Ref: MA/TH

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

You are invited to attend a **public (Part 1) meeting of the Board of Directors** to be held on **24th November 2021** at **08.30am to 12.10pm** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Staff Story**	Verbal	Dawn Harvey	Note	8.30-9.00
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	9.00-9.05
	a) Apologies for Absence:	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 29th September 2021	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**CEO Update**	Enclosure	Patricia Miller	Note	9.05-9.20
4.	**COVID-19 Update** a) Managing the COVID Public Inquiry	Verbal Enclosure	Anita Thomas	Note	9.20-9.30
5.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (October and November) a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee d) Risk and Audit Committee e) System Performance and Update (Standing Item)	Enclosure	Committee Chairs and Executive Leads	Note	9.30-9.50
6.	**Recovery Report** Standing Item	Enclosure	Nick Johnson	Note	9.50-10.00
7.	**ICS Development Update** Standing item until end of Financial Year 2021/22	Enclosure	Nick Johnson	Note	10.00-10.10

8.	**DCH Strategy Implementation Bi-Annual Update**	Enclosure	Nick Johnson	Approve	10.10-10.20
Coffee Break 10.20 – 10.35					
9.	**Business Intelligence Developments**	Enclosure	James Woodland	Note	10.35-11.05
10.	**WDES Report** (October People and Culture Committee)	Enclosure	Dawn Harvey	Approve	11.05-11.15
11.	**Board Assurance Framework and Risk Register** (November Risk and Audit Committee)	Enclosure	Nick Johnson/Nicky Lucey	Note	11.15-11.30
12.	**Social Value Action Plan Progress Update**	Enclosure	Nick Johnson Simon Pearson	Note	11.30-11.40
13.	**Ambulance Handovers**	Enclosure	Anita Thomas	Note	11.40-11.50
14.	**National Patient Surveys**	Presentation	Nicky Lucey	Note	11.50-12.00
15.	**Questions from the Public**	Verbal	Mark Addison	Note	12.00-12.10
	CONSENT SECTION				-
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
16.	**Maternity reports:** **a. Maternity Safety Report** (from Quality Committee)	Enclosure	Nicky Lucey	Note	
17.	**DCH Subco Annual Report**	Enclosure	Claire Abraham	Note	
18.	**Complaints/Patient Experience Annual Report**	Enclosure	Nicky Lucey	Note	
19.	**Mortuary Security Statement of Compliance** (From Nov Quality Committee)	Enclosure	Anita Thomas	Ratify	
20.	**Any Other Business** Nil notified				
21.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 26th January 2022** via MS Teams.				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 08.30am on 29th September 2021 via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Sue Atkinson	SA	Non-Executive Director
Margaret Blankson	MB	Non-Executive Director
Judy Gillow	JG	Non-Executive Director
Paul Goddard	PG	Chief Financial Officer
Dawn Harvey	DH	Chief People Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Deputy Chief Executive
Nicky Lucey	NL	Chief Nursing Officer
Ian Metcalfe	IM	Non-Executive Director
James Metcalfe	JM	Divisional Director
Patricia Miller	PM	Chief Executive Officer
Inese Robotham	IR	Chief Operating Officer
Stephen Slough	SS	Chief Information Officer
Anita Thomas	AT	Divisional Director, Urgent and Integrated Care Division / Incoming Acting Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Patricia Hilton	PH	Dietician *(Patient Story)*
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Kyle Mitchell	KM	Consultant *(Item BoD21/053)*
Audrey Ryan	AR	Director of Medical education *(Item BoD21/054)*
Sam Thornton	STh	Paediatric Diabetes Nurse *(Patient Story)*
Natalie Violet	NV	Corporate Business Manager
William Ward	WW	Paediatric Consultant *(Patient Story)*
Members of the Public:		
Simon Bishop	SB	DCHFT Public Governor
Judy Crabb	JC	DCHFT Public Governor
Kathryn Harrison	KH	DCHFT Public Governor
John Morris	JM	PriceWaterhouse Coopers
Lynne Taylor	LT	DCHFT Public Governor
Lisa Upchurch	LU	Member of the Public
Apologies:		
Richard Sim	RS	Divisional Director

BoD21/039	**Patient Story**	
	PH provided a brief history of diabetes and treatments and introduced some new technologies available to keep children with Type 1 diabetes independent. She introduced a video about the impact of childhood diabetes on family life for one family with a child with Type 1 diabetes and the positive impact the new technologies had. The family outlined their considerable anxieties when their son, Jo, had been initially diagnosed and the extensive learning they needed to acquire in order to understand how best to manage high and low blood sugar levels. Whilst Jo had initially felt much better when treatment had	

	commenced, there had been a need for finger prick blood testing constantly day and night during the first year. The introduction of new technology reduced the need for finger prick testing and dramatically improved their lives, providing assurance and reducing anxiety. The system provided remote blood sugar monitoring and alerts when blood sugar levels were low enabling corrective action. WW explained how the monitoring machines worked, often via mobile telephones, and that other technologies to deliver controlled insulin doses were also being introduced to the market. However, these were expensive and mobile telephones were not considered to be medical devices and available to patients via the NHS. The Board heard about the individually tailored arrangements in place within the Trust, which included group sessions, family shopping trips, pizza evenings to learn about carbohydrates and buddying schemes, to support children and families during transition to adult services and the additional anxiety experienced by patients and families at that time. Additional Psychology support was also being recruited. The Board noted the connection with outcomes of the recent Paediatric Diabetes Service Peer review, and the positive impact of the use of technology on children with Type 1 diabetes and their families. MA extended the Board's thanks to the team and the family for telling their story. STh, PH and WW left the meeting.	
BoD21/040	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed members of public and governors to the meeting. Apologies for absence were received from Richard Sim and the Board noted that SS would join the meeting later.	
BoD21/0410	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD21/042	**Minutes of the Meeting held on the 28th July 2021**	
	Members of the Board considered the minutes of the meeting held on 28th July 2021**.**	
	Resolved: that the minutes of the meeting held on 28th July 2021 were approved.	
BoD21/043	**Matters Arising: Action Log**	
	The action log was considered and the following updates were noted: **BoD21/027** Front sheet review would be returned to the Board in November **BoD21/028 T**he Race and Health Observatory (RHO) Board's Maternal Health Report had been circulated – Action completed	

	BoD21/030 a full report on the SHMI and coding issues would be returned to the Board in November. Approval was given for the removal of completed items.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD21/044	**CEO Update**	
	PM presented key highlights from the report as follows: • Amanda Pritchard, Chief Executive (CEO) of NHSE, was recruiting for the Chief Operating Officer role within the organisation currently; • Integrated Care Boards had identified Chair designates. Jenni Douglas Todd was the Chair Designate for the Dorset ICS and recruitment for the ICS CEO was underway with interviews expected to be held in mid to late October; • The Government was expected to outline funding arrangements for the second half of the year although NHS Providers had recorded the need for additional funding and staffing to support issues within social care; • Significant increases in demand for urgent and emergency care services with bed occupancy levels between 95-98%. A high percentage of hospital beds remained occupied due to the lack of available care packages and emergency and urgent care demand was expected to continue to rise over the winter period; • NHS funding was available to support 'Discharge to Assess' but there were continuing staffing pressures; • NHS Digital had published good practice guidance and NHS Providers would present on the subject at the Board Development session in November; • Good progress being made with WRES training across the region; • The Pathology LIMs system roll out continued and thanks were extended to the Pathology team for their commitment to successful roll out, noting that staff had worked frequently late into the evening; • The Trust had extended offers of health care and employment to Afghan refugees; • The Department of Health and Social Care had accepted the Estates Master Plan Strategic Outline Business Case enabling this to now be progressed; • The South West region had been selected to pilot an NHSE review of retention rates for overseas recruits within the NHS as these were poor nationally. The pilot would focus on the cultural issues within the NHS and the need to ensure pastoral care and equality of access to career progression. The pilot aimed to better understand the particular needs of this cohort of staff in order to formulate actions for change nationally, regionally and locally. The Chair noted the significant and sustained pressures facing the Trust and extended the Board's thanks to all health and social care sectors teams.	
	Resolved: that the CEO Update be received and noted.	

BoD21/045	**COVID-19 Update**	
	IR reported that there were currently 14 COVID positive inpatients with three patients receiving critical care support. An increased number of symptomatic staff and index cases had also undertaken testing. The Incident Management Team was monitoring fuel supplies and the Helpdesk maintained local supplier lists of local refuelling stations with availability. No major issues in staff obtaining fuel had been reported and the Trust was working with Wessex 4x4 and seeking to identify staff with electric vehicles to support as a contingency should this become necessary. BD blood bottle supplies had improved nationally and levels of routine blood testing were increasing. The extent of both staff and wider public communications of the need to remain vigilant and maintain social distancing measures were noted. It was also important to recognise the pressures arising from non-elective activity.	
	Resolved: that the COVID-19 Update be noted.	
BoD21/046	**Performance Scorecard and Board Sub-Committee March Escalation Reports**	
	The Non-Executive Chairs of the Board sub-committees provided feedback from committee meetings held the previous week, noting: **People and Culture Committee:** Committee discussion had reflected the pressures on the workforce and the committee escalated concerns around retention rates, particularly relating to the millennial staff group and work / life balance needs. The committee noted that the 'Lived Experience Report' was informing the review of the Trust's Disciplinary Policy and processes and the work to enhance the experience of overseas doctors. **Quality Committee:** Concerns had been raised regarding pressure ulcers incidents and the committee noted the improvement work underway. Similarly, the committee had undertaken a deep dive in respect of stroke service performance and was monitoring improvements on a quarterly basis. The committee had approved the use of socially distant bed spaces in extremis in line with an agreed risk assessment. The CCG were informed in the event of mixed sex accommodation use and the committee maintained close scrutiny of this. **Finance and Performance Committee:** No specific issues were highlighted as items were included within the Board meeting Agenda. However, the need to resist unrealistic efficiency targets proposed as part of H2 funding was noted. Relatively high agency expenditure as a result of the low base line was noted. The committee had learned that a trust in Plymouth had been able to significantly reduce the use of agency and the Trust was pursuing opportunities to learn from peers. The national support team	

	had offered support to reduce agency expenditure further as DCH appeared to have a proportionately higher spend than system partners. **Risk and Audit Committee:** Key issues were included within the Board meeting Agenda. The committee had reviewed the Internal Audit Plan and approved minor amendments to the order and timing of some planned audits.. PM noted national discussion promoting the 111 First service to alleviate primary care sector pressures arising from the additional vaccination requirements. Consideration was being given to subcontracting some services to the private care sector, as well as amendments to the treatment of minor injuries and the ambulance service See and Treat processes. National consideration was also being given to the creation of equivalent terms and conditions across health and social care in order to develop career pathways and apprenticeships into nursing in the medium term. AH noted the shift in clinical coding focus resulting from the Elective Recovery Fund requirements and the impact on the SHMI data which was largely related to the coding of emergency activity. A full report (Action Log item BoD21/030 from July 2021 meeting) would be provided to the Board in November and would outline actions taken to address gaps in the coding team establishment and technical difficulties experienced by staff working at home. Approval had been given to employing contract workers to address the coding backlog and this would be kept under review by the Finance and Performance Committee on a monthly basis.	
	Resolved: that the Performance Scorecard and Board Sub-Committee Escalation Reports be noted.	
BoD21/047	**Maternity Services – Learning from Sheffield CQC Review**	
	JH advised that outcomes of the CQC report on the Sheffield Maternity services review had been used as a comparator in an internal review within DCH. The benchmarking exercise had identified strong compliance, notably the recent appointment of a Care Group Manager and had also noted a number of action points as follows: • additional mandatory training sessions (particularly CGT training) with backfill funding available to ensure compliance; • scheduled simulation training; • a new process for Resus Trolley checking had been implemented; • a triage tool and risk assessment had been introduced within the digital record system; • regular ward rounds including at the weekend; • recruitment to six posts following a successful bid for national funding; • the planned roll out of the Electronic Prescribing and Medicines Administration system (EPMA). The Board thanked JH for the helpful report and acknowledged the significant progress made by the service and the open approach to seeking improvement.	

	JH left the meeting.	
	Resolved: that Learning from the Sheffield CQC Review be noted.	
BoD21/048	**Safest Nursing and Midwifery Staffing**	
	NL outlined that the report provided assurance on the process for ensuring safest staffing levels and mutual aid when services were experiencing significant service and staffing pressures. Staffing levels were monitored on a daily basis in order to mitigate risks and support clinical teams with additional support being provided by the Wellbeing team. Staffing level risks had been previously discussed by the Risk and Audit Committee. The Board was reminded that the risk was being tolerated. The impact of workforce pressures on service quality and patient experience was being kept under review by the Quality Committee with robust triangulation of metrics and communication between Board subcommittees. The Trust had been operating the safest staffing model since January 2021 and it was anticipated that this would continue over the winter period. The extensive work streams to recruit to a variety of posts was also noted.	
	Resolved: that the Safest Nursing and Midwifery Staffing Report be approved.	
BoD21/049	**Well-Led Self-Assessment**	
	SS Joined the meeting. The Board recalled the self-assessment exercise they had completed the previous month and noted discussion of how ratings would be applied by the Board given the Trust's position within the strategy review, planning and implementation cycle. The Board were asked to approve the assessment prior to submission to the independent external reviewer in order to commence the Well Led review. The following issues needed to be worked up: • the Trust's work on population health and inequalities – also reflected in the waiting list review work • the Board's use of information • environmental sustainability metrics • the anchor institution/references. • DCH hosting DISS and making better use of this modelling. The Board requested that Executive members be given the opportunity to reflect on these points and finalise content before submission to the independent external reviewer. The DCH strategy was currently well aligned to system thinking. The need to review early in 2022 was noted as ICS decisions were made about the long term plan and health inequalities.	**TH**
	Resolved: that the Well-Led Self-Assessment be approved	

	following the inclusion of final comments and submitted to the Independent external reviewer in order to commence the Well Led Review.	
BoD21/050	**Strategy Implementation Update**	
	NJ presented the Strategy Implementation Progress Update advising that the Trust was making good progress and remained on track against the plan agreed in May 2021. He noted the need to complete the review of the Board Assurance Framework (BAF) and reported that this would be presented to the Risk and Audit Committee and the Board in November. Implementation of the Strategy would be monitored by the Board on a six monthly basis and strategic measures would be embedded into regular performance reporting to Board. The Board acknowledged the lack of a wider sustainability ambition in national frameworks and the need for this, and for metrics addressing inequalities and desired outcomes, to be included locally within the delivery plan. MA summarised the need to incorporate longer term measures related to the strategy within the delivery plan and reporting, including the need for the organisational culture to shift towards a stronger focus on population health.	
	Resolved: that the Strategy Implementation Update be received and noted.	
BoD21/051	**Annual Emergency Preparedness, Response and Resilience assessment and Statement of Compliance be approved.**	
	IR reported that DCH was fully compliant with 45 of the applicable 46 standards, noting partial compliance against the mass casualty testing exercise. A testing exercise was planned in the coming months. The self-assessment provided substantial compliance overall and this had been agreed by the CCG following their review. IR also reported on the completion of a 'deep dive' relating to oxygen and the CCG's recognition that the review of the state of the service had been exemplary. The EPRR self-assessment and compliance statement were approved.	
	Resolved: that the EPRR statement of Compliance be approved.	
BoD21/052	**Charity Annual Report and Accounts**	
	PG presented the DCH Charity Annual Report and Accounts following conclusion of the audit process and requested that the Board of Directors acting as agents of the Corporate Trustee approve these prior to submission to the Charity Commission. DU reported good performance within the context of a difficult and challenging year for the charitable sector and noted that a 'stock take' of the Charity's performance and financial situation would be undertaken in November	**TH**

	2021. The DCH Annual Report and Accounts 2020/21 were approved.	
	Resolved: that the Charity Annual Report and Accounts be approved and submitted to the Charities Commission.	
BoD21/053	**Guardian of Safe Working Hours Report**	
	Dr Kyle Mitchell joined the meeting for this item and summarised that junior doctors were actively encouraged to formally highlight occasions where they were required to work flexibly. Reporting had been at low levels during the pandemic and had been reinvigorated at the new junior medical staff Induction in August. Such reporting identified areas where there were too few junior doctors, and was beneficial to the Trust. Issues raised included the need to improve resilience of the workforce and to match workload perceptions to expectations, providing support and assurance. Increasing numbers of short notice absences due to the need for isolation were also noted. KM reported that the Trust was transitioning to the use of e-rostering systems that would help to improve communications and cover. Discussion followed regarding the inclusion of students towards the end of their training within teams for an extended period to support their transition from the education setting into the working setting. These arrangements had worked well during the pandemic. A consistent approach was required across medical schools and further discussions about this would be had with the Deanery. This approach was supported by AR, Director of Medical Education, who had noted the adverse impact on team cohesion arising from the phased commencement of F1 doctors.	**PM**
	Resolved: that the Guardian of Safe Working Hours Report be received and noted, and the Deanery be made aware of the Board's view about improving transition arrangements.	
BoD21/054	**General Medical Council Survey Report**	
	AR attended for this item and presented an overview of the results of the GMC Survey of Doctors in Training in 2021. AR noted that an increased number of medical staff had remained in the UK during the pandemic. This, and use of Medical Support Workers (MSW) supporting clinical teams whilst awaiting GMC registration, had been beneficial for the Trust. Maintenance of the MSW role was consistent with the Trust's social value ambition and provided alternate ways of engaging and recruiting medical colleagues. However, national funding for this role would cease in March 2022. AR advised that focus on F1 wellbeing had been maintained. The results of the survey were in line with national average and noted a smaller number of trainees in some areas. Orthopaedic and Anaesthetic programmes evaluated in the top five training experience and Obstetrics and Gynaecology evaluated in the bottom five as a result of	

	staffing and supervision capacity. Some concerns had been raised regarding doctors dealing with areas beyond their level of competence, out of hours supervision, handover and workloads. The Emergency Department (ED) had seen significant improvements in junior medical staff to training experience. AR reported the following improvements made over the preceding six year period: • all groups would recommend DCH as a place to train and work; • the ED was recognised as having a good reputation; • increased numbers of medical staff; • the implementation of supplementary roles to support doctors; • doctors were increasingly involved in management decisions; • the outcomes of exception reporting were driving change; • increased support for Return to Training schemes; • strengthened recruitment processes and cross system working; • sharing areas of good practice and action plans in place to support the recovery of training post COVID. The need for further work in respect of accommodation, appraisal and wellbeing was noted in order to meet the needs of Locally Employed Doctors and provide support, as this was impacting recruitment. AR thanked the Trust for the opportunity to be Medical Education Lead and advised that she had reached the end of her term of office. JM extended his thanks to AR for the work she had led during that period, noting in particular, rapid report escalation and the prompt responses to these by teams. AH added his thanks to AR for contribution and commitment to the success of the Education Department. MA outlined his involvement as Chair of a number of consultant appointment panels and highlighted that a positive training experience often benefited recruitment of consultants many years later. He extended the Board's thanks to AR for her excellent work over the previous six years.	
	Resolved: that the GMC Survey Report be received and noted.	
BoD21/055	**Board Assurance Framework**	
	NJ recalled prior discussion of the Board Assurance Framework by the Board and noting the transitional period as strategic risks arising from the refreshed strategy were being included. NJ drew attention to the high volume of inpatients remaining in hospital with no acute care needs, and the national challenges facing children with complex needs. NJ acknowledged the need to ensure the inclusion of risks relating to the Trust's social value ambitions, inequality and environmental sustainability and welcomed the planned discussion by the Risk and Audit Committee in November.	
	Resolved: that the Board Assurance Framework be received and	

	noted.	
BoD21/056	**Recovery Report**	
	The Board noted that the Trust continued to make progress in delivering the recovery agenda. Capacity remained an issue. A benchmark of performance against system partners would be included in future reports. IR reported that the national ambition was to reduce the number of people waiting over 104 weeks for treatment to zero by March 2022 and that the Trust had advised that this would not be possible in some services due to a lack of specialists. In regional and national benchmarking DCH performed well in respect of ambulance handovers and trolley waits. Recovery benchmarking showed overall good performance although composition of the waiting list remained challenging with long waiting time particularly within the oral maxillofacial and orthopaedic services. The Board noted the ongoing work to review equalities within the waiting list, the need to include vulnerability markers and issues of ethnicity data completeness affecting about 20% of the waiting list. Qualitative interviews with patients on waiting lists had commenced to identify any inequalities. The Board acknowledged the commitment of teams to maintaining elective activity and the recovery agenda. PM highlighted that people in deprived communities were more likely to access the Emergency Department (ED) whilst on an elective waiting list and proposed further review of the waiting list in order to better understand this.	**AT**
	Resolved: that the Recovery Report be received and noted.	
BoD 21/057	**WRES Data**	
	DH apologised for the late circulation of the late paper which provided a summary of the Trust's annual performance against the Workforce Race Equality Standards (WRES) and was presented to the Board prior to publication at the end on the month. The report aimed to improve the experience of ethnic minority staff. DH highlighted that the review had been completed within the context of a developing inclusive culture that was encouraging staff to speak out about their concerns. She drew attention to the following key points: • the likelihood ratio of BME staff entering disciplinary processes was 1:44; • there was an increased number of staff reporting bullying from patients reflecting increased staff confidence to report; • there had been an increased incidence of bullying from staff – this was above the national average; • opportunities for equal career progression had deteriorated; • an increased number of staff experiencing discrimination by their line manager – this was above the national average; • BME headcount had increased across all bands of staff and there	

	was a positive increase in BME Board membership to 4%; • positively, the likelihood of BME staff not being shortlisting had halved. However, applicant data being collected had noted a significant number of applications with no right to work in the UK or with insufficient qualifications and a data cleansing exercise was being undertaken; • the need to create a culture where people wanted to stay; • non mandated training access and continuous professional development data was being reported for the first time. Next steps included continued efforts to improve for equity and equality of opportunity for staff, encouraging BME staff to speak out and the further development of an inclusive culture. Progress would be monitored via the People Dashboard by the People and Culture Committee. The three Staff Networks gave people space to discuss their concerns and an increased confidence that the organisation was addressing these. The networks scrutinised staff feedback from a variety of sources and demonstrated that more staff felt able to speak out about their concerns. The experience of BME staff when seeking accommodation locally and the poor attitude of the public was noted by the Board. The Board would ensure that staff were supported when they experienced inappropriate behaviours from patients. Clinical leaders also needed to be supported to challenge this behaviour.	
	Resolved: that the WRES Data be noted.	
BoD21/058	**Questions from the Public**	
	No questions were raised by the public.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD21/059	**Maternity Safety Report**	
	Resolved: that the Maternity Safety Report be noted.	
BoD21/060	**Charity Risk Policy**	
	Resolved: that the Charity Risk Policy be ratified.	
BoD21/061	**Infection Prevention and Control Annual Report 2020/21**	
	Resolved: that the Infection Prevention and Control Annual Report 2020/21 be ratified.	
BoD21/062	**Committee Risk Process**	

	Resolved: that the Committee Risk Process be noted and taken forward by Committee Chairs.	
BoD21/063	**Any Other Business**	
	PM requested that the risk assessment relating to the use of 'Sink Beds' in extremis be circulated to members of the Board. The Board noted that refreshed national infection prevention and control guidance was being reviewed at system level and would be presented to the Quality Committee in October and the Board in November. MA extended the Board's thanks to IR for her commitment, grip and leadership which had been critical in helping the Trust to navigate a particularly difficult period, and wished her well in her new post.	**TH**
BoD21/064	**Date and Time of Next Meeting**	
	The next Part One (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 24th November 2021.** It was hoped that this could be at Vespasian House and via MS Teams. Further information would follow.	

