particularly important as we enter the winter months.
- Developing Integrated Neighbourhood teams (INT) to enable people to stay at home where possible.
- New hospital programme, work ongoing here at DCH. Also with other system partners, UHD there is a large investment with the opening of the new Beach building. There will be a DHC unit for children that have MH needs and to increase bed base.
- The Government are looking to forward plan for the year ahead with strategic based commissioning.
- How we develop PLACE and how we focus in the East and West to ensure great services.

JW asked about tier 2 OM training – NP answered that a paper was taken to joint executives meeting two weeks ago to highlight there are 95% staff completed for tier 1. Then there is tier 1 part b, this is a live seminar for a certain cohort of staff. Tier 2 is a full day session with two tutors with lived experience and 1 other tutor. There has been funding from the Council around this. The completion rates are not currently where they need to be, however there is a plan in place and NP can share this with JW.

NP

MBy raised that a couple of points in the presentation link to empowered citizens. In particular about no admissions to hospital and those presenting with MH issues. Could the Directors explain more if this is an example of empowered citizens.

DD replied it's about how you enable people to be an equal partner in their healthcare. Partially people that have a long-term health condition and the coproduction of a plan of care that they agree with, that patient and healthcare provider work on alongside one another. Rather than the historic view that 'the doctor knows best' attitude.

If a patient with a MH condition has a physical health need it would be correct and appropriate that they did come into hospital. What we want to move away from is not having the capacity with the MH services and by default they arrive at DCH ED. As this is not good for the patient who needs the MH support.

AC asked DD in the survey were there any comments about patient waiting for medication in ED once they have been seen. As AC has spoken to some people that had great service in the ED but found they are waiting a long time for medication to be dispensed.

DD answered there were concerns about waiting times, but she cannot remember specifically concerns about medication but can look further into that.

AT added they are just about to complete an Audit about presentations in ED and can factor that into and look and when or why or if it's at particular times of day. Certain amounts of medication are kept in the

	<p>department and then if it's a rarer medication it can take longer to source. AT to email AC with an update around this.</p> <p>AC updated about a workaround at Weymouth last week. In the midwifery section they were telling us Badgernet, is this a separate system to the general hospital records?</p> <p>DD answered that Badgernet is a totally separate system for patients having a baby to be able to access all their records. It's sits digitally separately. You can conveniently access all your records on your phone.</p> <p>COO talks to the previously circulated slides and highlighted the following –</p> <ul style="list-style-type: none"> • Patients in an urgent setting in only up slightly more than last year. From this data we cannot determine the acuity of these presentations. • There has been an increase in patients with respiratory distress particularly in this last weekend. • Sunday into Monday's are increasingly busy in ED. • Part of the winter plan is promoting other routes into care, would encourage all to promote this information as it is released around social media. • We do stream from the front door of ED and where appropriate we will send patients to the urgent treatment centre (UTC). • We are meeting ED standard which is set at 78% this year. • No reason to reside the focus has been on reducing excessive stay. • There has been a focus on P 1 patients (patients who are going home with care) to support them short term to ensure they are discharged within 5 days. • There has been good work happening with our partners in the community hospitals and this has helped us reduce length of stay. This allows opportunities for patient to transfer from us to a better environment. • This winter we will focus on the front door and increase offer within same day emergency care. This care open 12 hours a day 7 days a week, GPs can book patients into this so they don't have to present at ED. This service can take people from ambulances or from ED. • The number of beds available on virtual wards is increasing as well as the number of pathways, such as gyne pathways and surgical pathways, there is more opportunity to go home from our beds. • Home is the best environment for patients. A familiar environment people cope better in and are in more control of who is around them. • There will be a frailty S deck in January 2025 once recruitment is complete and there will be assessment beds alongside. • Volunteer sector supporting to let people feel supported with shopping etc. 	<p>AT</p>
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DCS added that morning he had been with the NEDs on a call with the CEO for NHS England, Web Streeting and the Minister for Social care to learn about winters plans. Winter plans will be coming to Board and this call will help prepare the NEDs to hold the Board to account.