Action Log – Board of Directors Part 1

Presented on: 24th November 2021

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 29th September 2021						
BoD21/049	**Well-Led Self-Assessment**	Executive team to be invited to include any final actions / amendments to the self assessment prior to submitting the self assessment for review	**TH**	November 2021	Executive team invited to submit final amendments by 7th October 2021	Yes
BoD21/052	**Charity Annual Report and Accounts**	A stock take of performance and financial situation to be undertaken by the Charitable Funds Committee.	**TH**	November 2021	Scheduled for the November meeting of the Charitable Funds Committee	Yes
BoD21/053	**Guardian of Safe Working Hours Report**	A discussion to be had with the Deanery to propose an extended work placement for medical students towards the end of their training to support transition form the education to work setting	**PM**	November 2021		
BoD21/056	**Recovery Report**	Performance benchmarking against system partners to be included in future reports	**AT**	November 2021		
BoD21/063	**Any Other Business**	The risk assessment in respect to the use of 'Sink Beds' to be circulated to members of the Board post meeting.	**TH**	November 2021	Circulated 1.10.21	Yes
Meeting Dated: 28th July 2021						
BoD21/027	**Matters Arising: Action Log**	Review of the revised report front sheets be added to the Board action log (from the NED action log) for consideration by the whole Board.	**TH**	November 2021		
BoD21/030	**Performance and Escalations**	It was queried whether that Summary Hospital-level Mortality Index (SHMI) should be rated as green on the performance scorecard and the Chief	**AH**	November 2021	A full report will be provided to the meeting in November	Yes

		Medical Officer (CMO) said he would look in the rating.				
Actions from Committees…(Include Date)						

Meeting Title:	Board of Directors
Date of Meeting:	24 November 2021
Document Title:	**Chief Executive's Report**
Responsible Director:	Patricia Miller, Chief Executive
Author:	Natalie Violet, Corporate Business Manager to the CEO

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Chief Executive	15 November 2021	Approved

Purpose of the Paper	For information.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the Trust is performing and the key areas of focus. The key developments nationally are as follows: • The Government announced the launch of the most far-reaching review of health and social care leadership in 40 years. It will consider how to foster and replicate the best examples of leadership and aims to reduce regional disparities in efficiency and health outcomes across the country. • Key findings from a report from the House of Commons Committee of Public Accounts highlighted Test and Trace's failure to achieve the main objective of helping break chains of COVID transmission and allow people to return to normality despite the extensive financial investment. • The budget and spending review announced an additional £5.9bn capital spending however NHS Providers have highlighted the lack of confirmed multi-year investment to address workforce challenges. • The operational planning guidance has been published for the second half of this year. The organisation will be challenged in eliminating all 104 week waiters by the end of March 2022. Changes to the Elective Recovery Fund thresholds are being worked through as a system to establish whether we can achieve them. • A report from the House of Commons Health and Social Care, and Science and Technology Committees highlighted the lessons learned from the COVID-19 pandemic. A public inquiry is expected to commence in Spring 2022 and the organisation will be establishing a Public Inquiry Task Group to lead our preparations. • The Secretary of State for Health and Social Care announced COVID-19 vaccinations will be mandatory for frontline NHS staff in England from April 2022. We are in support of this approach and have already begun to scope the implications for our workforce. We are in a good position as we are the top performing acute Trust in the country, with 95% of our staff having received two doses. • November saw the announcements of Chief Executive designates for Integrated Care Systems from 01 April 2022 and I have been appointed for the Dorset system. • The Association of Ambulance Chief Executives published a report following a structured clinical review of handover delays at hospital emergency departments across England. The report focuses on the							

	learning and improvement required at national and system level to address this issue. The aim is to seek to identify and support an improved situation for the future. Locally the biggest concerns remain with emergency demand and staffing. October saw an increase in COVID demand which was also reflected nationally with the South West being the region with the highest incidence. November has seen a slight decrease in COVID positive patients however we continue to remain cautious and encourage everyone to continue to follow the infection prevention guidance. Non-COVID demand continues to result in very high bed occupancy rates which are mirrored across the system. Our teams are responding exceptionally well to these challenges. Staffing remains particularly challenging and our daily staffing meetings are continuing to ensure staff levels in clinical areas are as safe as possible. However, if international recruitment continues to go to plan, we will be fully staffed in terms of nursing establishments by March 2022
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the information provided.

Governance and Compliance Obligations

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

Chief Executives Report – November 2021

Strategic Update

National Perspective

Review of Health and Social Care Leadership
In early October the Government announced the launch of the most far-reaching review of health and social care leadership in 40 years. The review will be led by former Vice Chief of the Defence Staff General Sir Gordon Messenger who will report back to the Secretary of State for Health and Social Care, Sajid Javid, in early 2022. The review will consider how to foster and replicate the best examples of leadership and aims to reduce regional disparities in efficiency and health outcomes across the country.

Test and Trace
On 27 October 2021, the House of Commons Committee of Public Accounts published a Test and Trace Update report. The key finding of the report was the failure to achieve the main objective of helping break chains of COVID transmission and allow people to return to normality despite the extensive financial investment. The report recognised the significant increase in the number of tests available and reduction in the time to provide results, as well as collaboration with local authorities ahead of the UK Health Security Agency subsuming Test and Trace later this year.

Budget and Spending Review
On 27 October 2021, Chancellor Rishi Sunak announced the measures in the budget and spending review. The key highlights associated with healthcare include:

- The new Health and Social Care Levy, along with an increase to the rates of dividend tax, will raise around £13bn per year for spending on health and social care across the UK.
- £2.3bn over the next three years to transform diagnostic services with at least 100 community diagnostic centres across England to help patients access earlier diagnostic tests closer to home.
- £2.1bn over the next three years to support innovative use of digital technology so hospitals and other care organisations are as connected and efficient as possible, freeing up valuable NHS staff time and ensuring the best care for patients wherever they are.
- £1.5bn over the next three years for new surgical hubs, increased bed capacity and equipment to assist elective services recovery.

NHS Providers welcomed the additional £5.9bn capital spending however, highlighted the lack of confirmed multi-year increase in Health Education England's education and training budget despite workforce shortages being the biggest challenge across health and social care.

Local Relevance

2021/22 Priorities and Operational Planning Guidance – October 2021 – March 2022
On 30 September 2021, NHS England published the operational planning guidance for the remainder of 2021/22. The six priority areas set out in March 2021 remain:

A) Supporting the health and wellbeing of staff and taking action on recruitment and retention
B) Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
C) Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
D) Expanding primary care capacity to improve access, local health outcomes and address health inequalities

E) Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for emergency department patients and reduce length of stay
F) Working collaboratively across systems to deliver on these priorities

There will be continued focus on the five priority areas for tackling health inequalities and delivering sustained progress against the ambitions of the NHS Long Term Plan:

1. Restore NHS services inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are complete and timely
4. Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Strengthen leadership and accountability

Systems are being asked to maximise elective activity and eliminate waits over 104 weeks, taking full advantage of opportunities to transform the delivery of services. The ambition is to eliminate waits over 104 weeks by March 2022 except for those patients who choose to wait longer, hold or where possible reduce the number of patients waiting over 52 weeks, and stabilise waiting lists around the level seen at the end of September. Locally, the organisation will be challenged in eliminating 104 week waiters in Orthopaedics despite efforts in insourcing and outsourcing as part of our recovery ambitions.

The Elective Recovery Fund (ERF) continues into the second half of the year with £1bn of revenue available. ERF will now focus on completed referral to treatment (RTT) pathway activity above a 2019/20 threshold of 89%. This is different to the measure used during the first six months of the year which was based on total cost weighted activity. We are working through as a system whether or not we can achieve this.

With additional capital funding available, to support the continued recovery of elective activity and cancer services, we have been working with system partners to bid for capital funding to support our recovery efforts and await the outcome of the system submissions.

Coronavirus: Lessons Learned Report
On 12 October 2021 the House of Commons Health and Social Care, and Science and Technology Committees published the Coronavirus: lessons learned to date report. The report recognised the remarkable achievements of the NHS during what has been the most challenging period in its 73-year history. The vaccination achievements were highlighted as a success from the research and development through to the rollout, the report described it as "one of the most effective initiatives in UK history". There were, however, many lessons to learn from the response including the impact of delaying the first lockdown, access to personal protective equipment (PPE), testing, support from central government, coherent national policy, Test and Trace, and the devastating legacy of over 150,000 deaths and the disproportionate impact on those from ethnic minority backgrounds.

It is anticipated a public inquiry into the response to the pandemic will commence in Spring 2022. The Inquiry Chair is not expected to be appointed until next month, after which the scope and length of the inquiry will be determined. Internally we are preparing to be able to support the inquiry openly and transparently. A Public Inquiry Task Group will be established to lead our preparations.

Mandatory COVID-19 Vaccinations for NHS Frontline Staff
On 09 November 2021, the Secretary of State for Health and Social Care, Sajid Javid, announced COVID-19 vaccinations will be mandatory for frontline NHS staff in England from April 2022. This was following a consultation launched in September. The decision was taken to protect vulnerable patients, NHS staff, and the NHS itself. Only those who do not have face-to-face contact with patients or who are medically exempt will not be required to be vaccinated.

NHS Providers were pleased the Government delayed the implementation to the spring, avoiding the busy winter period and to help ensure Trusts can maximise their efforts to increase voluntary take up amongst their staff.

We are in support of this approach and have already begun to scope the implications for our workforce. We are in a good position as we are the top performing acute Trust in the country, with 95% of our staff having received two doses.

Integrated Care System Chief Executive Appointments
This month saw the announcements of Chief Executive designates for Integrated Care Systems from 01 April 2022. For the South West the following appointments have been confirmed so far:

- **Bath, North East Somerset, Swindon & Wiltshire:** Sue Harriman, currently Solent Trust Chief Executive.
- **Dorset:** Patricia Miller, currently Dorset County Hospital Foundation Trust Chief Executive.
- **Gloucestershire:** Mary Hutton, currently Gloucestershire ICS Executive Lead and Gloucestershire CCG Chief Executive.

Being appointed into this post provides me an opportunity to play a lead role in improving the lives of the Dorset population. It has been an absolute privilege being Chief Operating Officer and then Chief Executive for the last ten years. As an organisation, we have achieved so much together - being signed out of special measures in 2011, delivering some of the best performance in the country, and being rated as 'Good' by the CQC in 2018. I will miss Team DCH terribly and I thank everyone for the commitment and loyalty they have always shown me over the years. I wish Team DCH the very best in the future. During my time here I have developed a much deeper understanding of the needs of our local/rural population, and I am committed to do my very best for the residents of Dorset.

Delayed Hospital Handovers: Impact Assessment of Patient Harm
On 15 November 2021, the Association of Ambulance Chief Executives (AACE) published a report following a structured clinical review of handover delays at hospital emergency departments across England. The impact assessment was coordinated by AACE and was undertaken in all ten English NHS ambulance services who reviewed a sampled of cases from one single day in January 2021, where handovers exceeded one hour.

The review found the proportion of patients who could be experiencing unacceptable levels of preventable harm is significant. Over eight in ten of those whose handover was delayed beyond 60 minutes were assessed as having potentially experienced some level of harm; 53% low harm, 23% moderate harm and 9% (one patient in ten) could have been said to have experienced severe harm.

The report focuses on the learning and improvement required at national and system level to address this issue. The aim is to seek to identify and support an improved situation for the future.

Following receipt of a letter from NHS England and Improvement, in October, the Dorset Urgent and Emergency Care Board are overseeing the system response to eliminating ambulance handover delays. DCH continues to perform well with regular praise from South West Ambulance and we continue to maintain our position as best performing in the region**.**

Our Head of Emergency Planning and Response undertook a risk assessment of our Emergency Department 'front door' response to ambulance handovers including policy, procedure, and observation of implementation. The risk assessment has been shared with South West Ambulance and Dorset Clinical Commissioning Group. The assessment identified all efforts to reduce handover delays are in place, policies and procedures have shown to provide the least risks when queues form, and the FAB and 'queuing out' approach is good practice and has been recommended to other Trusts. This is because it supports flow, through the safest approach and has demonstrated positive results for ambulance handover times.

DCH Performance

Activity Summary
October saw an increase in COVID demand which was also reflected nationally with the South West being the region with the highest incidence. Dorset was showing over 600 new cases per 100,000 population per week which was higher than we saw during the last wave in January 2021 when it reached 350 per 100,000 per week. November has seen a slight decrease in COVID positive patients however we continue to remain cautious and encourage everyone to continue to follow the infection prevention guidance. Non-COVID demand continues to result in very high bed occupancy rates which are mirrored across the system. Our teams are responding exceptionally well to these challenges. Staffing remains particularly challenging and our daily staffing meetings are continuing to ensure staff levels in clinical areas are as safe as possible.

COVID Boosters
Our vaccination hub reopened on 05 October 2021 to commence booster vaccinations for eligible health and social care staff in West Dorset. The hub closed on 12 November 2021. Any staff who still require a booster vaccination can book this using the national booking system. During the six weeks that it was open the hub delivered 3970 booster vaccines, of which 1967 were DCH staff.

Neutralising Monoclonal Antibody Drug Therapy
The organisation is now able to prescribe and treat certain eligible COVID admitted patients with a new drug therapy called neutralising monoclonal antibodies. This treatment is like your own antibodies but made in a laboratory and targets the coronavirus spike protein, blocking the virus from entering the body's cells and therefore multiplying, hence they impact on the person having severe infection and reduce the risk of death.

Veteran Covenant Health Alliance
In October, we were informed our application to become a member of the Veteran Covenant Health Alliance had been successful. The Alliance represents a group of NHS acute hospitals which have volunteered to be exemplars of the best care for veterans and help to drive improvements in NHS care for people who serve or have served in the UK armed forces and their families. This includes committing to the Armed Forces Covenant, raising awareness among staff of veterans' healthcare needs, and establishing clear links with service charities and local support providers. The organisation is now 1 of 58 trusts able to demonstrate they are delivering these standards and have been accredited as 'Veteran Aware'.

Equality, Diversity, and Inclusion
Our Transforming People Practices programme, which began earlier this year working with members of our Diversity Network, continues with three key workstreams with the ambition to start to launch new policies this month.

- **Inclusive recruitment**: improving inclusivity and provide fair, equitable recruitment services that recruits the best candidate for the role. There are three initial priorities which include the assessment processes, criteria for roles, and a review of interview panels.
- **Appraisal and succession planning**: ensuring every member of staff have high quality conversations which focusses on the reflection on the previous year, performance and behaviours against objectives, clarity on future objectives, career aspirations and a development plan to include this. Appraisal training is being reviewed and a programme of development sessions and supporting resources for managers is being developed. There will be sessions for appraisees to help them recognise the part they play in the appraisal process, how they prepare, and to clarify alternative routes for the appraisal conversation if staff feel they are not being heard or supported. In addition, the paperwork is being simplified, recognising the conversation is more important.
- **Just and learning culture**: striving towards an environment where we put equal emphasis on accountability and learning. A lived disciplinary experience report was produced and shared as pre-reading for the third module of the Inclusive Leadership Programme in September. We are

looking to transform our Disciplinary Policy from process centred to people centred which will be the 'blueprint' for all future people policies.

The Inclusive Leadership Programme, aimed at helping leaders understand how to see, respond, and lead differently, is continuing to see very high levels of staff engagement and willingness to participate in difficult conversations and share aspects of their personal life. The progress we are seeing is helping participants understand why this programme is necessary. It has been an emotional journey for many as we learn not just how to see the world differently but also what is required of us as leaders to create and maintain positive human relationships within teams. The final sessions, of the initial cohorts, will take place in December.

To complement our work so far, October saw the launch of our new Dignity and Respect Workshop as part of our mandatory training package. The workshop will explore day-to-day communication, sometimes conducted under pressure, our own behaviours, and our responsibility to challenge inappropriate behaviours. The workshops are open to staff from Bands 2 to 6. The aim is to create an environment that allows everyone to feel like they belong and matter and feel safe enough to bring their 'whole self' to work.

Black History Month
During October we celebrated Black History Month including themed menus in the restaurant and displays of staff underpinning the Proud To Be theme for this year. We hosted an evening with Louisa Parker, a local writer and poet, talking about her experience of growing up in Dorset and Dorset's connection to the slave trade. It was an evening of listening to lived experiences, learning, and celebrating difference and the richness it brings to Team DCH. Some of our overseas nurses ended the evening by dancing for the audience.

We are also displaying a portrait, by Chloe Cox, of her grandfather. It is a wonderful piece of art which beautifully captures the positive contribution black people have made to British history. Chloe is the daughter of Doreen Cox, one of our Consultant Radiologists, who recently won Young Portrait Artist of the year. Her inspirational artwork signifies those underrepresented and empowers individuals from ethnic minorities in British art.

Chief Operating Officer
In October we said farewell to Inese Robotham following almost three years at DCH. Inese was instrumental in leading our COVID response. She has taken up the role of Chief Operating Officer at Swansea Health Board. Anita Thomas is currently Interim Chief Operating Officer. We are planning on advertising the permanent role towards the end of November with interviews taking place in January.

Director of Medical Education
In October, Audrey Ryan stepped down as Director of Medical Education after six years. Audrey led several improvements during her time and provided many of our trainees with pastoral support to enable them to further their careers. Following interview, Paul Murray has been appointed as Audrey's successor. He is an excellent clinician with a deep commitment to medical education.

Flu Vaccinations
We commenced our flu vaccination campaign in October with drop-in sessions and our team of Peer Vaccinators targeting departments. Uptake in the vaccination has been very positive and we are hoping to exceed last year's performance of 91%. We have also launched a survey to capture and understand the reasons why staff are choosing not to have their flu vaccination. We also have a mechanism to capture any staff who have received their vaccination elsewhere.

ISO Accreditation
In October, we received confirmation of successfully maintaining our ISO 27001 accreditation for Information Security Management in ICT. This is in recognition of providing a best practice service to an international standard, particularly how we manage confidential information and security management. Maintaining the high standards expected of this accreditation is a fantastic achievement. It means we will be accredited for a further three years with spot check audits taking place each year.

South Walks House
This month we commenced multi professional clinics from South Walks House in Dorchester. We are working in partnership with Dorset Council and our health care colleagues to offer a range of outpatient services in one location. Consequently, reducing footfall and travel to DCH.

GEM Awards
Our Going the Extra Mile (GEM) award ceremony took place on Friday 12 November 2021 at Kingston Maurward. It was a wonderful evening of celebration, after such a difficult 18 months it was an opportunity to thank all our staff and particularly those who have been identified as going above and beyond for colleagues, patients, and their families.

The GEM awards marked the end of our DCH Thank You Week which was an opportunity to shine a light on the incredible people we have at DCH and everything they do for each other, the organisation, and our communities. We celebrated with a pin badge in recognition of the last 18 months and complementary cake for all staff. Postcards were available to share personal messages with other people and teams.

Staff Survey
We have seen a positive start to our Staff Survey campaign which is due to close this month. We continue to encourage staff to complete the survey highlighting the importance of receiving feedback in order to make improvements within the organisation.

Chairman Recruitment
Our Chairman, Mark Addison, will be retiring in March 2022 by which time Mark will have been with the organisation for six years and reached his maximum tenure. The post is a Governor appointment, and the recruitment timeline has been approved. The post will be advertised this month with longlisting and shortlisting taking place in December. Interviews will take place in January. We are aiming to have a period of shadowing before Mark leaves at the end of March.

Non-Executive Director Recruitment
Ian Metcalfe is leaving his role as Non-Executive Director this month. Ian has been a fantastic colleague with a huge amount of commitment to DCH and never afraid to ask challenging questions to encourage us to think differently. In preparation for his departure, we interviewed for Non-Executive Directors in October.

The three successful appointments were agreed by the Council of Governors on 18 October 2021:

- **Stuart Parsons** will commence on 01 December 2021 as a Non-Executive Director. Stuart has a wealth of experience in finance and will chair Risk and Audit Committee.
- **Eiri Jones** will commence on 01 January 2022 as a Non-Executive Director. Eiri has a nursing background with a wealth of experience in improvement support, quality, and assurance.
- **Dhammikha Perera** will commence on 01 January 2022 as an Associate Non-Executive Director. Dhammika is a trained physician with experience in healthcare across Asia, Africa, the United States, and the United Kingdom.

Care Quality Commission – Inpatient Survey
In October the results of the latest inpatient survey, carried out by they Picker Institute on behalf of the Care Quality Commission were published. The survey captured the views and experience of 592 patients admitted to DCH in November 2020. The results revealed that 86% of patients rated their experience as a 7/10 or more; 99% felt treated with respect and dignity and 98% had confidence and trust in the staff. The hospital was rated significantly higher in eight of the questions in comparison to previous years.

Patients particularly highlighted how they were able to keep in touch with family and friends throughout the COVID-19 restrictions, the quality of the food, discussions around discharge, and being given written and printed information when leaving the hospital. Areas where suggested improvements can be made include giving further privacy when discussion conditions and treatment, further explanation on how patients might feel after their procedure, and getting more help from staff to eat meals. As a result,

action plans are being developed with the Divisions and will be monitored through the Patient Experience Group.

Urgency and Emergency Care Survey
In September we were ranked as one of the top 10 in the country for emergency care. The 2020 Urgency and Emergency Care Survey looked at the experiences of patients who attended our Emergency Department between November 2020 and March 2021. The results ranked the organisation above most other hospitals for eight of the questions and highlighted three areas patients believed the Emergency Department excelled in: arrival, waiting times, and leaving the department. Patient feedback highlighted the efficient ambulance handover times; privacy at reception to discuss their condition; not having to wait too long before first speaking to a doctor and being examined; being told about any symptoms to watch for after going home and the discussion of transport arrangements. Patients also ranked the hospital highly for involving them in making decisions about their care and treatment, the cleanliness, treating them with respect and dignity and for providing an overall positive experience.

Maternity Survey
October saw the publication of the Maternity Survey 2021. The survey, which was carried out by Picker on our behalf, was shared with the Quality Committee in October. Highlights include, during labour and birth, 96% of women felt they were treated with respect and dignity, 95% of women had confidence and trust in the staff, and 99% of women were involved enough in decisions about their care. There were some specific areas requiring attention, as a result a comprehensive action plan is being drawn together.

Patricia Miller
Chief Executive

Meeting Title:	Trust Board
Date of Meeting:	24th November 2022
Document Title:	**COVID-19 Public Inquiry – Preparedness Planning**
Responsible Director:	Anita Thomas, Interim Chief Operating Officer
Author:	Trevor Hughes, Head of Corporate Governance

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Executive Management Team	12.11.21	Additions to task group membership Present to Trust Board on 24.11.21
Risk and Audit Committee	15.11.21	

Purpose of the Paper	This paper outlines the initial plans in place to support preparedness for the COVID-19 Public Inquiry expected in spring 2022. The Terms of Reference of the Public Inquiry are yet to be confirmed and the Trust's approach, outlined below, is based on current advice from NHSE/I and legal firms providing advice to NHS organisations nationally via webinar sessions.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	In readiness for the COVID-19 Public Inquiry anticipated in Spring 2022, the Executive Management Team has approved the establishment of a COVID Inquiry Task Group to be led by the Interim Chief Operating Officer and supported by the Head of Corporate Governance, Deputy Chief Executive and Emergency Planning Officer. In line with advice received from Hempsons Solicitors and NHSE/I, the Trust has developed a proportionate response to its initial preparations in order to identify information and other requirements to support effective and open participation in the inquiry once the terms of reference for the inquiry have been settled.							
Action recommended	The Board of Directors is asked to: 1. **NOTE** the briefing paper outlining the Trust's preliminary response to the Public Inquiry preparations and the areas of initial preparatory work and reporting arrangements **2. NOTE** the further development of more detailed inquiry response plans once the scope of the Public Inquiry is settled and the level of the Trust's involvement is known.							

Governance and Compliance Obligations

Legal / Regulatory	Yes	The Inquiries Act 2005 (Section 21) allows for the Chair of an Inquiry to require a person to give evidence or provide any documents meaning that the Trust has a legal obligation to co-operate, support and participate in a Public Inquiry if asked to do so. Section 25 of the Act informs that it is an offense, punishable by imprisonment to conceal or prevent the release of documents to the Inquiry.

Financial	No	There is no known direct financial impact arising from the Trust's preparations for the inquiry at this point in time. As the scope and duration of the inquiry are clarified, along with the extent of the Trust's participation, the Task Group will need to monitor the impact on staffing capacity, data storage requirements, staff training and wellbeing support requirements which may have a financial impact.
Impacts Strategic Objectives?	No	
Risk?	Yes	There is a risk to the Trust's reputation if it fails to be adequately prepared to support the Public Inquiry in an open and transparent manner.
Decision to be made?	Yes	See Recommendations section
Impacts CQC Standards?	No	
Impacts Social Value ambitions?	No	
Equality Impact Assessment?	No	
Quality Impact Assessment?	No	

Trust Board 24th November 2021
COVID-19 Public Inquiry Briefing Paper

Executive Summary

This paper outlines the Trust's initial preparedness plans in order to provide a proportionate response and support to the COVID-19 Public Inquiry expected in spring 2022. The Terms of Reference of the Public Inquiry are yet to be confirmed and the Trust's approach, outlined below, is based on current advice from NHSE/I and legal firms providing advice the NHS organisations nationally.

1. Introduction

It has been announced that a Public Inquiry into the national response to the COVID-19 pandemic is expected to commence in spring 2022, with the Inquiry Chair being appointed in December 2021. The Inquiries Act 2005 (Section 21) allows for the Chair of an Inquiry to require a person to give evidence or provide any documents meaning that the Trust has a legal obligation to co-operate, support and participate in a Public Inquiry if asked to do so. Section 25 of the Act informs that it is an offense, punishable by imprisonment to conceal or prevent the release of documents to the Inquiry.

The Regional Office and Hempsons Solicitors have provided advice to support NHS organisations in their initial preparations for support the Public Inquiry, and the approach that the Trust is currently taking is based on this advice. This briefing paper outlines the Trust's initial plans to ensure it is adequately prepared and able to respond more fully and effectively should it be required to provide support, evidence and records to the inquiry. The Trust is in communication with the NHSE/I Inquiry Team and the Trust's proposed initial approach is supported by them.

The Trust's approach will be reviewed once the scope of the Public Inquiry has been settled and a more detailed action plan will then be developed.

2. Narrative

In readiness for the COVID-19 Public Inquiry anticipated in Spring 2022, public sector organisations are planning to be able to effectively support the inquiry openly and transparently. Actions taken to date and initial plans to enable the trust to be able to respond are set out below and the Executive Management team is asked to note the initial plans and approve the proposals contained.

Public Inquiry Task Group

The Executive Management Team approved the establishment of a Task Group to ensure the Trust is able to provide a comprehensive, timely, open, and transparent response to any requests for information to support the inquiry. The following were appointed to lead the Trust's preparations for the inquiry:

- Anita Thomas, Acting Chief Operating Officer and Executive Lead for the Public Inquiry
- Trevor Hughes, Head of Corporate Governance, planning and preparedness lead,
- Nick Johnson, Deputy Chief Executive, and project support lead
- Tony James, Emergency Planning Officer.

The Public Inquiry Task Group will comprise the appointed leadership team and representation from the following areas:

- Medical
- Nursing
- Workforce
- Patient Access

- Risk Management
- Divisional representation
- Digital Services
- Information Governance Manager and Data Protection
- Finance and Procurement
- Estates
- Communications

The Executive team has been asked to nominate appropriate individuals as members of the task group in order to progress preparatory plans.

The task group will report to the Senior Leadership Group on its activities on a monthly basis and that more detailed plans will be developed once the Inquiry Chair, scope of the inquiry and level of the Trust's involvement are determined.

Areas of Initial Focus / Tasks
The Inquiry Chair is not expected to be appointed until December 2021, after which the scope and length of the inquiry will be determined. Without a clear steer on the Inquiry's focus, it is difficult to prepare in detail and the Trust's response should therefore be proportionate at this point in time, balancing this against the current extensive service operational pressures. To this end, it is proposed that the task group, which will be established following approval of the membership, by the end of November, will focus initially on the following areas / key tasks:

Managing Emails and Documents
Work will be required to identify various records, communications and correspondence relating to the COVID-19 pandemic that may be called into evidence by the inquiry in order to preserve this information in accordance with the requirements of the Inquiries Act 2005.

> **Stop Notice**
> NHSE / I issued an Internal Stop Notice to staff providing instruction and guidance on the need to preserve and maintain clear records. Accordingly, the Executive Management Team approved the wording of an Internal Stop Notice on 15th October 2021 for use within the Trust and this was communicated to Trust staff via the CEO Brief on 22nd October 2022 and will be supported by a poster campaign.

Managing Emails and Documents of Leavers
Further work has commenced to identify various records, communications and correspondence contained within the digital accounts of key clinical and decision-making staff that have left the Trust since the beginning of the pandemic to date. A list of all staff that have left the Trust since January 2020 is currently under review by divisional and support services colleagues to identify key clinical and decision making staff in order that information contained within their digital accounts can be preserved and ensure that onward contact details of staff leaving the Trust are obtained.

Freedom of Information Approach
It is widely anticipated that once the Public Inquiry is announced, NHS organisations will encounter an increase in the number of Freedom of Information requests for information relating to the COVID pandemic that has been released to the Public Inquiry. The task group will need to agree which records and documentation that will be proactively published within the Trust's Publication Scheme in support of the inquiry and prepare a statement outlining the Trust's approach to responding to Public Inquiry related requests for information made under the Freedom of Information Act.

Staff Support and Wellbeing
Trust staff have worked under sustained pressure since the onset of the pandemic. Involvement in any formal legal process is stressful and it is important that the Task Group and the Trust ensures that robust arrangements are in hand to support wellbeing for those staff that may be required to support or give evidence to the inquiry.

Further Detailed Planning
The above outlines the Trust's initial approach and the Task group will keep this under review as further information regarding the scope of the inquiry and level of the Trust's participation are determined. Areas advised for further consideration are outlined in Appendix 1 and these will be reviewed by that task group once established.

3. Conclusion

A national Public Inquiry to the COVD-19 pandemic response is expected in spring 2022 and the Trust is making initial plans to support the inquiry. Approval to establish a task group has been given and the Executive Management Team has been asked to propose further membership of this group in order to further progress initial preparations.

Initial preparatory plans are proportionate and are based on advice received from NHSE/I and legal firms given that the scope of the inquiry has yet to be settled.

Initial preparatory plans relate in the main to the identification of records that may be called into evidence in order that these can be collated at a future point as necessary. This includes key clinical and decision making staff records and correspondence since the onset of the pandemic and staff that have left the employment of the Trust.

The task group will also need to determine an proactive approach to the management of Freedom of Information requests relating to evidence that may be submitted to the inquiry as these are expecting to increase when the inquiry opens.

Initial plans also include the need to make appropriate arrangements for additional staff support where staff may be involved in the formal process.

Initial plans will be reviewed by that task group once the Inquiry Chair has been appointed, the scope of the inquiry has been settled and the level of the Trust's involvement has been determined.

4. Recommendation

The Trust Board is asked to:

1. **NOTE** the briefing paper outlining the Trust's preliminary response to the Public Inquiry preparations and proposed membership of the Public Inquiry Task Group and to **NOTE** the areas of initial preparatory work and reporting arrangements.
2. **NOTE** the further development of more detailed inquiry response plans once the scope of the Public Inquiry is settled and the level of the Trust's involvement is known.

Trevor Hughes, Head of Corporate Governance
11th December 2021

Appendices
Appendix 1 Areas for further consideration and focus by the Task Group

Appendix 1
Areas for further consideration and focus by the Task Group

Areas for further consideration, inclusion, and review once the scope of the inquiry has been defined and the extent of the Trust's involvement and support to the inquiry is known:

- Establish and record a timeline of key events during the Pandemic
- Consolidate and collate evidence demonstrating the Trust's emergency response, management, and ongoing monitoring arrangements. This will include but is not restricted to:
    - Internal and external command and control arrangements
    - Decision Logs
    - Staff briefings and communications
    - Revised working arrangements and staff risk assessments
    - Environment risk assessments
    - Procurement arrangements and COVID specific expenditure
    - Revised contractual, performance and governance arrangements
    - Mutual aid provision and receipt
- Key risks and issues encountered
    - Internal Communication and escalation
    - Management response and wider escalation
- PPE
    - Training
    - Procurement
    - National guidance
    - Suitability
    - Availability
- Documentation and records for preservation, including:
    - e-mail accounts and records contained on personal devices
    - preservation of digital accounts for key decision-making staff that have left the Trust since January 2020
    - identification of suitable server capacity / storage area for these records
    - identification of suitable storage area for hardcopy documentation
- Vaccination Programme
    - Establishment of the Hub
    - Staff vaccination campaign and further actions to target hard to reach / reluctant groups
- Staff wellbeing
    - Assessment and ongoing monitoring of all staff groups
    - Support offers available and communication / uptake of these
    - Training and support to staff involved in the Public Inquiry
- Recovery
    - Waiting List Management and performance
    - Elective Recovery Fund performance
    - Cancer services
    - Staff support
- Reporting of action plan delivery and frequency

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**24th November 2021**
Document Title:	**Performance Scorecard and Board Sub-Committee Escalation Reports**
Responsible Director:	**Executive Team**
Author:	**Abi Baker, Governance Support Officer**

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee (performance metrics)	16 November 2021	See committee escalations

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

	• RTT • Diagnostic Waiting Times • ED – 4 hour standard combined with MIU • Cancer 62 day standard • Cancer two week wait standard • Cancer Breast symptomatic 2 week wait • Zero 52 week waits • Zero 104 week waits • Cancer- 31 day where treatment is surgery **Escalation Reports** The November Board sub-committees met as follows: Monday 15th November: People and Culture Committee Tuesday 16th November: Quality Committee, Finance and Performance Committee, Risk and Audit Committee. The attached reports detail the significant risks and issues for escalation to Board for action, key issues discussed, decisions made, implications for the Corporate Risk Register and Board Assurance Framework (BAF), and items for referral to other committees, arising from each of the Board sub-committee meetings.
Action recommended	The Board of Directors is requested to: 1. **NOTE** the performance data 2. **NOTE** the escalations from the Board sub-committees.

Governance and Compliance Obligations

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

Metric	Threshold/ Standard	Type of Standard	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Q1	Q2	Q3	YTD	Movement on Previous Period	12 Month Trend
Safe															
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	Contractual (National Quality Requirement)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	Contractual (National Quality Requirement) 2019/20	**3 (0.4)**	**4 (0.5)**	**2 (0.2)**	**2 (0.2)**	**5 (0.6)**	**5 (0.6)**	**3 (0.3)**	**9 (0.4)**	**12 (0.5)**	**3 (0.3)**	**24 (0.4)**	↑	
Never Events	**0**	Contractual (National Requirement)	0	0	0	0	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	0	0	2	0	0	0	0	2	0	2	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	11	5	10	7	7	9	10	26	23	10	59	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	0	0	0	0	0	0	0	0	0	0	0	**N/A**	
NRLS - Number of patient safety risk events reported resulting in severe harm or death	**10% reduction 2016/17 = 21.6 (1.8 per mth)**	Local Plan	**2**	1	**3**	**3**	**3**	0	1	**6**	**6**	1	**13**	↓	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**10% reduction 2016/17 = 9.9**	Local Plan	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	1 (0.1)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	2 (0.2)	1 (0.0)	1 (0.0)	2 (0.0)	4 (0.1)	↓	
Emergency caesarean section rate			20.1%	26.2%	21.6%	17.5%	N/A	N/A	N/A	22.6%	N/A	N/A	21.9%	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	100%	90.5%	95.6%	N/A	N/A	N/A	N/A	95.0%	N/A	N/A	95.0%	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	96.0%	96.6%	**88.9%**	97.7%	**89.5%**	**87.5%**	96.4%	92.6%	91.8%	96.4%	93.0%	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**83.3%**	**88.5%**	**82.8%**	N/A	N/A	N/A	N/A	**84.9%**	N/A	N/A	**84.9%**	↓	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**INPATIENTS** - collected from April 2017)	**90%**	2018/19 CQUIN target 2019/20 Contractual (National Quality Requirement)	**84.2%**	**88.9%**	**88.0%**	**89.2%**	100%	100%	**79.5%**	**87.5%**	95.9%	**79.5%**	**89.7%**	↓	
Effective															
SHMI Banding (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**2 ('as expected') or 3 ('lower than expected')**	Contractual (Local Quality Requirement)	**1**	**1**	**1**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↔	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.14 (ratio between observed deaths and**	Contractual (Local Quality Requirement)	**1.16**	**1.18**	**1.20**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↑	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	C						N/A	N/A	N/A	N/A	N/A	↔	**N/A**
Dementia Screening - patients aged 75 and over to whom case finding is applied within 72 hours following emergency admission	**90%**	Contractual (Local Quality Requirement)	**59.8%**	**58.5%**	**56.4%**	**64.6%**	**63.7%**	**49.6%**	**89.9%**	**58.3%**	**64.2%**	**89.9%**	**63.0%**	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	Contractual (Local Quality Requirement)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	Contractual (Local Quality Requirement)	**83.3%**	**85.7%**	**60.0%**	90.9%	**85.7%**	**83.7%**	**89.8%**	**80.9%**	**88.0%**	**84.4%**	**84.4%**	↑	
Caring															
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	For monitoring purposes only	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	21	16	27	32	48	34	26	64	114	26	204	↑	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	**94.5%**	**93.9%**	**93.2%**	**94.2%**	**92.5%**	**95.1%**	**93.1%**	**93.9%**	**94.0%**	**93.1%**	**93.8%**	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	88.0%	87.6%	85.4%	85.8%	82.7%	86.4%	86.2%	86.9%	85.0%	86.2%	86.0%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**93.0%**	94.2%	**93.6%**	**91.9%**	**92.8%**	**93.3%**	**93.3%**	**93.6%**	**92.7%**	**93.3%**	**93.2%**	↓	
Number of Hospital Hero Thank You Award applications received	**2016/17 = 536 (44.6 per month)**	Local Plan (2016/17 outturn)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	↓	

Metric	Threshold/ Standard	Type of Standard	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Q1	Q2	Q3	YTD	Movement on Previous Perio	12 Month Trend
Responsive															
Referral To Treatment Waiting Times - % of incomplete pathways within 18 weeks (QTD/YTD = Latest 'in month' position)	**92%**	Contractual (National Operational Standard)	**51.5%**	**54.6%**	**56.4%**	**57.1%**	**57.2%**	**56.5%**	**55.2%**	**56.4%**	**56.5%**	**55.2%**	**55.2%**	↓	
RTT Incomplete Pathway Waiting List size	**Trajectory Sept = 17688**		17,194	**17666**	**17928**	**18505**	**19089**	**19123**	**18854**	**17928**	**19123**	**18,854**	**18,854**	↑	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**69.1%**	**78.0%**	**56.0%**	**55.8%**	**44.3%**	**59.7%**	**38.2%**	**67.0%**	**52.7%**	**38.2%**	**56.3%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**0.0%**	**3.7%**	**8.3%**	**9.4%**	**9.4%**	**52.5%**	**7.0%**	**4.5%**	**24.2%**	**7.0%**	**12.2%**	↓	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	96.7%	97.7%	**93.8%**	97.3%	96.4%	98.5%	**93.3%**	96.1%	96.5%	**93.3%**	**96.0%**	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	**77.8%**	100.0%	100.0%	**92.3%**	**92.3%**	100.0%	**93.9%**	**93.8%**	100.0%	94.6%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	-	-	-	-	100.0%		-	100.0%		100.0%	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**81.0%**	**74.0%**	**74.2%**	**74.0%**	**70.5%**	**72.1%**	**70.0%**	**76.5%**	**72.2%**	**70.0%**	**73.7%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**62.5%**	**83.3%**	**57.6%**	**80.0%**	**68.8%**	**70.6%**	**81.3%**	**65.7%**	**73.6%**	**81.3%**	**70.6%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**80.0%**	**80.4%**	**82.4%**	**85.4%**	**86.3%**	**92.4%**	**94.8%**	**81.0%**	**87.8%**	**94.8%**	**84.3%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**80.7%**	**74.5%**	**71.1%**	**63.9%**	**61.1%**	**64.0%**	**60.3%**	**75.2%**	**62.9%**	**60.3%**	**69.2%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	Contractual (National Operational Standard)	**86.6%**	**82.6%**	**80.0%**	**76.9%**	**75.4%**	**76.3%**	**72.6%**	**82.9%**	**76.2%**	**72.6%**	**79.5%**	↓	
Well Led															
Annual leave rate (excluding Ward Manager) **% of weeks within threshold**	**11.5 - 17.5%**		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	3.08%	3.33%	**3.83%**	**4.18%**	**4.59%**	**4.38%**	N/A	**3.4%**	**4.38%**	N/A	**3.9%**	↑	
Appraisal rate	**90%**	Internal Standard reported to FPC	**77%**	**79%**	**78%**	**76%**	**75%**	**72%**	**72%**	**78%**	**74%**	**72%**	**76%**	↔	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	7.7%	8.3%	8.1%	8.3%	8.2%	7.6%	8.5%	8.0%	8.0%	8.50%	8.1%	↓	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,798.5	2771.36	2,801.8	2,765.2	2,790.0	2,819.8	2,837.0	2,790.6	2,791.7	2,837.0	2,797.7	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**6.6%**	**7.8%**	**7.7%**	**7.6%**	**6.8%**	**6.6%**	**5.7%**	**7.4%**	**7.0%**	**5.7%**	**7.2%**	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**11,215.1**	**11,068.2**	**11,064.0**	**11,004.0**	**11,385.9**	**12,443.5**	**11,378.7**	**11,141.7**	**11,611.1**	**11,365.6**	**11,363.5**	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	0	0	0	0	0	0	0	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**87%**	**88%**	**88%**	**88%**	90%	**89%**	**89%**	**88%**	**89%**	**89%**	**88%**	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,013**	**2,185**	**2,283**	**2,130**	**1,940**	**2,215**	**2,171**	**6,481**	**6,285**	**2,171**	**14,937**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£2,028,333**	**£2,270,086**	**£2,449,685**	**£2,336,202**	**£1,914,170**	**£2,254,269**	**£2,115,080**	**£6,748,104**	**£6,504,641**	**£2,115,080**	**£15,367,825**	↓	
Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M4 = £(310)**	Local Plan	**(502)**	**(693)**	**(717)**	**(602)**	**(570)**	**(592)**	**(1,215)**	**(717)**	**(592)**	**(1,215)**	**(1,215)**	**N/A**	**N/A**
Cash Balance	**2021/22 - M5 = 13,496**		17,900	16,319	15,841	17,527	16,964	14,761	20,591	15,841	14,761	20,591	20,591	↑	
CIP - year to date (aggressive cost reduction plans)	**H2 target - £1,506 M7 target £119**	Local Plan	N/A	N/A	N/A	N/A	N/A	N/A	Yet to be decided	N/A	N/A	N/A	N/A	**N/A**	**N/A**
Agency spend YTD	**2021/22 = No Annual value YTD M7 = £4,118**		**1,031**	**2,109**	**3,206**	**4,272**	**5,375**	**6,338**	**7,328**	**3,206**	**6,338**	**7,328**	**7,328**	**N/A**	**N/A**
Agency % of pay expenditure			**7.9%**	**8.4%**	**8.6%**	**8.4%**	**8.4%**	**8.1%**	**7.5%**	**8.3%**	**8.4%**	**7.5%**	**8.0%**	↑	

Movement Key

Favourable Movement ↑

Adverse Movement ↓

No Movement ↔

Achieving Standard

Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Sep-21	Oct-21
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	**81**	2 (0.2)	2 (0.2)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	**5 (0.6)**	**3 (0.3)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	0	0
	SHMI - Rolling 12 months (Jul-20 to Jun-21)	**<1.14**	**1.20**	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-20 to Mar-21)	**100**	**106.3**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**56.5%**	**55.2%**
	RTT Incomplete Pathway Waiting List size	**Trajectory Sept = 17688**	**19,123**	**18,854**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**72.1%**	**70.0%**
	Maximum 6 week wait for diagnostic tests	**99%**	**92.4%**	**94.8%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**76.3%**	**72.6%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,254,269**	**2,115,080**
	Surplus/(deficit) (year to date)	**2021/22 = Breakeven YTD M4 = £(310)**	**(592)**	**(1,215)**
	CIP - year to date (aggressive cost reduction plans)	**H2 target - £1,506 M7 target £119**	N/A	Yet to be decided
	Agency spend YTD	**2021/22 = No Annual value YTD M7 = £4,118**	**6,338**	**7,328**

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Dorset County Hospital NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 19th October 2021

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• WDES Data submission noting work in train and still to do • Level of expenditure relating to Agency staffing remains broadly consistent

Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports:
	• People Performance Report and Dashboard noting
	  ○ Sam Dewar Workforce Business Partner was welcomed to the Trust and would be working closely with the Divisions
	  ○ Current year Staff Survey had returned a 24% response rate to date and was on target
	• WDES data submission
	• Family and Surgical Services Divisional Report
	• Bank and Agency Usage Report
	• Education and Training Report
	• Workforce Risk Report
	• People Recovery Steering Group Escalation Report

Decisions made by the Committee	• WDES Data Submission approved and recommended to the Board
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The continuing workforce risks and mitigating actions
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 19th October 2021

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Committee / Board for action	• Seeking delegated authority to Quality Committee to approve the Mortuary Security Statement prior to submission in November 2021 • The Standardise Hospital Mortality Index (SHMI) was outside the expected range due to coding issues. • Continuing delays in the provision of mental health support for patients in the Emergency Department

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Improvement in pressure ulcer performance
	  ○ Maintenance of infection prevention and control measures
	  ○ Continued work to ensure timely Electronic Discharge Summaries and the planned implementation of a new digital system in quarter 4
	  ○ Continued single sex accommodation breaches and the absence of assurances that breaches would not continue over the winter period;
	• Maternity Safety Update noting the work undertaken to promote civility.
	• Dementia screening update noting that sepsis screening was an integral part of the admission clerking process and was included in the wider delirium screen process.
	• Audit of harms arising from virtual appointments – No harms issues identified to date.
	• Regional and national review of nosocomial infections noting good performance at DCH and the Get it Right First Time (GIRFT) approach to DCH to share best practice
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting that the Emergency Department remained within the top 10 for patient experience despite increased activity demands
	  ○ Family and Surgical Services Division noting increased need to use mixed sex accommodation
	• Sub-Committee Minutes and Escalations from
	  ○ Medicines Committee
	  ○ Infection Prevention and Control Group

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

referral to other Committees	

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 19th October 2021

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Recruitment to the Coding Manager post – to be advertised in November • The Emergency Department was cited as one of the top 10 departments nationally in the Health Service Journal

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report noting:
	  ○ Increasing number of COVID positive cases in the community translating into an increased number of admissions and staff testing positive;
	  ○ Consistently high percentage of inpatients with no reason to reside – this being 18-20% of the hospital's bed base
	  ○ Increasing numbers of two week referrals
	  ○ Improved diagnostic service performance
	  ○ Finance Report noting £600k variance from plan year to date.
	• H2 Planning Guidance noting
	  ○ A significantly increased efficiency target (Circa 3% to get to Breakeven)
	  ○ A reduction in COVID expenditure funding of 5%
	  ○ A shortfall in pay award funding
	  ○ A new targeted investment fund
	  ▪ Four project bids under consideration
	  ○ The trust's and the system underlying deficit positions
	  ○ System wide delivery requirement for Elective Recovery Funding
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care
	  ○ Family Services and Surgical Services
	• Nursing Proposal Elderly Care Wards
	• DCH Subco Quarterly Report

Decisions made by the Committee	The following items were approved by the committee: • The H2 planning submission would comprise realistic and not overly ambitious efficiency savings to ensure we can deliver the plan. This would mean a deficit would be reported in the first submission. • Progression of the South Walks House lease at risk whilst awaiting the outcome of the targeted investment bids, delegating authority to the Executive team for authorisation (as within their financial limits) • Investment in the Critical Care Nursing establishment
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Risks are contained within the Risk Register

Items / issues for referral to other Committees	• Escalation of unexpected mental health support delays to the Emergency Department to be escalated to the system-wide Quality Surveillance Group by the Chief Nursing Officer

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 15th November 2021

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Freedom to Speak Up Report • Progress and engagement activity relating to the further development of the People Plan
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • People Performance Report and Dashboard noting relatively static performance in month the vacancy rate had reduced in month with the commencement of a number of medical staff and overseas nurses. The number of staff completing the staff survey was progressing towards the target. • Urgent and Integrated Care Divisional Report • Estates and Facilities Departmental Report • Review of Whistleblowing arrangements with no formally reported incidents within the preceding six months. • People Plan Quarterly progress Update noting that this was driven by the clinical strategy development and plans were aligned to the wider system. • Annual Leavers Report providing an analysis of reasons and noting the processes in place to identify why staff left the trust's employment • Gender Pay Gap was noted • ED&I Steering Group Escalation Report
Decisions made by the Committee	• Freedom to Speak Up Report was approved and is recommended to the Board
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The continuing workforce capacity risks and significant operational pressures continued.
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 16th November 2021

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Challenges around patient flow and patients with No Reason to Reside. • Positive news that elective work was continuing despite the challenges. The new trajectories had been updated in the meeting papers, although the excellent work on recovery was not reflected in the regional analysis. • That the Trust was undertaking the volume but not the case-mix to qualify for elective recovery funding. • Challenges of CIP delivery in H2.