- AT continued to talk about the communication of letting everyone know they are safe this winter. What we are doing onsite and how we will work with social care and other to ensure peoples stay in hospital is as short as possible.
- AT moved onto next slide and addressed question from MPe about elective care and waiting lists. Demand is up on elective care. Audits have confirmed this is due to population growing in areas where there has been investment in housing.
- There is also growth in cancer referrals, important to note we are tackling this.
- The graphs on the slides show that long waits of patients waiting over 65 weeks have reduced. The vision was who have nobody waiting this long by the end of Dec 2024. However, due to event nationally this has been impacted. Aim is now to have nobody waiting over 65 weeks by end of March 2025. Unless they have chosen to wait longer.
- Regarding cancer patients there are now 3 standards, and, on this slide, there are only 2 displayed. In future months there will be all 3 standards displayed.
- Faster diagnosis standard aim to let a patient know if they have cancer within 28 days. Whenever possible and have started to plan care with them. This was not achieved in September, but it was achieved in October 2024.
- There has been a 46% increase in referral since pre-covid times.
- We have met the 70% standard of 62-day treatment standard. And we are slowly rising to reach the standard of 85% that we saw pre-covid.
- Recognising how many patients remain over 62 day this can be for reasons such as 'backlog' from covid, or due to complex pathways or patients may have delayed their own treatment.

MD asked a question about the colours on the slide, do the colours represent special cause variation?

AT confirmed yes, they do, and a positive view would be as little orange as possible and as much blue as possible.

- AT moved to the last slide and talked about diagnostics. Cardiology is by far our most congenial pathway. The recruitment process is now completed. A few of our international recruits managed to make it through all their exams and passed to become independent practitioners. AT praised the fantastic work of the department to attract and keep everyone through that process.
- We are hiring an extra unit, and we have put in bids to buy additional units to permanently increase our capacity.

- There is high demand for echocardiography as it supports many pathways. There is also a national staffing problem.
- The second issue is endoscopy, due to increase in our cancer pathways this is increasing the pressure here. We are now working 7 days a week in order to meet the need.

MBy asked there used to be patient choice about where they received treatment, does this still exist? If there is capacity in a particular trust, can the patient choose an alternative.

AT answered yes patient choice still exists and should be explained to the patient on referral in terms of being able to choose their initial hospital. Problems can arise if a patient has chosen DCH at the diagnostic stage without knowing there could be a constraint within a part of the pathway. We work with University Hospitals Dorset (UHD) to offer the patients the chance to be seen sooner wherever is possible. Similarly, UHD will work with us to do that and share the waiting times to reduce them for everybody.

People can also start or leave us from or onto a private pathway.

SB referred the Finance and Performance Committee notes that the trust has been put in tier 2 by NHS England. Could you explain what that means?

AT answered that every trust is placed into a tier based on waiting times.

Tier 1 meeting with national team on a weekly basis, tier 2 we meet regionally on a weekly basis.

Where DCH didn't meet zero patients on a 65 week wait we were placed into tier 2. Therefore, we meet regionally on a weekly basis to go through the numbers and see if they can offer support or give us access to other hospitals, offering patient choice to go outside Dorset.

Tier 2 is about getting support and hope to exit tiering in Q4 as we have giving assurance that we have solid plan and we are working with partner to resolve the issue.

DD delivered the Quality Update as CNO, DD talked to the previously circulated slides and highlighted the following.

- DCH are the first trust in the ICS and the Southwest to implement new training around infection, prevention and control.
- Evidence based risk assessment tool rolled out for understanding patients that are at risk of pressure ulcers.
- Family and Friends test (FFT) DCH currently looking for a new electronic supplier. In the interim we have been using paper copies which have been successful in some areas of the trust with people enjoying filling them in. Response rates are lower due to it not being electronic and this is on the risk register.

- Visiting policy has just changed to open visiting from 11 am to 8 pm. Visitors chartered to bring this positive change. Beneficial for patient care to have loved one and visitors coming in to see them.
- DD covers the Summary Hospital-level Mortality Indicator (SHMI) update in the Chief Medical Officer's absence. DD highlighted that the green line is illustrated a downward trajectory, this is positive for DCH as an organisation. The data is in line with what would be expected for an organisation this size.

JPL raised a question regarding increased visiting times. Has there been an assessment in the parking availability?

DD answered she is unsure about a formal assessment but would hope that with the increased visiting hours this would have a smoothing effect on the number of cars turning up to park at once.

JW asked the question about complaints and if there was any success in terms of resolving patient or members of the public complaints at an earlier stage and trying to prevent any escalation where they go to an external body like the ombudsman?

DD answered that complaints are monitored carefully; this includes number of complaint and how quickly we respond. As it's only week 1 it's too early to tell if it's solved the problem yet, after more time I will be able to come back and give you a more positive outcome.

MBy asked about the data on patient mortality, this data relates to patient mortality who are in the hospital receiving treatment. How does this relate to patients who are able to be discharged, and then in the not-too-distant future are no longer with us. Do we have a picture of that for example if a patient were to die 3 months after discharge is this data captured?