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report
	• Finance Report
	• ED15 Update
	• Winter Plan Risk Assessment
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care
	  ○ Family Services and Surgical Services
	• DCH Subco Annual Report and Accounts (consent item)

Decisions made by the Committee	The following items were approved by the committee: • H2 Operational Plan – approved by the committee for submission, noting that this would also be seen by the Board • Green Plan – recommended to Board with suggested amendments • Access Control Replacement Report – approved by the committee • Olympus Maintenance Contract Renewal – recommended to Board • Multi-storey Car Park Fire Safety Proposals– recommended to Board
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Risks discussed are contained within the Risk Register.
Items / issues for referral to other Committees	• It was agreed that an overview of all the mechanisms in place to minimise and monitor patient harm for long waiters was to be brought to the Quality Committee at the end of quarter 4. • It was noted that the Emergency Department Handover Report had been removed from the agenda and would be going directly to the Board. • It was agreed that the update on the Winter Plan, once the full response from the system was received, would be overseen at Quality Committee with FPC receiving updates via the divisional report.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 16th November 2021

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Continued progress with pressure ulcers • Mixed-sex accommodation remains an issue due to demand and capacity safety • Maternity safety report: Positive assurance received and recommended to board. To note: ongoing work reference Entonox exposure on the maternity unit post ventilation review. Maternity risk mitigations in place due to digital issues with BadgerNet system. Positive assurance on Ockenden actions with validated review re-submitted to regional team • The Standardised Hospital Mortality Index (SHMI) was outside the expected range. All the evidence so far links to coding issues. Coding action plan to come to sub-board committee. Assurance gained from other metrics. • Healthy Living: noted progress on partnership with Public Health Dorset regarding smoking cessation • Quality Committee approved the Mortuary Security Statement of Compliance, with delegated authority from the Board

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Sustained improvement in pressure ulcers
	  ○ Sustained standards on most quality metrics, including infection prevention and control
	  ○ Noted increase in number of patients sustaining a fall, noting none with none resulting in severe harm or death. Noted ongoing quality improvement work with risk and patient safety specialist.
	  ○ High rate of mixed sex accommodation
	• Maternity Safety Update: assurance on standards. Noted current risks with digital new system and review of Entonox ventilation – both being managed.
	• Learning from Deaths Q2 Report with a key focus on the high SHMI
	• Healthy Living update on partnership working and progress already made in maternity
	• Transformation Update highlighting key updates of the work the team are supporting across the Trust
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division: positive assurance received. Approved, delegated by the Board, the Mortuary Security Statement of Compliance
	  ○ Family and Surgical Services Division: noted Purbeck Ward had been awarded Ward Accreditation and agreed the Quality Impact Assessment had been signed off by CQC for South Walks House
	• Sub-Committee Minutes and Escalations from
	  ○ Clinical Practice Group

Decisions made by the Committee	• Delegated authority from the Board to the Quality Committee and subsequent approval by the committee of the Mortuary Security Statement of Compliance.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
Items / issues for referral to other Committees	• People and Culture Committee to be updated on what health promotion work, such as smoking cessation, is being undertaken for staff.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 16th November 2021

Presented by: Ian Metcalfe

Significant risks / issues for escalation to Board for action	• Cyber security update noting difficulties staff experience in understanding and managing phishing attempts. • The revised Board Assurance Framework is recommended to the Board for approval noting further work in train to enhance the document. • The Corporate Risk Register • Preparations for potential involvement in the COVID-19 Public Inquiry.
Key issues / other matters discussed by the Committee	The committee received and noted the following reports: • Internal Audit Progress Report, assurance received and completion of follow up recommendations from previous audits • Anti-crime Progress Update (previously Counter Fraud Progress Update) • External Audit Progress and commencement of initial planning for the current year audit work. Technical Updates and Benchmarking • COVID Public Inquiry Preparations • The committee noted that the Digital Programme Board would report to the Risk and Audit Committee going forward. The committee welcomed Stuart Parsons, Non-Executive Director Designate to the meeting and thanked Ian Metcalfe for his contribution to the Trust and good humour, wishing him well for the future.
Decisions made by the Committee	The committee approved the following Annual Cyber Security Report and recommended the revised Board Assurance Framework to the Board for approval.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Corporate Risk Register was discussed • A refreshed version of the BAF which was aligned to the refreshed Trust Strategy was discussed and is recommended to the Board
Items / issues for referral to other Committees	• None

Meeting Title:	Trust Board							
Date of Meeting:	24th November 2021							
Document Title:	**Dorset Integrated Care System Overview**							
Responsible Executive:	Nick Johnson, Deputy CEO							
Author:	Nick Johnson							
Confidentiality:	Yes							
Publishable under FOI?	Yes							
Purpose of the Paper	To provide an overview of the Dorset Integrated Care System performance, quality and finance							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance and Quality (Appendix 1)** Dorset County Hospital is reported to be the 2nd highest performing trust for staff COVID-19 vaccination, 1st amongst acute trusts, with 94.6% of staff being vaccinated, nationally There continues to be pressures due to the delays in handovers from ambulances to acute hospitals, due to the current hospital increase in occupancy affecting patient flow. Within University Hospitals Dorset a concern raised in relation timely completion of discharge summaries and the quality of those that are completed. Within Primary Care, the Health check data has shown over 50% of practices reported feeling that they are coping well currently. Key themes have been identified and support in place for practices continues. In safeguarding there has been an increased breakdown of placements for those Children in Care who have emotional dysregulation, because of trauma and adverse child experiences, this is impacting on acute hospital bed states. The safeguarding team have developed a quality assurance framework including safeguarding schedules linked to the NHSEI commissioning assurance toolkit which will provide overarching assurance to the ICS and NHSEI. Across Dorset another quality improvement project has begun focusing on Healthcare Associated infections – Clostridium Difficile infections. **Performance (Appendix 1)** **RTT Performance stabilised in August whilst the total waiting list increased by 1,803 patients (2.68%).** • **The growth in the total waiting list reflects a reduction in activity in August.** This not tracking trajectory and is an area under review by the Elective Performance Group following prior assurance requests. • Future reports will incorporate referral rates to enable a better understanding of the total waiting list position.							

	A small reduction of 23 patients waiting over 52 weeks in August. • **8.16%** of total waiting list is in the over 52 weeks cohort which is **lower** than at the end of July but should be read in the context of the growth in the wating list. Dorset is now the 6th worst performing area in the region out of 7 systems for >52 week waits. It had been bottom for over a year. **>78 weeks and >104 week wait totals worsened in August and continue to do so in September.** Major focus of the Elective Performance Group and plans have either been submitted or being finalised for addressing the areas. • % of the total list **waiting over 78 weeks increased to 4% in August** (up from 3.4% in July)**.** **DM01 performance** has **declined in August from 6.8% to 8.6%** against the backdrop of a seasonal decline in referrals. • Endoscopy DM01 performance at UHD went from 13.6% to 27.8% in August, interestingly a similar near doubling of their DM01 percentage occurred at DCH the previous month. • 6-week performance **ranks 1st in the region,** region performing poorly with 2nd place system nearly double Dorset percentage. **Cancer** • **2 week wait** performance (only reported at DCH) has **declined** and predicted to continue to decline before improving in September. • **Faster diagnosis** was **achieved in July** and expected to be repeated in August at UHD only. Improvement forecasted in DCH in September. • **62 day % standard** whilst beneath the threshold is **consistently above** the national average at both trusts (national average 70-71%). • **Backstops are predicted to plateau** against a pattern of higher referrals across all areas and complex cases requiring tertiary centre Latest week data is provisional, involvement. **Finances (Appendix 2)** **Financial Position** For the first half of 2021/22 the Dorset NHS system has submitted a breakeven financial plan and as at month 6 is forecasting a H1 deficit of £2.0m, arising from the additional costs of the Flowers settlement in SWASFT and a shortfall in ERF income the system will receive driven by the revised threshold criteria enacted after commitments to expenditure were made, based on the original criteria. The ERF shortfall is £1.1m. In reaching this position the system has mitigated £15m of risks identified at the planning stage as well as further cost pressures. NHS organisations delivered the required efficiency savings in H1. The Local Authorities are both reporting overspends in the quarter one forecast position, with a combined pressure of £16m. **Efficiencies** The system has delivered £5.0m efficiency savings in H1, which is less than the originally planned efficiencies of £6.2m. Of these savings 44% are from non-recurrent schemes, and 53% are from non-pay (recurrent and non recurrent). **Covid** The system received £47.3m in covid funding for H1 2021/22 (this includes

	an additional £1.6m for the GP expansion fund provided separately to the main covid allocation). A total of £35.7m has been spent on covid related costs, with the remaining £11.6m supporting other cost pressures across all organisations. **SDF** A total of £35.9m System Development Funding has been allocated to the system for 2021/22, including funding in H2 to support 111 and ambulance capacity and diagnostic hubs. **Capital** The ICS are reporting the system CDEL envelope will be met this financial year, with an underspend in other capital funding arising in Dorset Healthcare and University Hospitals of Dorset.
Action recommended	It is recommended that: • Trust Board note the key content of the report and appendices.

Governance and Compliance Obligations

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

CONFIDENTIAL **09.**

SYSTEM LEADERSHIP TEAM (SLT) MEETING

DORSET SYSTEM QUALITY AND PERFORMANCE REPORT

Date of the meeting	18/11/2021
Author	S Banister, Deputy Director Integrated Care Development P O'Shea, Deputy Director of Nursing and Quality J Swarbrick, Patient Safety Specialist K Payne, Head of Nursing & Quality (Quality Governance and Risk) L Plastow, Head of Safeguarding V Melville, Head of Nursing & Quality (Quality Improvement)
Purpose of Report	This report informs SLT of the key system performance and quality issues in the system.
Recommendation	The SLT is asked to **note** the report

Author's name and Title : **S Bannister, Deputy Director Integrated Care Development**
P O'Shea, Deputy Director of Nursing and Quality
J Swarbrick, Patient Safety Specialist
K Payne Head of Nursing & Quality (Quality Governance and Risk)
L Plastow, Head of Safeguarding
V Melville, Head of Nursing & Quality (Quality Improvement)

Date : 5 November 2021

APPENDICES	
Appendix 1	**Dorset System Quality and Performance Report**

Dorset System Quality & Performance Report

Quality Report November 2021
Performance Report October 2021

Quality Contents

Executive Summary

Dorset County Hospital is reported to be the 2nd highest performing trust for staff COVID-19 vaccination, 1st amongst acute trusts, with 94.6% of staff being vaccinated, nationally

There continues to be pressures due to the delays in handovers from ambulances to acute hospitals, due to the current hospital increase in occupancy affecting patient flow.

Within University Hospitals Dorset a concern raised in relation timely completion of discharge summaries and the quality of those that are completed.

Within Primary Care, the Health check data has shown over 50% of practices reported feeling that they are coping well currently. Key themes have been identified and support in place for practices continues.

Winton Health Centre have been rated Good across all domains by CQC this month, now leaving only one practice in Dorset as Requires Improvement.

In safeguarding there has been an increased breakdown of placements for those Children in Care who have emotional dysregulation, because of trauma and adverse child experiences, this is impacting on acute hospital bed states.

The safeguarding team have developed a quality assurance framework including safeguarding schedules linked to the NHSEI commissioning assurance toolkit which will provide overarching assurance to the ICS and NHSEI.

Across Dorset another quality improvement project has begun focusing on Healthcare Associated infections – Clostridium Difficile infections.

Quality Overview – NHS Acute Provider Trusts

Edited by: Karen Payne

Quality monitoring

The Business intelligence Quality Overview represents the most recent available data. Areas are being updated as soon as NHS digital restarts data collection or from direct monthly updates from providers. The dashboard contents and presentation are currently under review.

Dorset County Hospital (DCHFT):

Ambulance handover delays continue due to pressures within the system. Whilst the number of patients experiencing delays of over 30 minutes has not changed since August, the numbers waiting over 1 hour has increased.

DCH is reported to be the 2nd highest performing trust for staff COVID-19 vaccination, 1st amongst acute trusts, with 94.6% of staff being vaccinated.

The Patient Experience Platform, 'What Patients Think 2' survey has ranked the trust within the top 10 performing non-specialised acute trusts for patient experience.

Salisbury NHS Foundation Trust (SFT:

Significant concerns have been identified with the Sleep Service within the trust. There are significant waits for assessments, Continuous positive airway pressure (CPAP) set up and reviews with a significant disparity with the waits between Dorset and Wiltshire patients, assurances have been requested.

University Hospitals Dorset (UHD):

There continues to be significant numbers of ambulance handover delays, during October there were 16 patients who had delays of over 4 hours, a small increase from last month. In total 585 patients (169 in Poole and 416 in Bournemouth) experienced handover delays in excess of an hour. This is an increase of 120 patients since last month. As a result of the current pressures several 12-hour trolley waits continue to been seen. Progress on actions to address this continue to be monitored through bi-weekly calls.

Progress to address issues with the new pathology reporting system has been made and assurance is improving. Issues with radiology reporting is also making progress.

Significant concerns have been identified and escalated with the timely completion of discharge summaries and the quality of those that are completed. A contract meeting has been convened to obtain assurance on the provider's actions to address these concerns.

Independent Sector Providers (ISP) and Non Contract Activity (NCA):

BMI The Harbour Hospital have had a CQC inspection. The formal outcome of this is awaited.

Quality Overview - South Western Ambulance Service Trust (SWAST)

Edited by: Pam O'Shea

Activity and Demand

Demand for 999 services continues to remain high across Dorset and the wider South West region. This is having a negative impact on the time taken to answer 999 calls and to send a response crew. Delays in ambulance handover times at Emergency Departments continues to add further challenges for SWAST. This is creating increased risks to patient safety, experience and quality of care as well the impact this is having on the wellbeing and resilience of the ambulance workforce.

Quality Overview – Primary Care

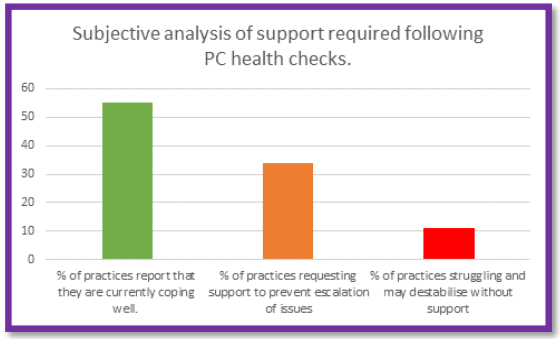
Edited by: Vicky Melville

Primary Care

GPPS/Health check piece of work has concluded with key findings as below . The P&CC and QI teams are to work jointly to review the outcomes of the health checks in supporting practices with issues raised from the completed health checks.

Key themes identified:

- Workload
- Staff morale, burn out and sickness
- Recruitment difficulties at all levels including accessing locum cover
- Increased complaints
- Inconsistent local/national messaging
- Unrealistic expectations and/or requests from patients
- Burdensome reporting
- Backlog of paused services
- Secondary care – waiting times/rejected referrals/referrals back to GP
- Access to community services – DN/HV
- A sense of *'…if in doubt, general practice will pick it up'*



55% report they are coping well
34% requested support to prevent further issues
11% report they are unable to continue without support

The CQC report following the reinspection of Winton Health Centre was published this month and has been rated Good across all domains. Within Dorset we now only have one practice rated as requiring improvement.

Quality Overview
Community and Independent Providers

Edited by: Vicky Melville

Dorset Healthcare Foundation Trust

The Adult Eating Disorders Provider Collaborative is now live for Dorset which is a partnership with Southern Health, Isle of Wight and Solent NHS trusts, along with Southampton independent sector provider The Priory Hospital, , Hampshire and Isle of Wight. NHS-led provider collaboratives aim to bring together local partner organisations, working with patients and carers, to help drive improvements in patient outcomes and experience. Dorset HealthCare has delegated commissioning and lead provider responsibility for the new collaborative.

There continues to be pressure on the workforce due to vacancies and absences across both community and mental health services.

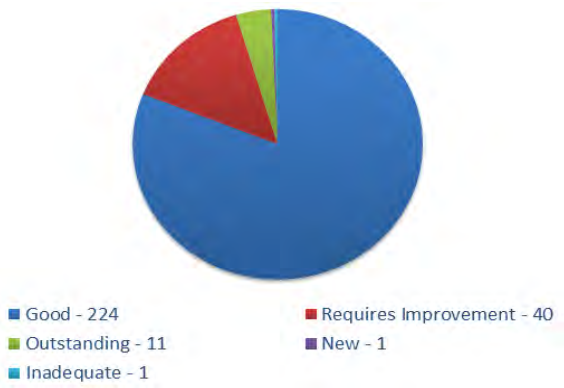
Independent Providers
(care homes, supported living & domiciliary care)

In the BCP council area three care homes, one with nursing, continue to plan their closures with system support. Two are aiming for closure at the end of November one in December.

Face to face quality assurance focused visits to care homes within Dorset are ongoing with 46 % of all nursing home visits completed (8% increase since the last report). These visits are being balanced with outbreak support to ensure care homes are not over- visited. Where an outbreak is open, quality assurance visits have been postponed to reduce foot fall during this time.

Restore 2 (R2) : 62% of care homes state they use the Restore2 tool. The hope is the impact of R2 on the management of the deteriorating patients may be demonstrable in conveyancing data in the next quarters.

CQC Ratings for Care Homes in Dorset



Infection Prevention Control

Edited by: Vicky Melville

Infection Prevention and Control (IPC) Dorset

SW regional Healthcare Associated infections – Clostridium Difficile infections (HCAI-CDI) Improvement Collaborative is up and running with workstream 1 Data Sprint 3 completed, which is a fast-paced quality improvement approach. Many risk factors are now suggested for data surveillance, however as a CCG this proves to be difficult due to not having direct access to patient identifiable information (PID). Plans to review and discuss further of our future approach as a system to include access to ICNET clinical system for the CCG.

An introduction and support meeting has taken place with colleagues across the number of Hospices in Dorset. An offer of support, engagement and collaboration as part of ICS IPC and promoting health and safety for all people of Dorset was the main priority.

International Infection Prevention and Control week – NHSE provided daily IPC webinar sessions that were available to all colleagues interested in IPC, this was shared widely across the system including with our care home and primary care colleagues.

COVID-19 Outbreaks Dorset

There are still minimal outbreaks reported in hospital sites or community teams.

Where Covid-19 outbreaks reported within our acute trusts in Dorset, it was identified promptly, and the wards closed accordingly, and were managed with good IPC measures put in place.

Outbreaks in care homes remained static over the last month, amongst staff and residents and system support continues.

Learning Disabilities & LeDeR

Edited by: Vicky Melville

Learning Disabilities (LD) and LeDeR

Learning from many recent events; Norfolk Safeguarding Adult Board review report, the National Unit of Concerns work and impact of the COVID 19 Pandemic, have identified that current quality oversight processes, are not always robust enough to identify poor standards of care, especially in relation to people's physical wellbeing and quality of life. A Safety & Wellbeing review of all patients with LD and/or autism in an out of area setting is to be undertaken from the end of October 2021 and are to be completed by the end January 2022. This review does not replace existing processes and can be completed within in existing mechanisms.

Restore 2 (R2) in Learning Disabilities services

The tool has been actively promoted to providers of LD services and Dorset Community LD Teams have recently been trained in the use if the tool to enable them to support service providers. A recent survey has identified that out of the 64 LD care homes in Dorset, 52% have had training in the use of the R2 tool. Of those 52% trained, approx. 70% are using either the R2 or the R2mini tool. Work continues to increase training and usage

Of the 33 trained homes, 15 (23%) homes have gone on to and are actively using the full tool, 8 (12%) homes are using the mini tool and 10 (17%) homes do not use either of the tools

Safeguarding

Edited by: Liz Plastow

Safeguarding

Improvements are being consistently noted for both local authorities in timely notification and consents, for initial health assessments (IHA's). Nineteen children were placed in care in August of which 17 required an IHA. Overall, 70.6% of IHA's were completed within 20 days, with BCP achieving 55.6% , whereas Dorset achieved an overall 100% for notification and consent; and 87.5% for IHA completion (one child was placed out of area).

Due to staffing issues, complexity of cases and the impact of COVID-19 pressures on staff well-being and resilience the Multi-Agency Safeguarding Hub (MASH) remains on Red Business Continuity Plan. Safeguarding teams across the ICS are working collaboratively in attending meetings to release capacity.

The volume of strategy discussions relating to children in care (CiC) continues to impact on the CiC Team. Work is ongoing with BCP and partner agencies to agree multi-agency pathways that ensure statutory responsibilities are met within available resource and reduce impact for CiC team. There is an increased breakdown of placements for those CiC who have emotional dysregulation, because of trauma and adverse child experiences, this is impacting on acute hospital bed states. The CCG are working with both LA's to monitor and improve the situation.

The two weekly meetings in response to the system wide concerns raised with BCP LA, were cancelled throughout October due to pressures at BCP. There remains concerns regarding changes by BCP, to the locally agreed Pan-Dorset policies and procedures and the impact this is having, this has been escalated to the Pan-Dorset Safeguarding Partnership executive team.

The safeguarding team have developed a quality assurance framework including safeguarding schedules linked to the NHSEI commissioning assurance toolkit which will provide overarching assurance to the ICS and NHSEI.

The Ofsted inspection has taken place in Dorset County Council, the outcome is awaited .

A Child Safeguarding Practice Review 'Iris' https://pdscp.co.uk/wp-content/uploads/2021/10/Iris-Report-Final-to-be-published.pdf and a Safeguarding Adult Review 'Katherine' df37056a-51cd-68c2-5133-491180d96d51 (dorsetcouncil.gov.uk) have been published this month.

Patient Safety and Mortality

Edited by: Jaydee Swarbrick

Local Maternity and Neonatal System (LMNS) Safety

The risks relating to workforce and staffing levels were escalated to LMNS Board, Quality Surveillance Group and the South West Regional team.

All units in the South West are facing similar pressures using local systems resilience and SW maternity diversion protocols to support delivery of care. To date there have been no serious incidents of patient harm, complaints or poor outcomes identified as a result, this is monitored through LMNS leads, Maternity Voices Partner and patient safety teams.

Quality Assurance visits are planned to take place in the maternity units at UHD and DCH in the next couple of months.

Patient Safety Strategy Steering group

Progress being made across the system against key priorities;

- All organisations are in discussion with local risk management system (LRMS) providers regarding transition to the new national Learning from Patient Safety Events platform,
- Options for a new LRMS for the ICS, rather than individual organisations to be considered by the Directors of Nursing group,
- Dorset representatives involved the NHSE SW workshop on the implementation of the Patient Safety Incident Response Framework,
- Options proposal being developed for the recruitment of Patient Safety Partners across the system,
- The level one eLearning module of the Patient Safety Syllabus has been released and implementation of this in Dorset is to be discussed with the Heads of Education to ensure a consistent approach,
- Links have identified for the 5 safety improvement programmes between Patient Safety Specialist and Wessex Academic Health Science Network (AHSN).