DD answered that the data of SHMI does not include post discharge deaths. Although what does happen is medical examiners look at all deaths. If there were concerns, then that would escalate that to us as an organisation if this was linked to the care we have provided. Some patients may be discharged as they are end of life and wish to die at home. Within the federation of DCH and DHC we are in a good place to understand what the mortality looks like, because towards the end of life there will be care provided by DHC or another provider in the home.

NP updated about the previously circulated People and Culture (P&C) slides and highlighted the following –

- Concerns are appraisal rates, there has been some improvement from June.
- Mandatory training remains steady.
- Sickness absence is high for this time of the year, which is worrying. Currently reviewing the sickness policy to give managers more guidance.

	<ul style="list-style-type: none"> • Staff survey is now closed, and we finished at 46% which is higher than last year. • Focus on vaccination rates. • Senior Leader Team will be going out shortly with mince pies and will be doing another stint in Damers restaurant. <p>JC raised that she has been around the hospital today doing some work as the 'Your voice' chair and a couple of members of staff have mentioned about fixed term contracts not being reviewed. Is there a policy around these contracts?</p> <p>NP responded to say they would currently be expecting fixed term contracts to be reviewed to look at where fixed terms are being used, to make sure that they're the most appropriate way to meet needs. This is a stressful time from the perspective of the employee when a contract is up for review and NP would expect there to be an open conversation as quickly and early as possible if there is a sense that a post is not going to be renewed. Work has been completed on temporary staffing arrangements and zero-hour contracts type contracts called 'fez' are being phased out. There is consultation and engagement with the individuals involved to move them to a more appropriate temporary staffing arrangements.</p> <p>JC added some of the people she has spoken to hold some excellent niche skills and it would be a shame to lose those skills at the end of a fixed term.</p> <p>NP encouraged anyone in this situation to talk to their manager, they are encouraged to approach any of the leadership team. If people have concerns, please turn to Human Recourses (HR).</p> <p>CM asked a question in the meeting chat – regarding the last slide of the P & C slide which are the 4 subjects that are below the 80% threshold.</p> <p>NP confirmed to look this answer up and place in the chat with the answer to the Oliver McGowen question.</p> <p>CM added to her question that she would like to know if there is a particular cohort of staff who don't manage to get released by their manager for training?</p> <p>NP to circulate more information around this after the meeting to CM by email. Typically, estates and facilities will struggle to get some of their training done. This is due to access to machines and computers.</p> <p>NJ talked to his previously circulated slides and highlighted the following –</p> <ul style="list-style-type: none"> • The joint strategy is now in place • We have talked previously about key enabling plans for effective delivery of the strategy. 	<p>NP</p>
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	<ul style="list-style-type: none"> • Enabling plans are - clinical quality, digital, people, finance. These plans will be developed by the end of March • Culture comms and engagement will be taking place along side the development of enabling plans. • Having conversations with colleagues across the organisation about what the strategy means for them. • Colleagues need to feel like it's different and understand what changes need to be made to implement the strategy at all levels. • Other key element within this pack is the One Transformation approach. • There are four key transformation portfolios – working together, sustainable services, Place and Neighbourhoods, Mental Health. • Final slide illustrates an update on the Provider Collaborative, this is the Partnership between DCH, DHC, UHD, and the GP alliance where we come together to deliver. • Currently a business case to look at how we could bring all of our procurement services together to benefit from economic of scale in terms of purchasing. • Held was a Chair's and NEDs informal steering group provider collaborative to ensure that is adequate oversight. <p>MBy asked a question on the issue about engagement, communication and information, is there a unified, comprehensive, integrated approach to this? Not just the role digital plays in that but when we talk about public health, Dorset Council, NHS Dorset, also within primary care with everyone talking about engagement, is there an integrated approach to engagement.</p> <p>NP answered the question that we don't. Health watch Dorset stated that communities are fed up with statutory organisations repeating each other when coming out to engage with them. There is work being done to coalesce around a single approach. Equally when we try to unify, we lose a diversity and risk not being able to be as part of as many communities and cohorts of people as possible. Broadly yes there is a ICB led engagement group and preference would be for DCH and DHC to do things through this group first to seek to not be going out and asking the same questions. This is still a work in progress. The Dorset provider collaborative is a really good question and discussion last week highlighted the importance of knowing that it's here and raising awareness for its accountability for anything that happens as a consequence of its existence. The important point is people know where to go when things aren't as they should be.</p>	
	Resolved: that the CEO report be received for assurance.	
CoG24/077	Finance Report	
	<p>CH ran through month 7 final position. All information is in the finance report that has been previously shared.</p> <ul style="list-style-type: none"> • At month 7 deficit of 1.4 million against surplus plan of 0.3 • Year to date deficit to 8.6 million. • This is averse to the plan we put in at the beginning of the year. 	