Clinical Lead GP for Patient Safety

Progress has been made jointly with the patient safety team and the Patient Safety Specialist in the following priorities;

- Raising awareness of patient safety across Primary Care,
- Links to the National team to influence the emerging Primary Care Safety Plan,
- Identifying opportunities for training in patient safety and quality improvement,
- Supporting the implementation of Medical Examiner scrutiny in Primary Care and ensuring links to governance processes,
- Involvement in the Patient Safety Strategy Steering group to provide the Primary Care voice,
- Project group established to lead on local improvement in patient safety in Primary Care.

Pan Dorset Mortality Group – COVID-19 deaths review

The September meeting was dedicated to the review of a variety of reports from system partners including Public Health Dorset, Local Authorities, NHS Trusts, NHSEI Health and Justice Commissioning and emergency planning teams.

The aim was to capture system learning following deaths from Covid 19 that can be used to develop recommendations and actions to improve the safety and experience of patients, residents and their families. A summary report to include identified themes will be presented to the Dorset Adult Safeguarding Boards in November.

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Dorset Quality Surveillance Group

Edited by: Vanessa Read

Dorset Quality Surveillance Group - Items for note, November Meeting

- Urgent Emergency care
  - Improved connection with Home First.
  - Workforce is a key issue.
  - Patient transport to aid discharge and not use ambulance service.
  - Plans for same day emergency care with direct referals going to next meeting.
  - Looking at gaps to reduce handover delays.
  - Primary care direct booking starts his month.

- SWASFT
  - Call stack. High risk of Harm.
  - Reset Monday. Concerted effort to reduce call stack. Non essential meetings cancelled to allow more staff to take a clinical role for recovery.
  - Teams have a great exposure to harm, planning short rounds with support from acute Trusts.
  - Working with 111 to revalidated CAT 2 calls on 15th Nov in a controlled pilot.
  - This is being escalated through Ambulance commissioning route, NHSE and Dorset ICS governance.

- 111 Element Dorset Integrated Urgent Care Service (IUCS).
  - Remaining in enhanced surveillance due to performance indicators and call stacking.
  - Direct bookings have increased to ED and MIU's.
  - Auditing work happening to look at the 19 incidents associated with call back.

Dorset Quality Surveillance Group

Edited by: Vanessa Read

Dorset Quality Surveillance Group - Items for note, November Meeting

- Current Issues
  - Significant increase in referrals to eating disorder service.
  - Workforce risk. Particular areas of concern are mental health, care sector and vaccination programme.
  - Slow progress in Healthy 12 -15 COVID vaccination programme.
  - Issue with Pathology, Radiology IT and eDischarge summaries at UHD.
  - Long waits for Dorset residents in access to the sleep service provided by Salisbury.
  - Blood bottle supply issue remains in East Dorset Primary Care.

- Themed reports / presentations received
  - Home First – Noted relationship with urgent care pathway and areas for further action.
  - Children's Health services – update in relation to National Priorities, RSV.
  - Learning Disability – Noted actions in relation to Cawsthorn Park, LeDeR update also received.
  - Safeguarding Report - Noted increases in activity and referral, LPS code awaiting publication, Safeguarding dashboard in development.

Dorset Quality Surveillance Group

Edited by: Vanessa Read

Dorset Quality Surveillance Group - Items for note, November Meeting

- Published reports
  - Annual state of care https://www.cqc.org.uk/publications/major-report/state-care
  - Homeless https://healthwatchdorset.co.uk/wp-content/uploads/HWD-CQC-Homeless-report-final-Oct2021.pdf

- Good practice noted
  - A Good vaccination take up with staff- Dorset County Hospital.
  - Opening of South Walks as outpatient facility – Dorchester.
  - Positive work around ligature management. Which has been picked up by other services and presented at a mental health conference. – Dorset HealthCare.
  - Ground breaking in new eating disorder unit and RBCH site.
  - National workforce award for communications programme for the large vaccination site – Dorset HealthCare.
  - Accreditation of Psychiatric Liaison at UHD.
  - Only one Primary Care Practice in Dorse now CQC rated as requires improvement, all others Good or Outstanding.
  - CQC survey results at DCH positive.
  - Dorset Health village which is transforming outpatient services.

Performance Contents

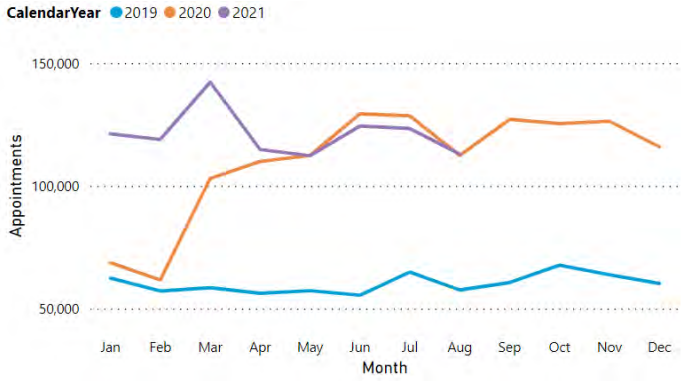
Primary Care

Source: Dorset OFRG Dashboard September 2021 & NHSE Appointments in General Practice July 2021

Reviewed by:
Rob Payne

Month-end Aug 2021 – Total Consultations delivered Face-to-Face

Month-end Aug 2021 – Total Consultations delivered Remotely



- Total consultations in August 2021 up by **10.1%** (30,399) compared to August 2019. A reduction of 30,315 consultations compared to July, this seasonal fluctuation is consistent to previous years and is estimated to rise again and peak in November.
- In August 2021, the did not attend (DNA) rate for booked appointments of all types was **2.69%,** compared to 2.53% in June. The national DNA rate was 7.6%.
- There were 427,233 booked appointments of all formats in August 2021 – this was 12.2% higher than August 2020 However, these figures do not include the 19,767 **Covid vaccination** appointments recorded in August 2021.
- Remote consultations include all video and telephone activity recorded within clinical appointments module, an accurate split between the two is not currently available. Expectation is that some migration occurs between delivery method but will not be reflected unless altered in SystmOne.

Other Metrics

Work ongoing with CCG Business Intelligence (BI) team to develop a primary care dashboard to better understand variations. A beta Version 1 is nearing completion and will provide Practice and PCN level Access and Workforce data to support system performance reporting.

Other workstreams:

- Primary Care Networks (**PCNs) delivering Covid Vaccine** across all 18 networks resulting in **7 out of every 10 Covid-19** vaccinations being administered in Dorset.
- Flu vaccination season has commenced and from next month's report it is planned to include data on take-up rates at PCN level.

Mental Health & Learning Disability

Edited by:
Mark Harris

Community Mental Health Teams (CMHT) Adults

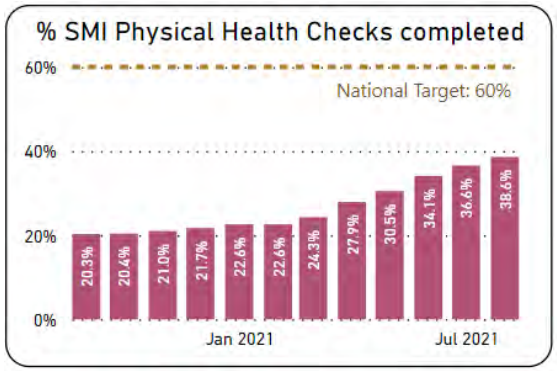
MHICC Care pathway design groups launched with inaugural meeting to take place in October Aligned work commencing to progress test of concept for co-produced hub in designated areas. **Limited uptake** of Mental Health Additional Roles Reimbursement Scheme (MH ARRS) – one primary care network at stage of agreeing memorandum of understanding (MOU) with Dorset Healthcare; two others have expressed an interest. **Continued pressure** on CMHT in the context of referrals and vacancy factor hampering referral to assessment timeframes.

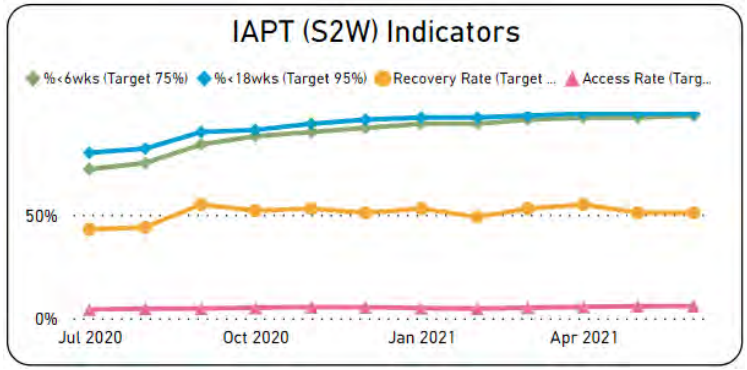
Perinatal – local access rate **will not achieve the national access trajectory**. Linked to investment prioritisation decisions. Systematic review of current operational processes to identify opportunities for improved optimisation and efficiency of the existing workforce in progress alongside demand and capacity modelling to inform a business case to support achievement of the Long-Term Plan ambition.

Improved Access to Psychological Therapy (IAPT) – Q1 Access trajectory missed by approximately 200 people. Linked to lower than modelled demand. Marketing programme developed to promote service and strengthen links with primary care and long-term health conditions teams.

Mental Health Indicator	Period	Target	Dorset	Direction
IAPT waiting time within 6 weeks	June 2021	75.00%	98.00%	▲
IAPT waiting time within 18 weeks	June 2021	95.00%	99.00%	➡
IAPT Recovery Rate	June 2021	50.00%	51.00%	➡
IAPT Access Rate	June 2021	5.50%	5.94%	▲
SMI Health Checks in last 12 months	August 2021	60.00%	38.60%	▲
Perinatal Access	June 2021	7.10%	4.70%	▲
Access to CAMHS within 4 weeks (tier 3)	July 2021	95.00%	97.00%	➡
Access to CAMHS within 8 weeks (tier 2)	July 2021	95.00%	77.00%	▼
Children & Young People Access Rate (MHSDS)	May 2021	35.00%	40.10%	▲
Children & Young People Urgent Access to Eating Disorders < 1 week	June 2021	95.00%	51.90%	▼
Children & Young People Routine Access to Eating Disorders < 4 weeks	June 2021	95.00%	45.95%	▲
Adult CMHT RTA <28 Days	July 2021	95.00%	86.00%	▼
OP CMHT RTA < 28 Days	July 2021	95.00%	93.00%	▼
Dementia Diagnosis Rate (% of prevalence)	August 2021	67.00%	55.40%	▼
Access Early Intervention in Psychosis within 2 weeks	June 2021	60.00%	88.90%	▲
Adult Acute Out of Area Placements	June 2021		5	▼
LD Inpatients Adult	August 2021		24	▼
LD Inpatients CYP	August 2021		7	▲

Referrals	Referrals 20/21 YTD	Referrals 21/22 YTD	Growth Ref's Actual	Growth Ref's %
AMH	3269	4064	795	24%
Aspergers Service	65	170	105	162%
CAMHS	454	1439	985	217%
Eating Disorders Service	131	310	179	137%
Learning Disability Services	225	252	27	12%
OPMH	1013	1884	871	86%
Perinatal	151	178	27	18%
Specialist Services	503	438	-65	0%
MH & LD Total	5811	8573	2762	48%
Steps 2 Wellbeing	5363	9809	4446	83%
Grand Total	**11174**	**18382**	**7208**	**64.5%**



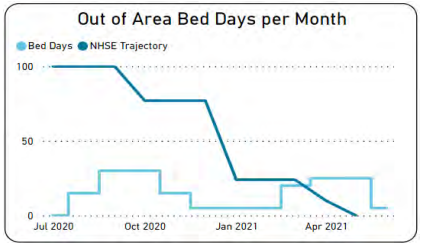


Mental Health & Learning Disability

Edited by:
Mark Harris

Access Mental Health Services (MH Crisis Care):

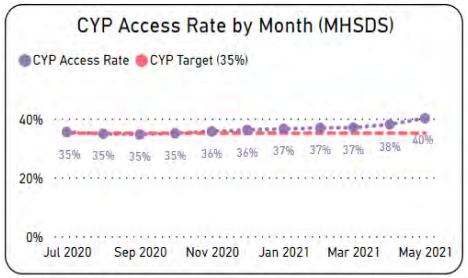
August return confirmed nil status for OOA bed days.
Workforce pressure related to vacancies and impact of Covid impacting on current service model resulting in intermittent closures of Retreats. Plan being developed proposing to improve resilience through consolidation of workforce at the Retreat in the east of the county and temporary closure of the Retreat in Dorchester. Plan being informed by activity profiles and Equality Impact Assessment will be completed.



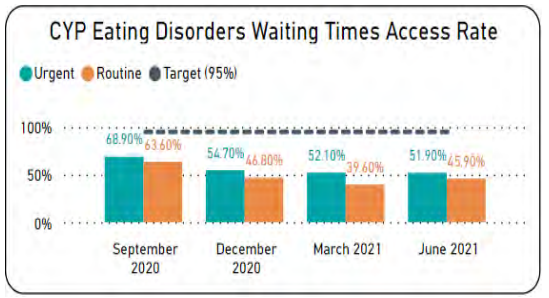
Children & Young People (CYP) Mental Health:

Ongoing challenges in relation to CYP eating disorders access with **continued pressure** associated with complex presentations. Exploring opportunities to increase access and enhance the current offer.

Overall access rate to **CAMHS on track** – aided by the development of the Gateway offer.

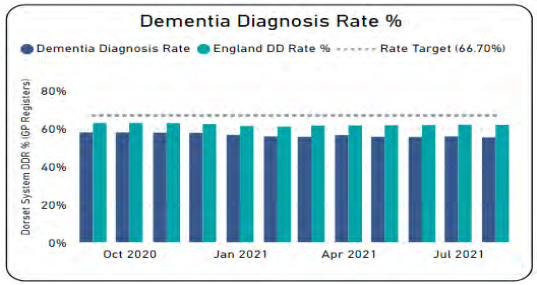


CYP Access is MHSDS data (as reported via NHS Future Collaborations Platform)



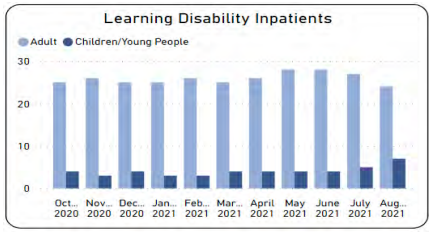
Dementia:

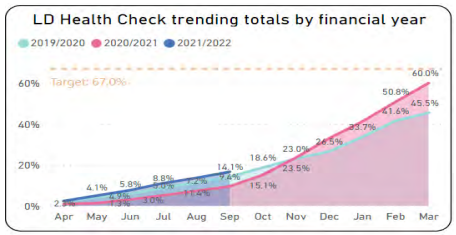
Dementia Diagnosis task and finish group in place to explore initiatives to improve dementia diagnosis rates and consider the impact of covid on this population, specifically in the context of local prevalence rates. New model of care continuing to be embedded



Learning Disabilities (LD) & Autism:

In-patient numbers of adults slightly reduced following successful discharges. CYP numbers on an increasing trajectory – increase in demand for emergency Care, Evaluation and Treatment Review meetings – possibly linked to schools returning. Local initiatives linked to 3-year roadmap commencing – key workstreams include strengthening behaviour support, development of CYP Respite and Short breaks, All Age autism pathway review. Ongoing monthly cohort meetings focusing on discharge planning. Use of Dynamic Support Register increasing – case review panel being developed with a view to agreeing preventative measures to avoid placement breakdown/hospital admission

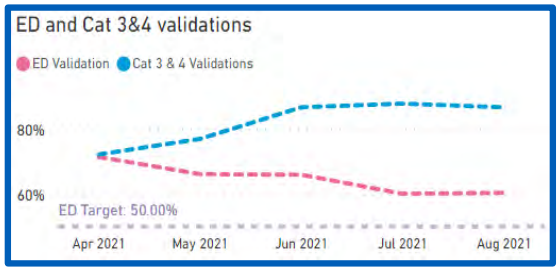


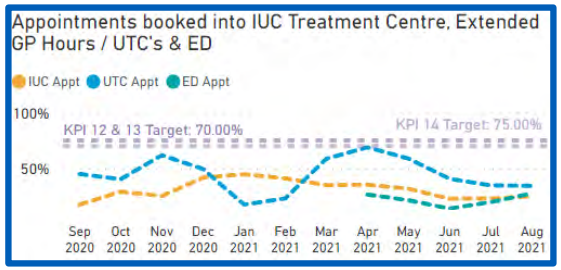


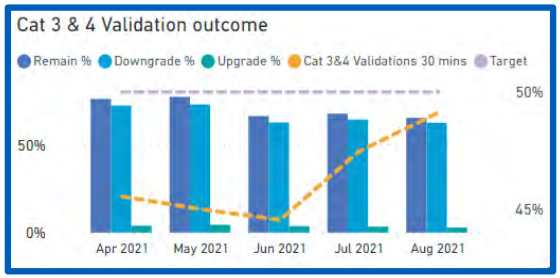
Integrated Urgent Care Service

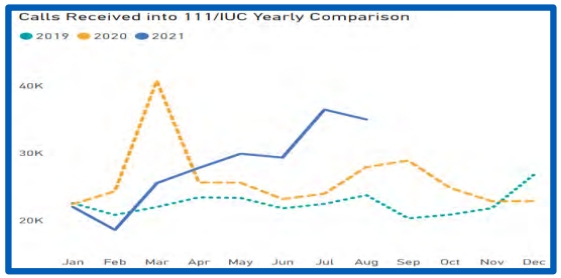
Edited by: Lou Crockett/Viv Ryan

- 111 call handling performance continuing to decline due to a substantial increase in activity above forecast demand. Nationally the increase is 45%. Consequently, the call abandonment rate has increased.
- Other systems across the country triggering National Contingency, resulting in the 'national' busy message being active since 1st June 2021. As a result of others Dorset is taking a proportion of their calls together with the Dorset increased demand. This has been raised nationally.
- During September, the Dorset service has had to declare OPEL 4 three times due to resourcing issues and demand.
- Revalidation of the category 3 & 4 and ED dispositions each have a national KPI of 50% but there is a SW agreement to increase this. In August, ED validations were over target at 60.35% although a slight reduction on the previous month. Cat 3 and 4 validations were 86.7%, with 49.1% completed in 30 minutes – the KPI is 50% in 30 minutes. The clinical queue is tracking between 100-400 calls waiting.
- In line with NHS 111 First, a direct booking by Health Advisors into GP in-hour appointments trial is due to begin at Sandford Surgery followed by a larger trial at Shore Medical. Patients will then be called back with 24 hours by the most appropriate member of the team leading to an MDT approach. Once the evaluation has been completed it will roll-out across Dorset.
- 111 Online has shown an increase in activity in Dorset from 11,244 in July to 13,315 in August. The highest dispositions reached were primary care (40.4%), self-care (18%) and urgent care (13.9%).









Source: Dorset UEC System Report September 26th, 2021

Urgent & Emergency Care

Edited by: Amy Lloyd

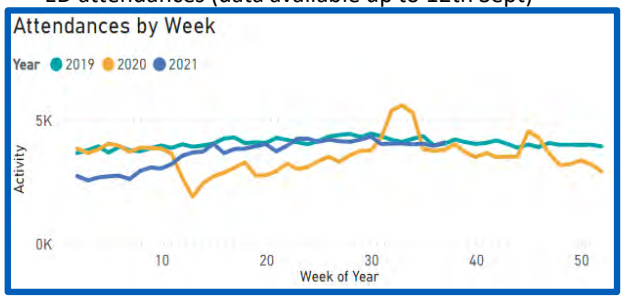
Handover Delays:

- Bi-Weekly monitoring at UHD focusing on progress against defined actions as per the Trust's overarching ED Improvement Action Plan.
- Handover delay position deteriorated in August compared to July. Figures to date in September (as of 22nd) indicate a slightly better position than at the same date in August. NHSE/I rolling 30-day position data as of 30 August shows RBH with 444 delays between 30-60 mins and 357 delays >60 mins. This does put UHD (RBH site) in the top half of the worst performing trusts nationally.

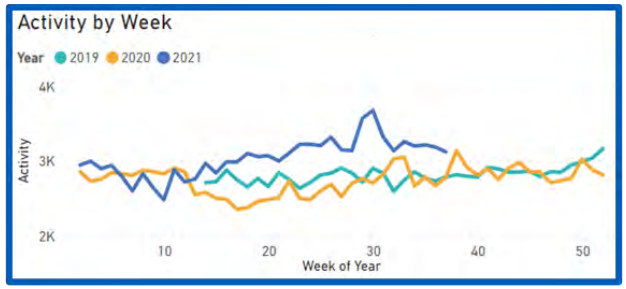
Numerous actions are being implemented to help improve the current ambulance handover delays position:

- UHD morning speciality meetings taking place to identify patients who can come out of ED.
- Senior clinicians recruited to and starting to support timely decision making.
- Emergency Care Improvement Support Team (ECIST) 'missed opportunity' audit being undertaken in UHD - Poole 22/23 Sept and RBH 6/7th Oct
- ED cohorting planning for UHD going forward via the Operational Delivery Group (ODG). DCH are' queuing out' rather than implementing the cohorting option.
- Developing the opportunity for SWAST taking prehospital bloods.
- RBH are developing a central medical admin hub for more staff to be in same place to make timely decisions.
- RBH are adopting Poole Symphony processes to save administrative time. Symphony is the clinical system used in ED on both sites.

ED attendances (data available up to 12th Sept)



999 Activity (data available up to 14th Sept)



Emergency depts and flow:

- The latest validated data for ED attendances show activity broadly in line with 2019 figures, whereas 999 activity is significantly higher and SWASFT have been at highest alert level (REAP Black) since mid-June. Local intelligence suggests acuity of attendances is higher than 2019 levels resulting in high % emergency admissions, with a backdrop of reduced bed capacity due to social distancing.
- Hospital bed occupancy is consistently above 90% mainly due to large numbers of patients who do not meet the clinical criteria to reside partly due to the lack of domiciliary care availability adversely impacting on flow, emergency department waits and ambulance handover delays.
- The Integrated Resilience Unit (IRU) is developing a Winter Plan, aligned to the UEC Recovery 10 Point Action Plan which was published on 22 September. The Winter Key Lines of Enquiry (KLOEs) have not been published. The UEC Board has agreed an action to look at analysis of discharges and this will be presented to the next Senior Leadership Team (SLT) meeting.
- The UEC Delivery Board has agreed to the commencement of a focused improvement project around the out of hospital offer. Work on this will start in October.