- The reasons for this are operational pressures, in month 7 we had 19 escalated beds and 76 no criteria to reside.
- Escalated beds are not funded through the commissioning, and the trust must fund this itself which leads to a cost pressure. Therefore, escalated beds are very important in terms of getting the trust back to delivering its financial plan.
- DCH's efficiently programme or cost improvement programme of £14.4 million which is 5% of the operating budget, to date we have delivered £3.3 million and are anticipating by the end of year to be delivering £8 million against the target of £14.4million. Although this amount falls short of the target it is a significant improvement on previous years where we have achieved £4 – 5 million.
- Final pressure highlighted is inflation. Although inflation has reduced to 2% there are number of contracts linked to energy prices that are bring renewed for the first time in 4 years and we are seeing 30 – 40 % increases.
- We have a weekly financial recovery group chaired by Nick Johnson. Supported by the other executives to ensure we are doing everything we can to bring the finance in line, fully recognising the quality impacts and performance impacts associated with this.
- All decision made from a finance point of view are formally Quality Impact assessed (QIA) to ensure we understand quality impact and make informed decisions.
- Robust workforce controls in place around recruitment, around the trust and also across the system, every post is scrutinised to ensure the post is essential.
- DCH is part of wider integrated care system in Dorset and therefore financial performance plays into performance of the whole county. Current position indicates we are unlikely to achieve the financial plan of £20 million deficit and we are in current talks with NHS England regarding this.
- There is a deteriorating financial position across the country, and we are not unique in Dorset. The rest of the detail can be found in the previously circulated report.
- CH invited any questions.

JC asked about the use of external management consultation company, is there a priority system so are clinical a priority? How does this work in the current financial climate?

CH answered from a DCH point of view we only use external consultants where there is a skill set, we don't have, or we do not have capacity to deliver. Looking across the system there are two key pieces of work, a review of urgent emergency care, we have a company called Newton supporting the work. The work of INT we have an organisation called NAPC who are specialists in those fields that we needed to bring in.

Across the wider NHS there is the use of broader use of management consultancy. Particularly where an organisation might not be achieving its performance or financial targets.

SB asked CH are you taking account of the cost of the joint working project. If so, how as it must be very difficult? Do you keep a track of the cost?

CH answered there are costs involved in the investment and the benefits of sustainability, this is also one of the key workstream of the joint strategy. Having joint executives will release funding. One key area is using physical infrastructure across the county. I.e. sharing theatres, an example is the reopening of Weymouth theatres in order to deliver certain elective activities which has income generation associated with this. While this is a DHC estate delivering DCH services it has allowed us to go further with the income generation. Associate cost of joint working is tracked across both trusts however it generates overall financial sustainability as opposed to broader costs.

JW asked about recruitment of staff and the scrutiny. The posts that are being taken in terms of cost and if it's meeting the needs of the trust, is there any estimated impact on services or departments and especially any adverse impact of staff that can't be recruited or where there are areas to prioritise over others?

CH answered a key metric that NP previously mentioned was around the vacancy rate, there has been a significant reduction in the number of vacancies, this is due to effective substantive recruitment which reduces agency. This creates a positive financial impact and longevity and sustainability of staffing, smaller pool of vacancies within the boarder organisation, we had a recruitment control panel process before these significant challenges, more scrutiny now due to finance pressures. At these panels there is a quality voice in the room, finance voice and operational voice. If there is a Quality impact associated with a role we would not be deciding not to recruit.

DD added to this within our inpatient units we must do twice yearly safe staffing reviews. This is going to board tomorrow to give assurance to the board that we have done that, and we have ensured we have sufficient resources in terms of staff on wards to deliver the needs of patients and there are built in protections there are inpatients units.

The second arm of that is around quality impact assessment, so if anything was being stopped or we were not recruiting into a particular service that would have to go through a process to ensure that we go through a process to consider impact to patients and the remaining staff.

MBy asked given the potential shift toward prevention and promotion in terms of our financial planning. Regarding the governments message about shift and change when will the positive impact of these be affect our finances?

	<p>CH answered the Darzi report had a clear focus on delivering suitable care outside the acute setting and as previously mentioned today we have many no criteria to reside patients, about a quarter of our bed base with several escalated beds. So, the focus and shift onto prevention of people who don't need to be there and are being correctly directed. Therefore, as much activity as possible being delivered in the appropriate community setting. Urgent Emergency Care is looking at just that. It has three providers within the system, the ICB, ambulance service and the local authorities. With finite resources they are looking at how to shift to deliver care in the right place. There is a significant piece of work that was in train before the review in train and before the national announcements. There will be a lead in time with this that requires short term investment to see longer term financial benefits. Some of our areas of activity we are on a block contract for. Reducing number of no criteria to reside and number of escalated beds will naturally lead to a positive contribution for the trust.</p> <p>DCS thanked the executives for their reports and added that although money is a focus there is some great care being provided in the hospital and some significant improvements.</p>	
	<p>Resolved: that the Finance report be received for assurance.</p>	
<p>CoG24/078</p>	<p>Reflections on recent Governor meetings</p>	
	<p>KH updated about recent Membership Development Committee (MDC) which met last week, the main thing the committee talked about was the proposal of whether we should be forming a joint committee with Dorset HealthCare (DHC) or working more closely with them.</p> <p>JH added we had a similar discussion at DHC membership committee as well. And after both discussions there was the balance between do we want to work more together? Do we need to formalise that or can we start on a journey of working more closely across both sets of governors in respect to membership and membership engagement. We did then cover about going broader and working with the ICB and other providers. That is something we would be interested in but also not to let that hold us up in starting our journey of working more closely together. Broadly we were supportive of it but didn't think we need to go to a joint membership committee yet, but we could start doing more together on our membership engagement activities and that might be specific subjects where we felt that was a good thing to do where we were working jointly across both organisations or with specific groups of people, this would not mean we have to do everything together just when we think it's the right thing to do .</p> <p>KH agreed with this and added if we were going to hold a membership event in the foyer of the hospital, we would keep that as DCH only. However, if there was a membership event in the café in Weymouth you have people there who are also interested in DHC services. As previously said the public don't recognise the difference between differing trusts, particularly when talking to governors. So, there are events where it would be helpful to have governors from both trusts present. Invite DHC governor along, and we would go anyway even if they didn't want to joint us but open up the conversation whereby, we</p>	

	<p>do open up some of the events we do and start the process of working together in an incremental way.</p> <p>DCS praised KH and JPL for the success of the events they held in Weymouth with the mother and baby group and the knitting group.</p> <p>JH added there is now a joint membership and governor manager working across the two trust and there was recently an event in Wareham where governors from both trusts attended.</p> <p>Constitution Review</p> <p>KH raised that we have had the initial meeting for the constitution review and asked if an external consultant to lead on the constitution review was necessary?</p> <p>KH continued although the constitution review may be needed however is it absolutely a priority? Can we have some transparency around priorities in terms of areas such as clinical practise where people are on fixed term contracts and are doing good job but don't know if they will have job next year due to lack of money. So how will spending money on a constitution review improve patient care. And could it have waited until the new financial year?</p> <p>JH picked up the question about using an external consultant review but is unable to comment on how this more broadly compares to how we approach fixed term contracts more generally. We thought the constitution review was a priority now as it was impacting how we work across DCH and DHC, for example there was a difference in the number of non-executives' directors in terms of the committee, the differences were starting to cause us challenges. Bringing in an external consultant is low cost and cheaper than doing it internally, regarding our combined hourly rate. As the Corporate team at DCH and DHC have been working significantly below capacity for most of the year, whilst we are nearly there in terms of having a full team, we still are not quite there. We decided to not have any temporary staff in during the year which meant there was some spare budget. Claire Lea is a national expert on governor and constitutions, we can draw on her knowledge of working with other trusts. We can enter the new year on a solid footing with governance in place at both trusts.</p> <p>JC added she has an email to send on that, they call that non-clinical priority and that is what I hear from the staff.</p> <p>DCS confirms that the council governors are right to ask the question. But the executives' priorities are decided by the executives. We do think this is relative cost but to try to run in a joint way with different constituencies, different numbers, different names for the subcommittees is time consumptive and difficult. It is important to have the balance between non-clinical and clinical as some things need to be in place for clinical.</p>	
	<p>Resolved: that the reflections on recent governor meetings be received for assurance.</p>	