July 2021

Handover Delay	DORSET COUNTY HOSPITAL	POOLE HOSPITAL	ROYAL BOURNEMOUTH HOSPITAL
15-30 Mins	161	315	476
30-60 Mins	61	189	287
1hr to 2hr	30	73	128
2hr to 3hr	4	18	21
3hr to 4hr	0	2	8
4hr plus	0	1	5

August 2021

Handover Delay	DORSET COUNTY HOSPITAL	POOLE HOSPITAL	ROYAL BOURNEMOUTH HOSPITAL
15-30 Mins	216	501	593
30-60 Mins	82	298	454
1hr to 2hr	31	150	263
2hr to 3hr	6	45	79
3hr to 4hr	2	12	29
4hr plus	2	5	7

Sept 2021 (as at 22/09/21)

Handover Delay	DORSET COUNTY HOSPITAL	POOLE HOSPITAL	ROYAL BOURNEMOUTH HOSPITAL
15-30 Mins	135	358	388
30-60 Mins	63	179	269
1hr to 2hr	18	58	161
2hr to 3hr	2	7	51
3hr to 4hr	0	2	14
4hr plus	0	1	5

Source: SWAST & UEC Dashboards 22nd September 2021

Hospital KPIs

Edited by: Brian Matthews

DORSET SYSTEM POSITION		Jul-21	Aug-21	*19/09/2021 (Unvalidated)*	Target
RTT -Total	% 18 Weeks	63.02%	63.06%	61.60%	>=92%
	Incomplete Pathways	67,192	68,995	69,638	-
	>52 Weeks	5,658	5,635	5,824	Nil
	>78 weeks	2,291	2,782	3,092	Nil
	>104 weeks	192	250	312	Nil
RTT - Admitted	% 18 Weeks	43.00%	43.96%	41.82%	>=92%
	Incomplete Pathways	15,697	15,892	15,703	-
	>52 Weeks	2,917	2,868	2,900	Nil
	>78 weeks	1,372	1,519	1,562	Nil
	>104 weeks	164	217	265	Nil
RTT - Not-Admitted	% 18 Weeks	69.13%	68.78%	67.36%	>=92%
	Incomplete Pathways	51,495	53,103	53,935	-
	>52 Weeks	2,741	2,767	2,924	Nil
	>78 weeks	919	1,263	1,530	Nil
	>104 weeks	28	33	47	Nil
DM01	% > 6weeks	6.80%	8.60%	Not Available	<=1%
	Total >= 13 weeks	98	86		Nil
	% >= 13 weeks	0.70%	0.70%		Nil
Cancer	2 week wait %	55.9% (DCH)	44.2% (predicted)	Not Available	>=93%
	62 day %	77.70%	76.1% (predicted)		>=85%
	Faster Diagnosis %	75.20%	71.7% (predicted)		>=75%
	Backstops	14	12		0

Latest week data is provisional, monthly values in **RED** are below target

RTT Performance stabilised in August whilst the total waiting list increased by 1,803 patients (2.68%).

- **The growth in the total waiting list reflects a reduction in activity in August.** This not tracking trajectory and is an area under review by the Elective Performance Group following prior assurance requests.
- Future reports will incorporate referral rates to enable a better understanding of the total waiting list position.

A small reduction of 23 patients waiting over 52 weeks in August.

- **8.16%** of total waiting list is in the over 52 weeks cohort which is **lower** than at the end of July but should be read in the context of the growth in the wating list. Dorset is now the 6th worst performing area in the region out of 7 systems for >52 week waits. It had been bottom for over a year.

>78 weeks and >104 week wait totals worsened in August and continue to do so in September. Major focus of the Elective Performance Group and plans have either been submitted or being finalised for addressing the areas.

- % of the total list **waiting over 78 weeks increased to 4% in August** (up from 3.4% in July)**.**

DM01 performance has **declined in August from 6.8% to 8.6%** against the backdrop of a seasonal decline in referrals.

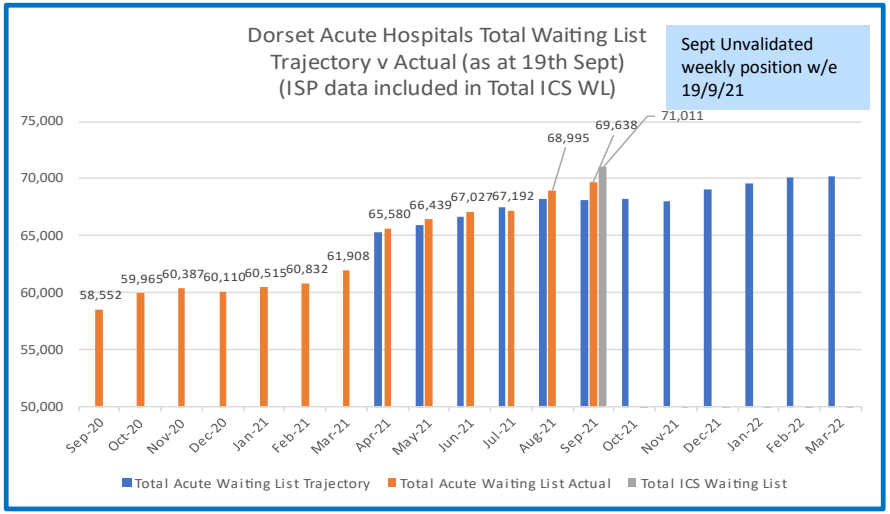
- Endoscopy DM01 performance at UHD went from 13.6% to 27.8% in August, interestingly a similar near doubling of their DM01 percentage occurred at DCH the previous month.
- 6-week performance **ranks 1st in the region,** region performing poorly with 2nd place system nearly double Dorset percentage.

Cancer

- **2 week wait** performance (only reported at DCH) has **declined** and predicted to continue to decline before improving in September.
- **Faster diagnosis** was **achieved in July** and expected to be repeated in August at UHD only. Improvement forecasted in DCH in September.
- **62 day % standard** whilst beneath the threshold is **consistently above** the national average at both trusts (national average 70-71%).
- **Backstops are predicted to plateau** against a pattern of higher referrals across all areas and complex cases requiring tertiary centre involvement.

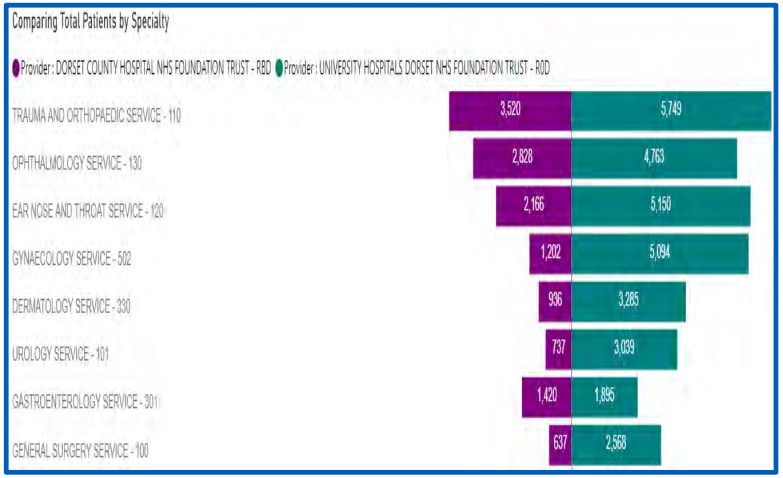
RTT Total Waiting List August 2021

Edited by: Brian Matthews / Louise Taylor



Current Waiting List by Pathway and Provider

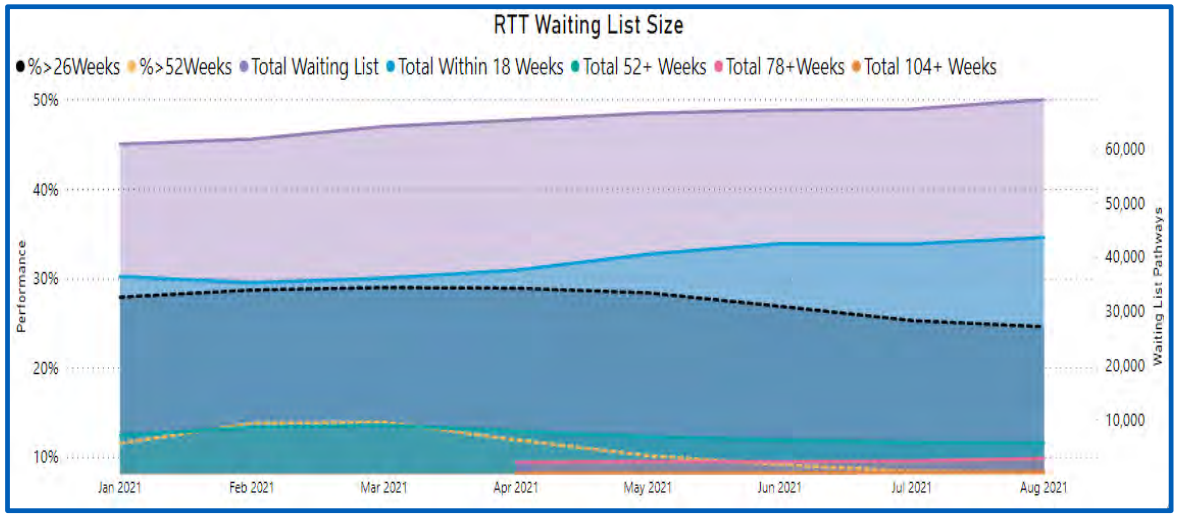
	DCH		DCH Total	UHD		UHD Total	Grand Total
Key Specialties	Admitted	NonAdmitted		Admitted	NonAdmitted		
CARDIOLOGY SERVICE - 320	33	517	550	374	2212	2,586	3,136
CARDIOTHORACIC SURGERY SERVICE - 170					31	31	31
DERMATOLOGY SERVICE - 330	345	591	936	879	2406	3,285	4,221
EAR NOSE AND THROAT SERVICE - 120	145	2021	2,166	645	4505	5,150	7,316
GASTROENTEROLOGY SERVICE - 301		1420	1,420	312	1583	1,895	3,315
GENERAL INTERNAL MEDICINE SERVICE - 300		2	2	308	624	932	934
GENERAL SURGERY SERVICE - 100	208	429	637	776	1792	2,568	3,205
GYNAECOLOGY SERVICE - 502	224	978	1,202	909	4185	5,094	6,296
NEUROLOGY SERVICE - 400				2	1802	1,804	1,804
OPHTHALMOLOGY SERVICE - 130	516	2312	2,828	1440	3323	4,763	7,591
ORAL & MAXILLOFACIAL SURGERY 140/144	351	1945	2,296	1520	1375	2,895	5,191
PAEDIATRIC SERVICE - 420		414	414		1011	1,011	1,425
RHEUMATOLOGY SERVICE - 410		411	411	20	1527	1,547	1,958
TRAUMA AND ORTHOPAEDIC SERVICE - 110	1433	2087	3,520	2451	3298	5,749	9,269
UROLOGY SERVICE - 101	205	532	737	793	2246	3,039	3,776
OTHER	176	1869	2,045	1638	6487	8,125	10,170
Grand Total	**3636**	**15528**	**19,164**	**12067**	**38407**	**50,474**	**69,638**

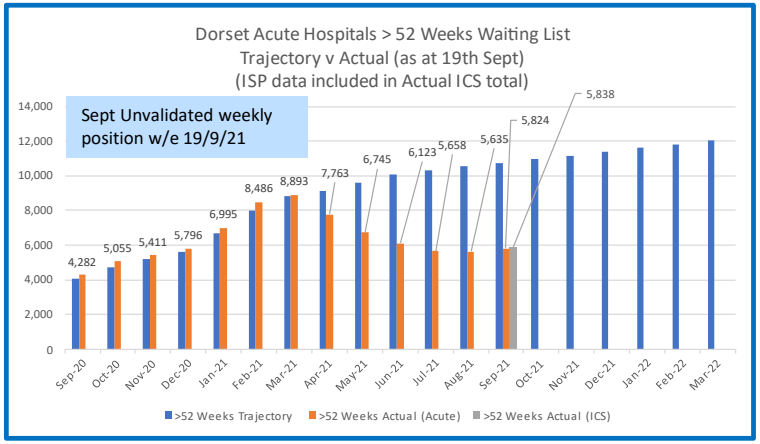


- **Total waiting list increased in August by 1,803 (2.68%)**. Independent Provider data available since start of September and included in unvalidated total (grey column) in Total Waiting List versus Trajectory image.
- Proportional increases across all key specialties reversing the trend in July and indicative of end of lockdown restrictions.
- Total waiting list **is not in line with trajectories** – specifically at DCH and being investigated as part of earlier assurance requests.
- Progressing use of new providers to support high volume ophthalmology & Oral Surgery cases. Contract formalised with SpaMedica in Poole for Cataracts.
- Launch of 'Think Big' and Orthopaedic 'Super Clinics' initiatives to deliver positive impact on waiting list size and length of waits.
- The total waiting list at the end of August was **13.98% higher** than August 2019 at **8,464 more cases**.

Total WL by Week Bands as at 19/09/2021

Edited by:
Brian Matthews / Louise Taylor





- 5,635 patients waiting >52 weeks at the end of August, **a reduction of only 23 over July position**. Confirms the projection made last month that reductions were slowing to a plateau. The numbers of cases at 40-52 weeks **pose a threat** to any further reduction in the 52 weeks plus cohort. Recent appearance of cases with unknown waiting time status.
- As with the total waiting list position, data from the independent sector is being received since early September to give a better overall Dorset position, numbers over 52 weeks small at 14 cases.
- The proportion of waits **over 78 weeks** has **worsened to 4%** of the total waiting list, having increased by 491 cases in the month. The **number waiting in excess of two years increased by 58 cases**. National and local ambition to eliminate 104 week waits by March 2022. Preparations being made for scrutiny by NHS England and Improvement with focus on 104 weeks and non-admitted pathways.

*RTT Waiting List Size at August month-end used due to non-availability of weekly data from some providers for September

Waiting List by Specialty and Weeks Waiting - Latest Week

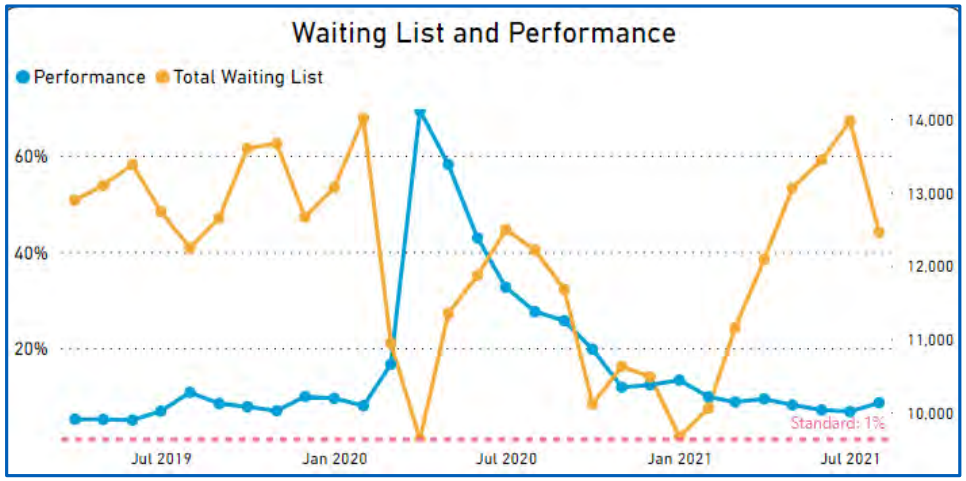
Specialty Group	0 ≤ 18	18 ≤26	26 ≤ 40	40 ≤ 52	52 ≤ 78	78 ≤ 104	> 104	Unknown	Grand Total
CARDIOLOGY SERVICE - 320	2,814	227	82	10				3	3,136
CARDIOTHORACIC SURGERY SERVICE - 170	14	6	11						31
DERMATOLOGY SERVICE - 330	3,195	521	379	85	8	7		26	4,221
EAR NOSE AND THROAT SERVICE - 120	3,234	955	1,023	820	596	652	36		7,316
GASTROENTEROLOGY SERVICE - 301	2,033	432	378	203	147	98		24	3,315
GENERAL INTERNAL MEDICINE SERVICE - 300	696	101	96	15	4			22	934
GENERAL SURGERY SERVICE - 100	1,963	387	356	212	110	141	36		3,205
GYNAECOLOGY SERVICE - 502	3,765	1,025	809	341	204	137	12	3	6,296
NEUROLOGY SERVICE - 400	1,368	324	100	7	5				1,804
OPHTHALMOLOGY SERVICE - 130	4,982	1,118	776	425	164	102	5	19	7,591
ORAL AND MAXILLOFACIAL SURGERY - 140/144	2,049	441	630	521	423	977	150		5,191
PAEDIATRIC SERVICE - 420	1,140	186	67	14	17	1			1,425
RHEUMATOLOGY SERVICE - 410	1,573	223	145	16		1			1,958
TRAUMA AND ORTHOPAEDIC SERVICE - 110	4,402	1,463	1,375	791	655	461	48	74	9,269
UROLOGY SERVICE - 101	2,070	672	548	195	183	100	4	4	3,776
OTHER	7,600	1,043	782	363	216	103	21	42	10,170
Grand Total	**42,898**	**9,124**	**7,557**	**4,018**	**2,732**	**2,780**	**312**	**217**	**69,638**

Source: RAIDR Elective Waiting List (RTT Data) 19/09/2021

Diagnostics (DM01) August 2021

Edited by:
Brian Matthews/Louise Taylor

	Diagnostic Tests by Weeks Waiting	< 6 weeks	6 > 12 Weeks	13 Plus Weeks	Total WL
Imaging	Magnetic Resonance Imaging	1637	257	4	1898
	Computed Tomography	1630	49	2	1681
	Non-obstetric ultrasound	3778	39	4	3821
	Barium Enema	0	0	0	0
	DEXA Scan	686	31	3	720
Physiological Measurement	Audiology - Audiology Assessments	321	1	0	322
	Cardiology - echocardiography	1085	86	22	1193
	Cardiology - electrophysiology	0	0	0	0
	Neurophysiology - peripheral neurophysiology	730	94	0	824
	Respiratory physiology - sleep studies	40	2	0	42
	Urodynamics - pressures & flows	18	5	11	34
Endoscopy	Colonoscopy	469	189	9	667
	Flexi sigmoidoscopy	188	63	4	255
	Cystoscopy	119	9	12	140
	Gastroscopy	676	164	15	855
	Total	11377	989	86	12452



- Waiting list has reduced by 1,532 in August
- Those waiting over 6 weeks has **increased to 8.6%** of total (was 6.8% in July).
- There has been a reduction in waits over 13 weeks of 12 cases, the second consecutive monthly reduction.
- Dorset DM01 performance places it **1st in the region where performance is poor.**

Provider	TotalWaitingList	Over6wks	13+Weeks	% Over 6 Weeks	% Over 13 Weeks
DCH	4,175	571	35	13.7%	0.8%
UHD	8,277	504	51	6.1%	0.6%
Total	**12,452**	**1,075**	**86**	**8.6%**	**0.7%**

Diagnostic Test	Endoscopy		Imaging		Physiological Measurement	
Provider	6+ Week Perf	13+ Week Perf	6+ Week Perf	13+ Week Perf	6+ Week Perf	13+ Week Perf
DCH	18.4%	2.6%	12.9%	0.2%	12.1%	1.2%
UHD	27.8%	1.8%	1.2%	0.1%	7.3%	1.5%
Total	**24.3%**	**2.1%**	**4.8%**	**0.2%**	**9.2%**	**1.4%**

- The decline in DM01 performance is highlighted by Endoscopy at UHD, where the % has moved from 13.6% to 27.8% in August. In all modalities across UHD the performance has gone from 3.2% to 6.1%.
- DCH performance, whilst generally poorer has not declined by the same margin this month. However, their challenged month was July which saw their performance go from 9.8% to 17.4%.
- Lower referrals in August is following a pattern of previous years and anticipated will rise in Quarter 3.

Cancer Performance

Edited by:
Alison Ashmore

	Measure	Target	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22 - FINAL	July 21 - FINAL
Dorset Cancer Partnership	Cancer Two Week Wait (DCH only)	93%	92.3%	86.7%	64.8%	73.0%	67.0%	55.8%
	Cancer Plan 62 Day Standard (Tumour)	85%	77.0%	78.4%	77.3%	77.4%	78.3%	77.7%
	62 Day Screening Standard (Tumour)	90%	70.0%	64.7%	87.6%	86.1%	82.6%	82.6%
	31 Day First Treatment (Tumour)	96%	96.1%	95.2%	97.3%	96.6%	96.8%	98.0%
	Subsequent Treatment - Surgery	94%	89.9%	88.6%	95.9%	87.9%	91.8%	91.8%
	Subsequent Treatment - Radiotherapy	94%	98.8%	99.0%	98.7%	99.0%	97.0%	99.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	99.7%	100.0%	99.7%	99.8%	99.3%	100.0%
	Faster Diagnosis	75%	74.5%	74.2%	74.2%	74.3%	75.2%	75.2%

2WW Referrals

UHD: The PTL for remains over 3,000 and for context, when comparing to national data, UHD has the 21st highest PTL.

DCH: Throughout August the PTL has been 1,200+ which is about 300 patients larger than the usual PTL, mainly this is due to the wait to 1st seen for many services coupled with the increase in referrals the PTL is now starting to reduce as the wait to 1st seen is reducing for Skin / Breast which are high referral volume sites.

Faster Diagnosis Standard (FDS)

Faster diagnosis standard was achieved for July 2021 for Dorset – demonstrating steady progress across all tumour sites.

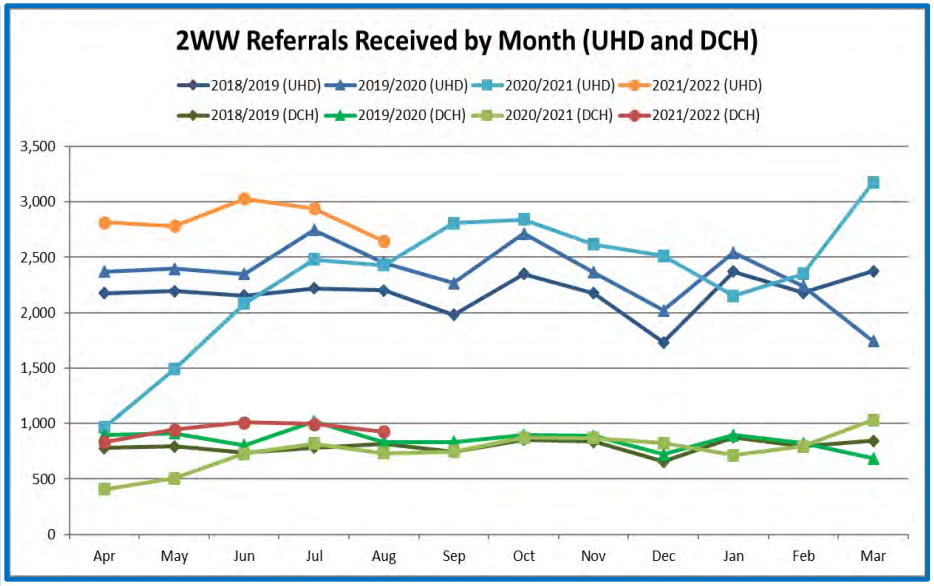
Backlog 63 days – 103 days

The backlog of patients over 62 days remains a challenge for both UHD and DCH. When compared nationally this the Wessex Cancer Alliance continues to have the lowest number of patients waiting over 62 days.

Backstops 104 days

UHD: Numbers have risen against an increasing PTL. UHD have the 3rd lowest % of backstops when looking at comparable Trusts nationally. Regionally, for context, UHD PTL is approaching double the size of any other Wessex trust.

DCH: Backstop is the highest since the significant surges in May / Jun 2020 around COVID 1st phase and equates to 1.89% of the PTL. Delays are multifactorial in challenged pathways - with multiple diagnostics and various Tertiary centres involved

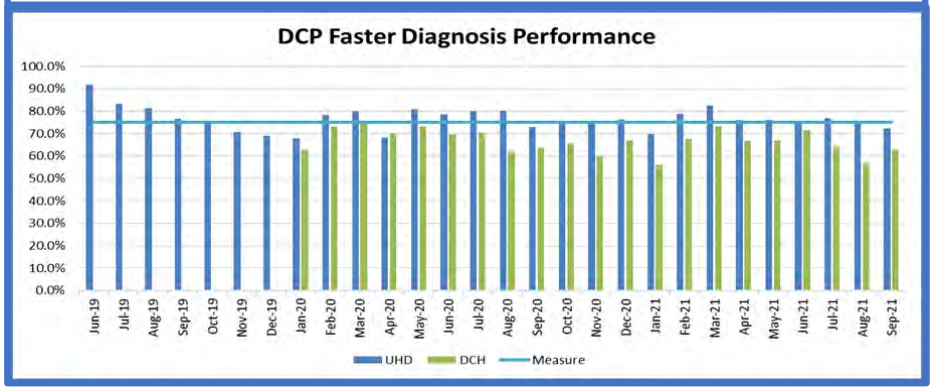


Cancer Standards & Screening

Edited by: Alison Ashmore & Kate Connolly

NHS Cancer Standards

- FDS was met in July at 75.2% (UHD achieving 78.2.% and DCH at 62.9%) Performance for August is likely to be achieved at UHD. DCH remains challenged due to 2ww appointments being booked outside of 14 days. September however is likely to show an improved position at DCH.
- Performance against the 62 Day Standard for July was 77.7% which while below the threshold was above the current National average of 71.5% (UHD achieving 78.8% and DCH achieving 74.0%.)
- The 31-day standard for first definitive treatment was achieved by both Trusts for July. Dorset Cancer Partnership (DCP) reporting 98%.
- The number of first treatments throughout July (which is now a metric monitored as part of recovery) have shown steady improvement. July 2019 showed 480 treatments – July 2021 shows 489 treatments recorded by DCP (9 treatments higher than pre-COVID).
- DCP achieved the performance threshold for subsequent treatments in radiotherapy and anti cancer drugs. However, the standard for surgery was below the threshold at 91.8% mainly due to Robotic Assisted Radical Prostatectomy (RARP) capacity and annual leave.
- As mentioned in previous slide, UHD has 3,000+ patients on an open cancer pathway (which is it's highest recorded level), 1,200+ at DCH (an extra 300 patients than usual). This remains much higher than previous years putting considerable strain on the all services across DCP.