CoG24/079	Governor matters	
	<p>a) Minor injuries services- question from AL</p> <p><u>Weymouth Hospital's urgent treatment centre provides an excellent service for Weymouth. All who use it praise the staff and facilities. It alleviates the Accident and Emergency at DCH allowing it to be used for the most needy patients. Apparently, these treatment services are being reviewed and I would like to ask if the Minor Injuries Unit at Portland Hospital will be considered for reinstatement. It provided an excellent service which was highly valued by Portland as has been reported at every public meeting/consultation on future services?</u></p> <p>AT updated that the services here are minor injury units and treatment centres not run by DCH. These are DHC contracts held there so in some ways not appropriate for AT to comment on. Although we are doing a lot of work with Weymouth and Portland around the best services to be providing, we are feeding into this process alongside the population. We do expect the UTC's in that minor injuries unit to go through review in the next 12- 18 months. Which will be led by the ICB who commission that service. It is in the interest of DCH to make sure that service works as efficiently and effectively as possible. We will work alongside DHC and ICB to make sure something is designed that's best for the population. As well as working side INT to support people to stay well rather than need urgent care.</p> <p>AL added that many people need to come to ED and anything that can help that in the locality to ease that must be good.</p> <p>AT answered if we can provide the right expertise yes absolutely, it's about manning the workforce with the right expertise.</p> <p>DCS added that Anne's point indicates why we are doing the joint work and if we can help people, so they don't need to come in that is a good thing. There will be increasing questions about this from both trusts.</p> <p>b) Dissemination of information – KH</p> <p>First point KH raised was she is sent a huge amount of information from many sources. Occasionally she will send on to governors, sometimes KH will not send on so inboxes do not become full. How much do governors want to see, there is wealth of information available so how much you want to see or not?</p> <p>JH asked if all information from governors can be send through SA so questions and information can be collated and passed on as necessary. JH added she is not trying to stop anyone contacting DCS if they need to but if you route questions and information emails through SA you will get a more collated and timely response.</p> <p>Second point KH raised is sharing of information. There is a huge amount of information so if desired we will send out info about NHS</p>	

	<p>Providers, Kings fund, NHS confederation and then people can access this themselves if they wish to.</p> <p>MBy added he thought it was a good idea to make central and make everyone aware of the key sources of information that is available and through digital apps etc. MBy found it was helpful when previously working with PPG and GP practices how we promote to make patients aware of different things happening within the changing picture of the NHS.</p> <p>DCS summarised that this does not stop anyone contacting him but please can link about information be directed to SA to be collated.</p> <p>SB asked stretching this subject to include public attendance at these CoG, we are supposed to invite the public in but on the external DCH webpage there is information about the AMM but no link for the CoG. Can the webpage be updated with a link for members of the public to attend. SA to make sure there is information about CoG on the external webpage,</p> <p>KH raised about governors' attending part 2 board meetings.</p> <p>DCS answered that part 2 board meetings are called that as they are not in the public domain, there is often information about individuals or part formed ideas. DCS confirmed KH can attend but it is not open to all governors. DCS proposed he will produce a brief board report for governors for part 1 and part 2 and this will circulated to all governors.</p> <p>AC reflected we do take that personally as we have all come from areas where we have been dealing with confidential information. What DCS has suggested is a good way forward. As governors we would like to know what has been agreed at part 2 as it keeps is in the loop and we can speak to you if we need more details on matter.</p> <p>DCS confirmed we can give the brief report a trial and see if governors find it useful.</p> <p>c) Insurance policy for wheelchair assistance -TL</p> <p><u>We have a lot of frail patients who often need assistance from their car to the clinic, but staff aren't allowed to provide wheelchair assistance outside the building. Perhaps the insurance policy could be amended to include use next to the building, not the outlying car parks.</u></p> <p>AT confirmed she will supply some wording to ensure she is correct about this as this is not her area of expertise. We've clarified the NHS indemnity. This covers the actions of staff and also includes volunteers as long as they are working within their job description (JD) and role they have been trained in etc. If there was to be a third party claim we would need to disclose the JD, the training record etc, and the risk assessment associated with that.</p> <p>To expand that specifically on the volunteer's role there is no expectation of patient manual handling, although there is manual</p>	<p>SA</p>
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handing training and within certain roles within the volunteer work for some enhances training for wheelchair use in specific circumstances this is not patient handling training. We are not expecting volunteers to do any type of patient moving and handling. Or moving medical equipment and disclosing or handing patient information. In very specific circumstances a volunteer could perhaps push a patient to Damers restaurant if there was a full risk assessment and therefore we have full detail of what they are expected to do and they understand their role in that too. AT appreciated it can be difficult when you see a patient struggling in the carpark, so there is a understanding of staying with the patient if the family has gone to bring the car closer. To keep everyone safe within the rules that you've been staying within your JD or volunteer agreement.

TL added he is not specifically talking about volunteers, that is an aside. But if for example an elderly couple come and park and the patient needs help in the carpark. And the patient needs transferring or help from the carpark to the building there is no facility for anyone to help them be it a porter or whatever.