Dorset Breast Screening Service:

- Internal data trajectory suggests recovery by mid-April 2022 which is later than other modelling. Capital delay for additional site & equipment breakdowns have slowed recovery. Activity reduced to allow staff recovery who have been working additional hours for over 12months. Pathology services in a period of transformation.
- Total backlog is circa 15,000, this is an improving position. Recovery action plan is in operation and helping backlog to decrease.
- Challenges experienced include van maintenance and changes of personnel as well as staff isolating.
- There has been successful recruitment into mammographer, and consultant radiographer posts – predominantly via the international route.

Cervical Screening:

- The Cervical Screening programme has recovered sample taking activity in primary care, mindful that winter flu/covid season will put extra pressure on Practice Nurses as these professionals are usually providing the vaccination as well as doing the screening
- Colposcopy at UHD/Bournemouth site has a waiting list for low grade referrals due to staff shortages. There is a recovery plan is in place.
- Colposcopy clinics report an increasing number of inappropriate referrals made via the 2WW pathway of cases who should be screened in primary care.
- Elective Recovery fund (ERF) investment can be applied for to aid with impact on colposcopy units deriding from, for example, an increase in the number of referrals.

Bowel Screening:

- Developing a business case to improve screening in low uptake groups. Initiative led by the Dorset Cancer Partnership in collaboration with the NHS England South-West Screening and Immunisation Team, Dorset screening providers and charities such as Jo's Cervical Cancer Trust.
- The Bowel Screening Programme has recovered. Dorset has 0 weeks wait and has recovered to meet 6 weeks after due date.
- Dorset commenced age extension during May 2021 and were the first provider in the SW to go live – reducing the age of first invite from 60 to 56, to reduce to age 50 by 2024-25.

Source: UHD data team/Wessex Cancer Alliance

South West Performance Dashboard: Elective

Week Ending : 19 September 2021

		Elective											
		RTT				Diag				Cancellations		Cancer	
		%>52 week	No over 78 weeks	No. of 104 weeks	Total Incomplete	All Diag %>6 week	Endoscopy % >6 weeks	Imaging % >6 weeks	Physiological Measurement % >6 weeks	Cancelled OPs P1-2	Cancelled OPs P3-4	%>62days	No. of 104 days*
BNSSG	N Bristol	6.4%	706	52	28851	43.3%	73.7%	31.7%	53.7%	11	50	19.4%	233
	UHB and Weston	6.8%	1311	147	46426	40.0%	63.5%	31.1%	54.3%	25	60	10.2%	61
	UHB												
	Weston												
BSW	Great Western	2.6%	248	0	27171	36.5%	52.1%	33.1%	36.5%	2	5	6.7%	9
	RUH	3.6%	255	0	30903	32.5%	57.0%	24.1%	71.8%	0	0	8.8%	28
	Salisbury	No Data	0	0	0	8.6%	15.2%	4.8%	28.4%	0	0	9.9%	37
Cornwall	Royal Cornwall	2.5%	288	5	33750	21.7%	11.1%	23.1%	20.1%	7	105	4.7%	14
Devon	Northern Devon	7.3%	318	2	16504	63.0%	50.3%	68.5%	40.5%	0	4	12.0%	13
	Royal Devon & Exeter	9.3%	2267	205	65886	44.5%	41.7%	46.6%	37.8%	12	73	8.9%	57
	Torbay & S Devon	No Data	0	0	0	33.3%	59.8%	25.4%	31.5%	19	12	8.2%	21
	Plymouth	7.3%	1106	223	37682	35.0%	16.9%	33.0%	53.8%	29	65	14.8%	41
Dorset	Dorset County	12.2%	1271	146	19181	15.0%	21.7%	11.9%	18.8%	5	34	10.1%	30
	UH Dorset	6.9%	1838	166	50999	5.9%	24.1%	0.7%	7.8%	53	81	7.3%	61
	Poole												
	Bournemouth												
Glos	GHFT	2.7%	367	5	61751	22.3%	15.2%	3.7%	64.7%	5	46	8.5%	47
Somerset	Somerset	5.3%	797	57	32561	45.1%	20.0%	28.0%	75.9%	8	29	8.5%	28
	Yeovil	5.2%	261	1	12037	18.8%	11.2%	14.6%	44.9%	2	13	9.3%	23

Please note: Salisbury and Torbay & South Devon submissions did not make it into the SDCS extract due to technical issues.

Weekly RTT PTL	Weekly Activty Return	UEC Daily Sitrep	Weekly Cancer PTL

Where data is reported weekly the actuals for the week ending in C2 are reported.They are then compared with the average of the previous 6 weeks (not including the current reported week).

Weekly Performance is below that of the average of the previous 6 weeks
Weekly Performance is below that of the average of the previous 6 weeks but within 10%
Weekly Performance is above that of the average of the previous 6 weeks

South West Performance Dashboard: Non Elective

Week Ending : 19 September 2021

		C19			UEC							
					Front Door				Throughput			
		C19 Adult Bed occupied	C19 Adult CC occupied	% of Absence C19 Related	A&E all type attendances	All types - 4 hours performance	Ambulance Handovers over 60 minutes	>12 hour Decision to admit	Bed occupancy	Patients with a LOS +7 days *	Patients with a LOS +21 days *	Patients m the criteria be discharge
						%						
BNSSG	N Bristol	5.8%	21.4%	23.8%	1969	59.6%	124	0	97.1%	473	189	227
	UHB and Weston	5.3%	7.4%	25.3%	4670	71.2%	140	31	89.0%	435	155	
	UHB	5.8%	8.1%	25.0%	3387	68.7%	108	0	85.9%	300	117	227
	Weston	4.0%	2.4%	26.6%	1283	77.8%	32	31	98.2%	135	38	
BSW	Great Western	7.0%	22.6%	17.2%	2347	71.2%	31	2	96.4%	184	47	155
	RUH	5.5%	46.9%	48.3%	1802	65.7%	81	0	91.6%	266	75	116
	Salisbury	1.5%	13.5%	47.5%	1459	78.9%	1	0	93.3%	207	77	68
Cornwall	Royal Cornwall	7.4%	12.9%	15.9%	3574	77.7%	152	115	92.8%	261	90	147
Devon	Northern Devon	2.4%	35.7%	29.5%	1045	73.8%	4	0	87.9%	109	30	71
	Royal Devon & Exeter	3.2%	17.3%	26.9%	2601	77.1%	0	0	85.4%	298	92	158
	Torbay & S Devon	5.4%	4.8%	20.0%	1989	64.5%	15	16	94.9%	149	43	76
	Plymouth	4.3%	15.5%	24.4%	2986	CRS Pilot	137	37	92.4%	434	188	258
Dorset	Dorset County	1.7%	34.5%	16.0%	1503	76.6%	4	0	94.4%	147	70	98
	UH Dorset	1.4%	15.8%	20.4%	3780	CRS Pilot	38	0	88.9%	473	198	
	Poole	1.6%	8.6%	15.3%	2115	CRS Pilot	30	0	89.7%	244	102	298
	Bournemouth	1.1%	23.8%	26.7%	1665	CRS Pilot	8	0	88.0%	228	96	
Glos	GHFT	2.8%	11.9%	5.0%	4098	67.4%	179	1	95.0%	482	190	254
Somerset	Somerset	5.3%	25.0%	14.8%	3621	81.8%	6	0	93.0%	265	93	178
	Yeovil	2.9%	14.6%	29.1%	1241	87.8%	3	0	94.1%	142	54	107

Data Source: C19 Acute Daily Sitrep | A&E Daily Sitrep

Where data is reported daily it is totalled up for the current week. This then compared with the previous 42 days (not including the 7 days i the week ending referenced in C2).

Weekly Performance is below that of the average of the previous 6 weeks
Weekly Performance is below that of the average of the previous 6 weeks but within 10%
Weekly Performance is above that of the average of the previous 6 weeks

Areas Requiring Further Assurance

- Assurance on timescale for availability of primary care reporting to support analysis of variations in performance; to include usage of e-consult activity in addition to other remote delivery methods
- Assurance on plan to focus on non-admitted pathways (outpatients and day case) and how virtual consultations will play a role in driving down waiting lists
- Assurance that fluctuations in DM01 performance between sites and months are understood and plans to anticipate future variations are being considered
- Assurance that backlog in Breast Cancer Screening (circa 15,000) will meet target date for clearance
- Assurance that cause of RTT Waiting List cases displaying an unknown waiting time status has been addressed and information corrected

Glossary

Acronym	Definition	Acronym	Definition
2WW	2 week wait referral	**LES**	Local Enhanced Service
BI	Business Intelligence	**MRI**	Magnetic Resonance Imaging
CAMHS	Child and Adolescent Mental Health Service	**MSK**	Musculo-Skeletal
CAS	Clinical Assessment Service	**NHSE / I**	NHS England / Improvement
CCG	Clinical Commissioning Group	**OMF**	Oral & Maxillofacial Surgery
CYP	Children & Young People	**OP / IP**	Outpatient / Inpatient
DCH	Dorset County Hospital NHS Trust	**PCN**	Primary Care Network
DES	Direct Enhanced Service	**PHT**	UHD - Poole
DHC / DHUFT	Dorset Healthcare NHS Trust	**PTL**	Patient Tracking List
ED	Emergency Department	**RBCH**	UHD - Bournemouth
ENT	Ear, Nose & Throat	**RTT**	Referral To Treatment
FDS	Faster Diagnostic Service	**SDEC**	Same-day Emergency Care
GI	Gastro-intestinal	**SMI**	Severe Mental Illness
IAGPS	Improved Access to General Practice Services	**SOP**	Standard Operating Procedure
IAPT	Improved Access to Psychological Therapies	**SPA**	Single Point of Access
ICS	Integrated Care System	**SWAS**	South West Ambulance Service
IPC	Infection, Prevention & Control	**UEC**	Urgent & Emergency Care
ISP	Independent Sector Provider	**UHD**	University Hospitals Dorset NHS Trust
IUCS	Integrated Urgent Care Service	**VCSE**	Voluntary, Community & Social Enterprise
KPIs	Key Performance Indicators	**WL**	Waiting List

CONFIDENTIAL **10.**

SYSTEM LEADERSHIP TEAM (SLT) MEETING

DORSET ICS FINANCE REPORT

Date of the meeting	18/11/2021
Author	Michael Gravelle, Assistant Director of Finance Dorset CCG
Purpose of Report	To provide an update on the financial position of Dorset ICS.
Recommendation	The SLT is asked to **note** report.

1. Introduction

1.1 The attached appendix presents the financial position for Dorset ICS as at month 6 of 2021/22 financial year.

1.2 For the first half of 2021/22 the Dorset NHS system has submitted a breakeven financial plan and as at month 6 is forecasting a H1 deficit of £2.0M, arising from the additional costs of the Flowers settlement in South Western Ambulance Service Foundation Trust (SWASFT) and a shortfall in Elective Recovery Fund (ERF) income.

1.3 The system has delivered £5.0M efficiency savings in H1, which is less than the originally planned efficiencies of £6.2M. Of these savings 44% are from non-recurrent schemes, and 53% are from non-pay (recurrent and non-recurrent).

2. Conclusion

2.1 The SLT is asked to **note** the report.

Author's name and Title: **Michael Gravelle**
Assistant Director of Finance – Strategy
Date: **09/11/2021**

APPENDICES	
Appendix 1	**Dorset ICS Finance Report Month 6 2021/22**

Dorset ICS Finance Report
Month 6 2021/22

Our Dorset
Local NHS and Councils Working Together

Meeting date: November 2021

Summary November 2021

Financial Position

For the first half of 2021/22 the Dorset NHS system has submitted a breakeven financial plan and as at month 6 is forecasting a H1 deficit of £2.0m, arising from the additional costs of the Flowers settlement in SWASFT and a shortfall in ERF income the system will receive driven by the revised threshold criteria enacted after commitments to expenditure were made, based on the original criteria. The ERF shortfall is £1.1m.

In reaching this position the system has mitigated £15m of risks identified at the planning stage as well as further cost pressures. NHS organisations delivered the required efficiency savings in H1.

The Local Authorities are both reporting overspends in the quarter one forecast position, with a combined pressure of £16m.

Efficiencies

The system has delivered £5.0m efficiency savings in H1, which is less than the originally planned efficiencies of £6.2m. Of these savings 44% are from non-recurrent schemes, and 53% are from non-pay (recurrent and non-recurrent).

Covid

The system received £47.3m in covid funding for H1 2021/22 (this includes an additional £1.6m for the GP expansion fund provided separately to the main covid allocation). A total of £35.7m has been spent on covid related costs, with the remaining £11.6m supporting other cost pressures across all organisations.

SDF

A total of £35.9m System Development Funding has been allocated to the system for 2021/22, including funding in H2 to support 111 and ambulance capacity and diagnostic hubs.

Capital

The ICS are reporting the system CDEL envelope will be met this financial year, with an underspend in other capital funding arising in Dorset Healthcare and University Hospitals of Dorset.

2021/22 System Position - Month 6 2021/22 November 2021

At the end of month 6 the Dorset NHS organisations are reporting a deficit position of £2.0m. This is a movement of £1.0m further deficit from the forecast in previous months and arises from a national correction to calculation of ERF income which was notified at the end of the financial period. The impact of the Flowers settlement continues to be an unfunded cost pressure in SWASFT.

	H1		
	Planned Surplus/(Deficit) £'000	**Actual Surplus/(Deficit)** £'000	**Variance to Plan Surplus/ (Deficit)** £'000
Dorset County Hospital	-	(521)	(521)
Dorset Healthcare	-	-	-
University Hospitals Dorset	-	(528)	(528)
South West Ambulance Service	-	(1,002)	(1,002)
Provider Surplus / (Deficit)	**-**	**(2,051)**	**(2,051)**

Dorset CCG - Dorset ICS Organisations	-	-	-
Dorset CCG - Primary Care	-	-	-
Dorset CCG - Other Commissioned	-	-	-
CCG Surplus / (Deficit)	-	-	-
Aggregate system position	**-**	**(2,051)**	**(2,051)**

2021/22 Local Authority Financial Plans November 2021

The quarter one financial position for both Local Authorities is summarised below

	Budget Surplus / (Deficit) £'000	Forecast Surplus / (Deficit) £'000	Commentary
Bournemouth, Christchurch and Poole Council	0	(7,570)	The projection for the 2021/22 revenue account is an overspend of £12.6 million within services. The application of one-off central resources reduces this to £7.6 million. A mitigation strategy has been developed against this sum should attempts to deliver services within the constraints of their original budgets prove unsuccessful. This position assumes full delivery of the £7.5m transformation programme savings target for 2021/22. At this stage £2.4m has been delivered and a full progress report will be included in the second quarter budget monitoring report once the savings from the council's smarter structures and third party spend programmes have been confirmed. For scale, £7.6m represents 3% of BCP Councils £241.1m net budget for 2021/22.
Dorset Council	7,304	(955)	Dorset Council are forecasting net budget pressures of £8.259m, with overspends anticipated in all Directorates. The forecast includes 7.7% overspend in Adult Social Care, arising from more people entering care, unrecoverable costs of operating the HDP and a loss of savings opportunities. The long term impact of covid-19 is currently estimated at a £9.2m budget pressure, which contributes to an expectation of a significantly increasing budget gap over the Medium Term. Dorset Council has a 2021/22 Capital budget of £63m made up of projects which are funded externally (£15m), partially funded externally (£9m) and projects with no external funding (£39m). There is also an estimated slippage of £76.1m from 20/21 to 21/22, meaning the predicted capital spend to £138.9m in 2021/22 although it is unlikely that the full spend will be delivered in the year and there will be some slippage into 22/23.

2021/22 ERF System Position - Month 6 2021/22 November 2021

The H1 ERF position is shown below.

Provider	H1 Additional Expenditure (£) £'000	H1 Additional Activity (Income) £'000	H1 (Benefit)/ Risk £'000
Dorset County Hospital	3,507	2,915	592
Dorset Healthcare	59	59	0
University Hospitals Dorset	8,638	8,110	528
Dorset CCG (Non-NHS Providers)	1,200	1,200	0
Total	**13,404**	**12,284**	**1,120**

The shortfall in income compared to the expenditure arises from the change in criteria to receive funding that was announced for Q2, meaning that commitments to fund activity did not result in as much income as calculated under the original criteria for the scheme.

2021/22 CIP and QIPP - Month 6 2021/22 November 2021

The system has delivered £5.0m efficiency savings in H1.

Of these savings, 44% are non-recurrent (£2.196m).

	H1		
	Recurrent £'000	Non recurrent £'000	Total CIP/QIPP £'000
	Actual	Plan	Actual
DCH	93	98	191
DHC	919	210	1,129
UHD	376	1,095	1,471
SWAST	0	793	793
Dorset CCG	1,423	0	1,423
Total	**2,811**	**2,196**	**5,007**

In H1 there 53% of savings are in non-pay, meaning £2.249m has been achieved through pay efficiencies.

	H1			
	Pay £'000	Non-Pay £'000	Income £'000	Total CIP/QIPP £'000
	Plan	Plan	Actual	Actual
DCH	0	191	0	191
DHC	648	481	0	1,129
UHD	808	575	88	1,471
SWAST	793	0	0	793
Dorset CCG	0	1,423	0	1,423
Total	**2,249**	**2,670**	**88**	**5,007**

CIP delivery in DCH continued to be challenging in H1 and arose largely from procurement and pharmacy.

UHD are reporting that 61% of the planned CIP has been delivered through non-recurrent savings. There is an anticipated recurrent shortfall of £2.4m at the year end, with significant work to be undertaken to identify further savings.

Covid Spend M6 November 2021

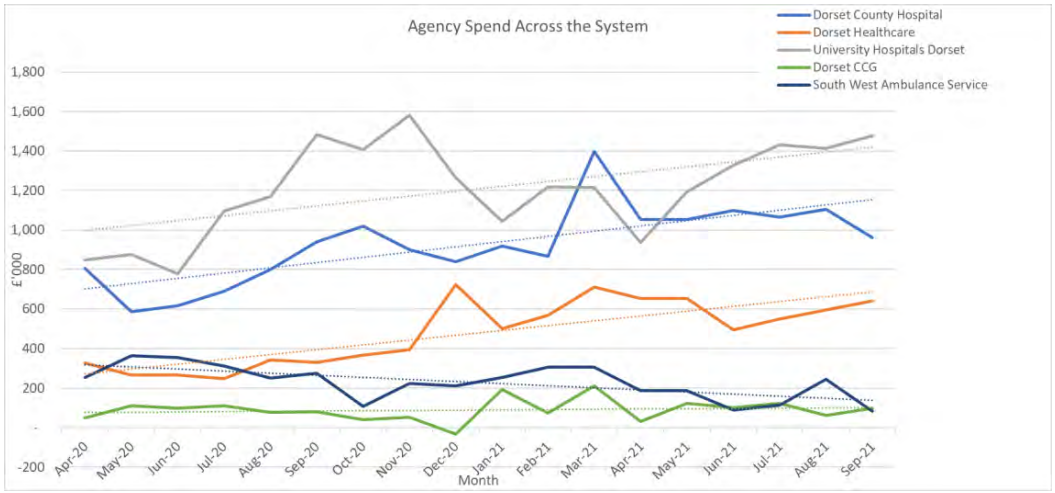
The system received £47.3m in covid funding for H1 2021/22 (this includes an additional £1.6m for the GP expansion fund provided separately to the main covid allocation). A total of £35.7m has been spent on covid related costs, with the remaining £11.6m supporting other cost pressures across all organisations.

In May 2021 the system completed a covid cost return forecast for the full financial year, which indicated expectations regarding both recurrent and non recurrent costs. This showed £56.8m expected spend, which suggests that the H1 position represents 63% of the total covid spend this financial year. University Hospitals Dorset have spent 39% during H1, indicating that the full year forecast is unlikely to be realised unless spend increases disproportionately in H2, when costs are probably expected to reduce rather than increase.

			H1		FY	
	Allocation £'000	**Additional National Funding** £'000	**YTD Covid Spend** £'000	**Allocation utilised for non Covid** £'000	**21/22 FYE per covid return** £'000	**% spend in H1** %
Dorset CCG	2,136	1,649	2,593	1,192	-	0%
Dorset County Hospital	10,004	0	3,166	6,838	6,526	49%
Dorset Healthcare	3,914	0	3,729	185	4,853	77%
University Hospitals Dorset	11,872	0	9,023	2,849	23,212	39%
South Western Ambulance	17,676	0	17,157	519	22,208	77%
Total	**45,602**	**1,649**	**35,670**	**11,581**	**56,799**	**63%**

Agency Spend – M6 2021/22 November 2021

All four trusts are overspending their budget, with the main areas of spend being nursing and consultants. Monthly agency spend is increasing in UHD and has returned to levels seen in Autumn 2020. Dorset County and Dorset Healthcare have more static levels of spend in 2021/22 but are both also above the levels seen last autumn.



The total pay costs (including agency) were overspent in H1 by £13.8m, with the agency overspent by £8.5m of this and indicating that the other pay budgets are overspent by £5.3m. Agency spend in Dorset County are a significantly higher percentage than the other organisations, with pressures due to vacancies, sickness and activity for recovery and bed occupancy levels. Work is underway internally and with the system to identify solutions.

	H1					
	Agency			Workforce		
	Plan £'000	Actual £'000	Variance Surplus/ (Deficit) £'000	Plan £'000	Actual £'000	Agency as % of total £'000
Dorset County Hospital	3,118	6,338	(3,220)	74,261	79,126	8%
Dorset Healthcare	2,973	3,589	(616)	124,207	121,568	3%
University Hospitals Dorset	3,921	7,780	(3,859)	214,788	225,081	3%
South West Ambulance Service	96	904	(808)	113,587	114,852	1%
Provider Surplus / (Deficit)	**10,108**	**18,611**	**(8,503)**	**526,843**	**540,627**	**3.44%**

2021/22 System Development Fund

November 2021

Dorset ICS has a total of £35.9m SDF money available in this financial year, allocated across a range of service areas as set out below. The organisations that will be using the funds within the system are also shown.