AT answered a Porter would be able to help, as a porter is covered by a wealth of training to be able to undertake that duty. So from the perspective of an observer or a volunteer actually locating a porter and asking for assistance would be one way to intervene in that scenario.

TL stated that this has caused him confusion and pain as this is not what he was previously told.

NP added a perspective of empathy for this situation. NP's mother was a wheelchair user and when both elderly parents would need to practice their route for two days before a hospital appointment. NP advised them to contact PALS to ask for help, but people don't think of that as they don't want to cause a fuss. Where is the accessibility information here, if a person has accessibility needs can we make sure those who would be there in the first place to address those we have a consistent response.

d) Cleanliness of exterior area at South 1 and North 1 -TL

The exterior around South 1 and North 1 is disgusting and frequently attract rats. I'd like to see this area kept clean

CH responded to this matter that we have previously discussed that we do have a substantial estate that exists with finite resources, money and people, we will always focus in clinical areas but do strive to keep all estates clean. The question included cleanliness and the issue of rats and we do action this asap and pull in relevant companies to action this.

e) Security guard costs – JPL

Would it be possible to provide the annual cost of security guards at DCH as well as a breakdown by relevant categories – such as securing the premises, protecting A&E staff and patients, taking care 24/7 of patients with dementia, and taking care of patients with mental health

issues. Related sub-questions: which are the security firms, how are the cost of guards caring for patients funded and is there a path to charge a failing service provider (for example no space available for mental health patients); do the guards receive specific training to operate in a hospital environment and to care for patients with dementia or mental health issues.

JPL clarified his question comes from the realisation that in some wards there is a need for security guards in the case of patients who have Alzheimer's or who may become aggressive. These patients are long term residence, sometime for several months, so there is a cost associated with the security. What's the overall cost of security within the hospital for allocation within A & E. When security guards have contact with patients are they trained to be around vulnerable patients? If we have patients who are residing with us for several months is there a way we can charge the non-provider, rather than us taking the cost?

CH answered he is happy to cover some of this now and then it would be good to have a conversation offline as there is quite a lot of detailed information within the question. From 2024 going backwards we utilize an external security provided within the trust, for the reasons you described we are in the process of bringing that inhouse. This is due to cost but also to have a greater degree of control over some of the matters you have described. Security guards are always trained whether internal or external. They are training in areas such as Prevention and management of violence and aggression as well as a long list of others such as safeguarding, dementia. CH and JPL to pick this up offline.

CH/JPL

f) Renal Services – East Dorset satellite unit – SB

SB asked for clarity regarding the future of East Dorset Renal Satellite Unit staff, this was an item discussed at part 2 board.

AT answered it was covered in part 2 board due to a break clause in the contract, it was in part 2 as commercially sensitive details within it. We discussed the staffing model and decided it would remain the same for the duration of the contract.

g) Waiting list data – MPe

Why we do not see the DCH Waiting List data for each meeting as a distinct item? After the quality of treatment/service, this is the statistic(s) most important to the patients we represent.

AT confirmed she has covered waiting list data in her report today, if there was a more specific request about waiting list data from MPe please do let her know. Waiting list data is also available in the corporate dashboard which goes to board.

JPL asked is there a way to express the number of months or years it would take to eliminate or reduce by half the waiting list at the current consumption?

	<p>Anita to get back to JPL about that and would need to add caveats into that.</p> <p>JC highlighted she had the pleasure of coming into DCH this morning, as she had been looking at some things on the Mary Anning ward for Jo Howarth. JC met with Shane, the matron and Neil Johnson and some other staff on the ward and JC wanted to voice what an amazing job the staff are doing on the ward and making a huge difference for the benefit of the patients.</p>	AT
	Resolved: that Governor matters be received for information	
CoG24/080	NED Update, Feedback and Accountability session	
	<p>DCS shared an update about the Strategy Transformation & Partnerships (STP) Committees in common (CIC) that although slightly unusual for the trust Chair to be chairing a Board CIC he will continue to chair for another few months.</p> <p>DCS highlighted that this committee covers the plans on the slides that NJ took you through earlier, you have the strategy, and then the enabling plans in order to make sure we can deliver the elements coming through. Adding to that the conversations we're having with UHD about how we get the acute provision across the country running efficiently.</p> <p>Integrated Neighbourhood Teams (INT) linking with Primary care and the GP's and how is that going to work, how is this going to link with the local authorities to make sure they all move together. This committee doesn't do the work rather makes sure the work is being done.</p> <p>There are difficult trade-offs and priorities to make between what we'd love to do with digital and what must be done with the electronic health records to make things better for patients.</p> <p>Examples of things that were escalated to Board from the last STP CIC were -</p> <ul style="list-style-type: none"> • Forming a subsidiary company for all the back-office service procurement, items such as lightbulbs. This is a workup of an idea. The idea to make a cost saving in this way rather than cutting a service. • Electronic Health record, very important to find a way of making sure that the acute provision into UHD works, so there are no discussions for patients or for their referring GPs as to where the operation is taking place and the doctors via the shared record. The new system will replace 28 old systems. The idea is although very expensive to do if we had one system to replace all, it would be easier to use, and we won't lose information between systems. 	

- Final part of the new hospital programme – to ensure the absolutely value of the contract. To ensure all work is completed with no surprises.
- Ensuring the one transformation approach is using the same methodology. There are standard metrics that we can look at.
- One reasons we needed to change the constitutions of the two trusts is that DHC has a financial transformation committee and DCH had a finance reform, so we needed to tidy those up.
- We found that the transformation committee at DHC was doing plenty of planning but struggling to transform anything. Planning is the easy part, and making thing happen is the difficult part. Having the standard methodologies to agree really helps with the programme going forward.
- Simon asked earlier about the cost of the joint working the answer is it is not that much greater, and we can really focus on how we transform services. So, they give us better value. It is important to put value with cost.
- This is an aspect that DCS must do as a NED is to hol the executives to account for making sure we're doing some really complex stuff which connects to NHS England and the wider system, so we won't exist in isolation. And deliver for the benefit of patients, the trust, and the staff in a sensible prepared way.

NJ leaves the meeting to attend another meeting.

KH raised that we have overrun today and if all the NEDs were here, we would not hear from them. KH suggested could the CoG be alternated to have one structured like we did today and then the next meeting dedicated to hear from the NEDs who can present their reports and give us more time and freedom. This will also give the chance to hear from the governor observers.

DCS updated that at Board they have changed the NED reports to the beginning of the meeting, we can look at the order of the agenda and perhaps do something similar, then the governor observers can pick up topics?

SB raised regarding CoG meetings now six a year, there were going to be two meetings with NEDs. We have had six CoGs but can the two extra meetings be arranged?

SB also raised he though it had been agreed that there was a main governor to observe, and the other governors were allowed to observe if they wished. SB stated he can't find any link to who to contact to attend the meetings; in addition, the packs were also going to be available if you were going to attend the meeting.

	<p>JH updated that SA is the contact should any governors like to observe the committee, SA to send out email with committee meeting dates and details about how to observe.</p> <p>KH updated that the two extra meetings were used for the joint governor/NED workshop that was held in Poole. This was an in person meeting only.</p> <p>DCS confirmed it is important to strike a balance of not burning up too much time in meetings and not having the executive in meetings for three hours at a time. DCS asked do you feel you are not connecting with the NEDs as much as you should?</p> <p>KH added that would be the appeal of having an alternative system where the NEDs came for one meeting and the executives came for the other. They neither the NEDs or executive are not coming every two months, it would be every four months.</p> <p>JPL commented the best to see how the NEDs operate is by observing the Board meetings or the committees, it is useful to see them working rather than giving a presentation. JPL gave a 10 second elevator report and updated that the Finance Committee which is in common now is working extremely well. The issues are debated in a lot of detail. It is an upgrade to the single DCH committee.</p> <p>MBy stated he struggles with the agenda and separating out what issues governors need to be aware of which are immediate issues in providing hospital services, which he would call ongoing management issues. And the issues which we're also having to address about the way forward and the vision. Have we got that balance right in the way the agenda and the way the reports work. Do we give enough attention to the vision of the strategy or get caught up in the immediate management issues?</p> <p>DCS answered that is an issue for the executive, NEDs and governors together, the pressing issues are always there. What the council must be assured of is there is a good process by which the strategic thinking is taking place and that the executives are being held to account by the non-executives.</p> <p>The governors were able to input into the strategy. The governors are not a conduit for developing strategy and as a council are available to provide a sense check on what's happening on the ground and what issues are and where. Particularly whether our system related things where residents and patient might tell us it's OK here and then you go to Weymouth and it's difficult.</p>	SA
	Resolved: that NED update, feedback and Accountability session be received for assurance.	
CoG24/081	Chair's closing remarks	
	DCS confirmed have reached the end of part 1 agenda; we will move to part 2 and the executives are excused.	

CoG24/082	Date and Time of Next Meeting The next meeting of the Dorset County Hospital NHS Foundation Trust Council of Governors will take place on 3 rd March 2 pm – 5 pm
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Signed by Chair Date

DRAFT