Programme	Programme Name	Organisation	H1 Allocation	H2 Allocation	Total Allocation
Primary care		Dorset CCG - Primary Care	3,921	3,823	**7,744**
Mental health		Dorset Healthcare	5,337	4,056	**9,392**
IT & Tech	*Blood Pressure at home*	Dorset CCG	17	17	**33**
Ageing Well		Dorset Healthcare	2,059	2,109	**4,168**
Diabetes		Dorset CCG	174	188	**361**
LD & Autism		Dorset CCG	414	283	**697**
CVD, Respiratory and Stroke	*Long Covid*	Dorset Healthcare	251	386	637
	Spirometry and Pulmonary rehab		33	57	90
Maternity			318	318	**635**
Prevention	*Tobacco dependence treatment allocation*		66		**66**
Emergency & Elective Care	*UEC Summer Preparedness*	Dorset Healthcare	10		10
	UEC Pathways Upgrade	Dorset Healthcare	10		10
	NHS 111 H2 Capacity Funding	Dorset Healthcare		1,066	1,066
	Additional 21/22 Ambulance Funding	South West Ambulance Service Trust		4,597	4,597
	NHS 111 First	Dorset Healthcare	480		480
System Transformation		Dorset CCG	179	108	**287**
Children and Young People (CYP)		Dorset Healthcare	101	101	**201**
Outpatients	*Video consultation*		50	50	**100**
Nursing	*IPC training*		9	51	**60**
SCN	*Long Covid Asssessment Clinics*		374		**374**
People	*HWB Initiatives - Ambulance Trusts*	South West Ambulance Service Trust	24	146	170
	Enhanced Health and Wellbeing - Systems		175	175	350
	Inclusive Health and Wellbeing		25	25	50
Diagnostics Programme	*Diagnostic hubs*	Dorset CCG	72	4,212	**4,283**
Total			**14,097**	**21,765**	**35,861**

The H2 allocation includes £1.1m for 111 capacity, £4.6m for ambulance capacity and £4.2m for diagnostic hubs.

The majority of the funds are non-recurrent.

2021/22 Capital Position - Month 6 2021/22 November 2021

The ICS are reporting the system CDEL envelope will be slightly overspent. At month 6 there is greater variation of spend against plan but that will be resolved by year end. UHD are forecasting a capital underspend against other funding of £10.1m which is principally due to the theatres project.

	YTD CDEL Plan £'000s	YTD CDEL Actual £'000s	YTD CDEL Surplus/ (Deficit) £'000s	FY CDEL Plan £'000s	FY CDEL FOT £'000s	FY CDEL surplus / (Deficit) £'000s	YTD Other Funding Plan £'000s	YTD Other Funding Actual £'000s	YTD Other Variance Surplus/ (Deficit) £'000s	FY Other Funding Plan £'000s	FY Other Funding FOT £'000s	FY Other Variance Surplus/ (Deficit) £'000s
Dorset County Hospital	2,355	2,306	49	6,267	6,283	(16)	3,020	3,390	(370)	14,066	14,066	-
Dorset Healthcare	4,376	1,758	2,618	11,009	11,009	-	2,126	153	1,973	9,464	6,458	3,006
University Hospitals Dorset	7,468	13,566	(6,098)	32,203	32,203	-	10,864	6,584	4,280	46,025	35,904	10,121
South West Ambulance	9,412	7,813	1,599	12,732	12,732	-	825	2,973	(2,148)	8,589	8,589	-
Provider Total	**23,611**	**25,443**	**(1,832)**	**62,211**	**62,227**	**(16)**	**16,835**	**13,100**	**3,735**	**78,144**	**65,017**	**13,127**
Dorset CCG	-	-	-	-	-	-	994	-	994	994	994	-
System Total	**23,611**	**25,443**	**(1,832)**	**62,211**	**62,227**	**(16)**	**17,829**	**13,100**	**4,729**	**79,138**	**66,011**	**13,127**

DCH capital expenditure is ahead of plan at the current time due to timing of medical equipment and IT purchases earlier than originally planned.

Meeting Title:	Board of Directors
Date of Meeting:	24 November 2021
Document Title:	**Recovery Overview**
Responsible Director:	Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships
Author:	Natalie Violet, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Chief People Officer, Interim Chief Operating Officer, and Deputy Chief Executive and Director of Strategy, Transformation and Partnerships	18/11/2021	Approved

Purpose of the Paper	The purpose of the report is to provide the Trust Board with an overview of progress against the Trust's Recovery Framework following the COVID-19 pandemic.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	Highlights include: • Agreed duties and responsibility of the People Recovery Steering Group are now in place. • The Freedom To Speak Up Guardian has been added to the People Recovery Steering Group membership as it was recognised they will have useful information to feed to the group relating to matters of concern and vice versa. • The Trust has signed up to the Stay and Thrive Community of Action; a national initiative to help overseas recruits to settle, progress, and stay within the NHS. This is a key area of work for the organisation, and the outputs will be fed into the People Recovery Steering Group. • The Divisions have already begun to share wellbeing issues with the People Recovery Steering Group. The group will triangulate this with other data provided to the People and Culture Committee and use it to target support from the People Team and others. The group will report agreed actions and outcomes to the People and Culture Committee as an assurance mechanism that necessary action is being taken. • The Elective Recovery Fund will continue into the second half of the year. The guidance requires a threshold of 89% of Referral to Treatment (RTT) clock stops, compared to 2019/20. • The organisation performs well when monitored against the volume of clock stopping events, with a year-to-date performance of 95.28% against the baseline volume of 2019/20. • As part of our Health Inequalities work, BI Teams across the system are working on automated reporting for deprivation waiting times. • In October the total waiting list decreased by 350 patients compared to the previous month. This takes the total waiting list size to 1,043 below trajectory. • The waiting list profile has had a positive change with a 304 patient reduction in the time band 78-103 weeks. • There has been a reduction of 213 52+ week waiters during October. The organisation now has its lowest number of patients waiting over 52 weeks in a rolling 12-month period.							

	• Maxillo-facial, who have been particularly challenged with 52+ week waiters, have mobilised insourcing resulting in a reduction of 185 patients waiting over 52 weeks. • Following the release of a new regional reporting tool DCH is ranked 14th out of 15 for the percentage of the waiting list over 52 weeks and worst in the region for both the percentage of the waiting list over 78 weeks and over 104 weeks. DCH however continues to demonstrate strong recovery, with a reduction in the number of long waiters and continued improved diagnostic performance and the gap between the ranking positions is closing. • We have commenced multi professional clinics from South Walks House. We are working in partnership with Dorset Council and our health care colleagues to offer a range of outpatient services under one roof.
Action recommended	The Trust Board is recommended to: 1. **Note** the information provided.

Governance and Compliance Obligations

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

Title of Meeting	Board of Directors
Date of Meeting	24 November 2021
Report Title	**Recovery Overview**
Author	Natalie Violet, Corporate Business Manager to the CEO
Responsible Executive	Nick Johnson, Deputy Chief Executive and Director of Strategy, Transformation and Partnerships

1.0 Introduction

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

2.0 Recovery Framework

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

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

3.0 People Recovery

The People Recovery Steering Group
The People Recovery Steering Group is meeting on a bi-monthly basis, the inaugural meeting took place in September. The focus of the steering group is broader than traditional health and wellbeing steering groups. It attends to the foundations of wellbeing – supply, retention, experience, in addition to directing individual and team wellbeing support. The agreed duties and responsibility of the group are as follows:

- Act as a channel through which policies, procedures, and organisational issues relating to people recovery will be discussed. This will include feedback from the regular wellbeing walkabouts and emerging themes from the counselling, Employee Assistance Programme and Occupational Health services.
- To provide communication with, and feedback to, Divisions regarding people recovery initiatives and programmes being supported, implemented, or considered.
- To review annual and quarterly staff survey data and develop appropriate Trust level action plans to raise satisfaction levels in relation to health and wellbeing.
- To review its own performance, constitution, and terms of reference on an annual basis to ensure it is operating at maximum effectiveness

All operational matters shall, wherever possible, be addressed at local department level and only if satisfactory resolution through the appropriate channels and procedures cannot be achieved it will be necessary to refer the matter to the People Recovery Steering Group.

Items discussed during the first meeting included:

- Pressure caused by staff vacancies and the need to better communicate initiatives being undertaken to fill roles.
- How to capture and use information from the wellbeing rounds undertaken by Mental Health First Aiders.
- The need for a roadmap/menu to ensure staff who are looking for support are directed to the correct intervention.
- Support for those who are supporting staff in crisis – leadership development and coaching.
- The ongoing need for more staff rest spaces.

The membership of the group was also discussed, and it was agreed to ask the Freedom To Speak Up Guardian to join future meetings. It was recognised the Freedom To Speak Up Guardian will have useful information to feed to the group relating to matters of concern for staff and vice versa.

Since the first meeting the Trust has signed up to the Stay and Thrive Community of Action; a national initiative to help overseas recruits to settle, progress, and stay within the NHS. This is a key area of work for the organisation, and the outputs will be fed into The People Recovery Steering Group.

Encouragingly the Divisions have already begun to share wellbeing issues with the group. The group will triangulate this with other data provided to the People and Culture Committee and use it to target support from the People Team and others. The group will report agreed actions and outcomes to the People and Culture Committee as an assurance mechanism that necessary action is being taken.

Looking After Our People
The organisation saw a decrease in the overall sickness percentage in September by 0.21% to 4.38%. This is the first reduction since April 2021. This reduction was in long term sickness, short term sickness increased to 2.28% with many staff experiencing non-COVID cold and flu symptoms. The Operational HR team continue to offer additional support to Managers in this regard and regular wellbeing rounds continue to take place, supported by Mental Health First Aiders. The onsite counselling service remains busy with continued uptake from staff. 209 sessions were delivered in October and the present waiting time for onsite counselling is 16 days. Alongside onsite counselling it is evident that staff continue to use other support on offer, including Occupational Health, telephone counselling and access to the Vivup Employee Assistance Programme.

4.0 Service Recovery

Elective Recovery Fund (ERF)
Following publication of the operational planning guidance for the remainder of 2021/22 it has been confirmed the ERF will continue into the second half of the year with £1bn of revenue available. The guidance requires a threshold of 89% of Referral to Treatment (RTT) clock stops, compared to 2019/20. A weighted methodology is applied to ensure that the case mix of activity is comparable and additional income earnt will be based against the weighted income.

A clock stop is where the patient is either treated or discharged and therefore is no longer on the incomplete waiting list. The organisation performs well when monitored against the volume of clock stopping events, with a year-to-date performance of 95.28% against the baseline volume of 2019/20.

Activity type	Target from Oct	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Clock stops	89%	94.68%	92.76%	102.82%	85.96%	97.10%	99.82%	90.20%

Table 1 – percentage of clock stops, by month, compared to 2019/20

ERF Gateways
The metrics in the updated planning guidance and the transformaitonal ask has changed, as a result, the reporting requirements are under development. A full breif and the new reports will be included in the Finance and Performance Committee performance paper from December 2021 onwards. This will then be reflected in the Recovery Overview from January 2022.

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

Analysis of patients awaiting treatment by ethnicity code is undertaken monthly. October's data indicates a variance of 3.55% in patients who identify as white being treated within 18 weeks, compared to patients of an ethnic minority. The variance in performance decreased from September which was

4.75%. There are 213 patients of the total waiting list from ethnic minorities, 1.12%. Further analysis is underway to investigate the difference in wait times and BI Teams across the system are working on automated reporting for deprivation waiting times.

There are several patients with an unknown ethnicity recorded on our Patient Administration System (PAS). Our Information Assurance Team continue to work with services to improve the collection of ethnic group data on PAS.

Elective Waiting List Size

In October the total waiting list decreased by 350 patients compared to the previous month. This takes the total waiting list size to 1,043 below trajectory. The waiting list profile has had a positive change with a 304 patient reduction in the time band 78-103 weeks.

W/L total size	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total W/L trajectory	17274	17171	17516	17711	17812	17599	19816	20571	21470	21818	22406	22815
Total W/L actual	17194	17666	17928	18505	19089	19123	18773					
Variance	-80	495	412	794	1277	1524	-1043					

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

At the end of October, there were 1,911 patients waiting over 52 weeks for treatment. This is a reduction of 213 patients compared to the previous month and 289 fewer than trajectory. This is the lowest number of patients waiting over 52 weeks in a rolling 12-month period.

52+ week waiters	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
52+ww trajectory	3000	3091	3153	3188	3206	3168	2200	2100	2000	1900	1800	1700
52+ww actual	2947	2589	2386	2256	2227	2124	1911					
Variance	-53	-502	-767	-932	-979	-1044	-289					

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

The Trust's approach to service recovery recognises the waiting list demand outweighs service capacity and the need to not overburden staff. Both insourcing and outsourcing activity continues to be utilised. Maxillo-facial are the latest specialty to mobilise insourcing resulting in a reduction of 185 52+ week waiters.

The planning guidance required organisations to a submit 104+ week waiter trajectory. Our submission highlights our inability to reach zero 104+ week waiters by the end of March 2022. At the end of the financial year, we are anticipating 138 104+ week waiters, all of which are in Orthopaedics. Regional mutual aid is currently being explored.

At the end of October, the trajectory is behind plan, with 20 more patients waiting over 104+ weeks than forecasted, the position is expected to be recovered in November.

104+ week waiters	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
104+ww trajectory							169	192	215	109	125	138
104+ww actual	20	41	70	91	117	161	189					
Variance	20	41	70	91	117	161	20					

Table 4 – the total number of 104+ week waiters vs trajectory, by month

Performance within the Region

Following the release of a new regional reporting tool, all providers in the South West are now ranked by waiting list profile. DCH is currently ranked:

- 14th out of 15 for the percentage of the waiting list that is over 52 weeks
- 15th out of 15 for the percentage of the waiting list that is over 78 weeks
- 15th out of 15 for the percentage of the waiting list that is over 104 weeks

DCH however, continues to demonstrate strong recovery, with a reduction in the number of long waiters and continued improved diagnostic performance and the gap between the ranking positions is closing.

STP	Organisation	Total Incomplete Pathways	Number of 52+ Weeks	52+ Weeks %	52+ Weeks % RANK	Number of 78+ Weeks	78+ Weeks %	78+ Weeks % RANK	Number of 104+ Weeks	104+ Weeks %	104+ Weeks % RANK
Grand Total		539,975	32,396	6.0%	1	10,115	1.9%	1	1,667	0.3%	1
BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE STP	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	27,863	666	2.4%	1	131	0.5%	2	1	0.0%	2
	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	31,841	1,336	4.2%	5	186	0.6%	3	0	0.0%	1
	SALISBURY NHS FOUNDATION TRUST	20,195	724	3.6%	4	273	1.4%	6	7	0.0%	5
BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE STP	NORTH BRISTOL NHS TRUST	38,456	2,286	5.9%	7	694	1.8%	8	107	0.3%	8
	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	53,484	3,402	6.4%	9	1,156	2.2%	11	203	0.4%	11
CORNWALL AND THE ISLES OF SCILLY HEALTH & SOCI..	ROYAL CORNWALL HOSPITALS NHS TRUST	35,441	1,125	3.2%	3	276	0.8%	4	17	0.0%	6
DEVON STP	NORTHERN DEVON HEALTHCARE NHS TRUST	17,862	1,235	6.9%	12	184	1.0%	5	4	0.0%	4
	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	67,597	7,076	10.5%	15	2,102	3.1%	14	339	0.5%	13
	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	31,850	2,071	6.5%	10	560	1.8%	7	116	0.4%	10
	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	38,363	2,871	7.5%	13	1,111	2.9%	13	316	0.8%	14
DORSET STP	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	18,815	1,918	10.2%	14	916	4.9%	15	189	1.0%	15
	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	51,798	3,456	6.7%	11	1,441	2.8%	12	252	0.5%	12
GLOUCESTERSHIRE STP	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	62,193	1,654	2.7%	2	199	0.3%	1	3	0.0%	3
SOMERSET STP	SOMERSET NHS FOUNDATION TRUST	32,483	1,831	5.6%	6	652	2.0%	10	105	0.3%	9
	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	11,734	745	6.3%	8	234	2.0%	9	8	0.1%	7

Table 5 – South West Region waiting list profile ranking by provider

South Walks House

In November, we commenced multi professional clinics from South Walks House. We are working in partnership with Dorset Council and our health care colleagues to offer a range of outpatient services under one roof. Initially Orthopaedic clinics are operating from this location, developing a high flow operational model to reduce current waiting times. We have improved collaboration with wider colleagues and services including physiotherapy, hand therapy, MSK and prevention services. Providing the opportunity to run joint clinics and deliver best value patient interactions.

The Family Services and Surgical Division are working with teams to utilise space at South Walks House and community hospitals by relocating outpatient clinics from the main DCH site.

5.0 Summary

The health and wellbeing of our people is our priority. We are invested in delivering initiatives and practices to support our people through listening and learning from lived experiences. This is key to supporting their recovery following the pandemic. Recruiting, retaining, and developing people is vital to the recovery of services. The mobilisation of South Walks House demonstrates the commitment and dedication of our teams. The organisation's waiting list profile ranking in the Region is not ideal however, the significant reduction in 52+ week waiters beyond trajectory is pleasing. Recognising the mismatch in capacity and the demand of services we continue to utilise insourcing and outsourcing of activity, not to overburden our people.

Meeting Title:	Trust Board							
Date of Meeting:	24th November 2021							
Document Title:	**Dorset Integrated Care System Development Programme Update**							
Responsible Executive:	Nick Johnson, Deputy CEO							
Author:	Nick Johnson							
Confidentiality:	Yes							
Publishable under FOI?	Yes							
Purpose of the Paper	To provide an update on the development of the Integrated Care System as anticipated by the draft Health and Care Bill.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	This report provides an update on the development of the Integrated Care System and particularly draws attention to proposals for the Integrated Care Partnership, Provider Collaboratives and Place Based Partnerships.							
Action recommended	It is recommended that: • Note the ICS Development Programme progress • Note and comment on the proposed Integrated Care Partnership proposal • Note, comment and endorse the Provider Collaborative proposals • Note and comment on the Place Based Partnerships proposals							

Governance and Compliance Obligations

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

1. Introduction

1.1 This report provides an update on the development of the Integrated Care System and particularly draws attention to proposals for the Integrated Care Partnership, Provider Collaboratives and Place Based Partnerships.

2. Background

2.1 Following on from initial circulation and comment, proposals for the Integrated Care Partnership and Provider Collaboratives are being taken through governance routes for formal system endorsement in November and December. This will mark a major milestone to begin work to implement these new structures for April.

2.2 Engagement activity continues to develop the proposals around form and function for Place Based Partnerships (PBP), draft proposals are being shared with key stakeholders throughout November

2.3 Recruitment process for the Chief Executive is complete. Formal Chief Executive Officer (CEO) announcements expected mid-November.

2.4 Part 1 constitution consultation has been carried out and Part 2 is to commence shortly with 'appropriate' stakeholders across our Dorset ICS system with the draft Integrated Care Board (ICB) Constitution being complete by end of November.

2.5 It has been agreed to work with NHS England to progress joint commissioning arrangements from April 2022, but not take full delegation of Community Pharmacy; Optometry and Dental services until April 2023.

2.6 Financial framework principles have been agreed through the summit and SLT and are being written into the System Collaboration and Financial management agreement. They will become part of contracts from April 22.

2.7 An expression of Interest has been submitted to NHSE&I for funding and support from The Picker Institute to develop a Citizen's panel for the ICS, which would reach out to diverse communities and areas of inequalities. This panel would be a key enabler for all system partners to collectively and continuously listen and act on, the experience and aspirations of local people and communities – in line with the ICS Design Framework.

2.8 Plans and methodology to develop the People Strategy have been agreed with a senior workforce leads event taken place in October. Professional workforce faculties have identified key workforce themes regarding the integrated Workforce Plan to take forward into the design phase.

2.9 The framework for the ICS Culture development programme has been presented to the System Partnership Board (SPB). NHSEI are keen for Dorset to be one of four system early adopters to test collective leadership methodology and how this can be adapted and applied to a system as opposed to an organisation. The ICS Progression Tool has been reviewed and ICS development plan updated and submitted to NHSE&I for Q2 submission deadline.

2.10 The CCG transition to a New NHS body is on track against plans. The Ready to Operate statement (ROS) has been reviewed and an initial assessment carried out. Work within

the Due Diligence Checklist is well underway, and the process has been agreed through the audit committee.

2.11 A paper went to the Clinical Reference Group (CRG) in September regarding Clinical and Care Professionals Leadership development asking CRG to approve the assessment process and content outlined in the report. An update is due back to CRG in November to agree the proposed actions that need to be taken to meet the national principles. A draft framework will need to be submitted to NHSE&I by 31 December 2021.

2.12 Reporting processes into NHSE has now commenced with Bi-weekly updates on overall programme status and updates on the ROS.

2.13 Naming Conventions guidance was released, which gave rise to very limited options. Draft recommendations based on our current public identity, maintaining simplicity, and understanding of the term integrated to the public are currently being considered.

2.14 The programme is on track against our current plans with focus very much on that critical activity for April 2022 delivery. The Programme is monitoring one risk scoring 12+ relating to tight timescales for delivery**.**

3. Key Issues

3.1 Integrated Care Board

3.1.1 Draft proposals for the Integrated Care Board have previously been agreed by the ICS Programme Board and System Leadership Team. A Chair Designate, Jenni Douglas-Todd, has been appointed and an ICB Chief Executive, Patricia Miller, has been appointed following a national recruitment process.

3.1.2 The focus for the Chair and Chief Executive will now be to complete recruitment of agreed Board positions and ICB Executive Team and finalise the ICB Constitution.

3.2 Integrated Care Partnership

3.2.1 Following the co-design session at September 2021 System Partnership Board and further engagement with key partners a draft proposal for the Integrated Care Partnership (ICP), which was developed and presented to SPB, and SLT in October and November 2021. Appendix A sets out the current proposal for the Integrated Care Partnership.

3.2.2 The proposal is not seeking to freeze the design of the ICP; rather it sets a proposed outline structure and foundation to begin further co-design and co-production work prior to the establishment of the ICS and inaugural ICP meeting in April 2022. Additionally, it should be noted that the ICP will be a dynamic forum recognising the environment that it exists within and evolving accordingly from April 2022 onwards.

3.2.3 The ICP is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on the Integrated Care Strategy, but it does not take on functions from other parts of the system and nor does it hold any statutory authority to hold partners to account. The ICP is expected to highlight where coordination is needed on health and care issues and *challenge partners to deliver the action required.* Together, the ICP will *generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable*.

3.2.4 It has also been agreed that Jenni Douglas-Todd will be the Chair of the Integrated Care Partnership to ensure consistency from the System Partnership Board, of which she is the current Chair, and co-ordination with the Integrated Care Board, of which she is Chair Designate.

3.3 Provider Collaboratives

3.3.1 By 1st April 2022 all NHS Providers must be members of one or more Provider Collaborative. A Provider Collaborative working group, consisting of representatives from across the ICS, has been meeting regularly to develop a proposal (Appendix B) for the establishment of a Provider Collaborative.

3.3.2 In summary the Dorset PC will consist of the three Foundation Trust's and SWAST. There will be primary care representation and it will seek to build on the strong foundations already in place across forums such as UECB, Home First and Elective Care Oversight Board. The PC will interweave with the Place approach with two LAs, and VSCE engagement.

3.3.4 The first phase up to April 2022 will be to establish the governance arrangements for Provider Collaboratives for partners to begin making joint decisions, develop shared transformation plans and lay the foundations to create future accountability and risk. The second phase will focus on developing a shared plan, outlining key delivery priorities for the Provider Collaborative and the ambition for further integration between partners. The third phase will focus on developing thriving collaboratives, establishing formal mechanisms for accountability, allowing risks and benefits to be shared across partners, support delegation of some commissioning functions from the ICB and implementing the ambitions of the collaborative.

3.3.5 There are a number of recommendations in the Provider Collaboratives proposal which are reflective of the above points. For clarity, these are:

- A Provider Collaborative leadership Function should be established
- To support the development of a single Dorset-wide Provider Collaborative
- That a shared leadership board (individual basis) governance model be established where CEO's (or named exec leads) are delegated the authority to make decisions on behalf of their organisation
- the following minimum organisational memberships is recommended:
    - Dorset County Hospital
    - Dorset Healthcare
    - University Hospitals Dorset
- SWAST should also be included in the membership of the Provider Collaborative and attend as required.
- A primary care representative is included in the minimum membership of the Provider Collaborative.
- In principle membership of Provider Collaboratives should also include wider partners, but that this is developed as part of Phase 2 (recognising further work and engagement is needed to determine specific roles and responsibilities of these partners within the governance arrangements).
- Existing priority transformation groups (such as UEC board, Elective Care Oversight Group, Home First Board, Dorset Cancer Partnership Board etc) are realigned to the Provider Collaborative and from April 2022, will report into it. A proposal of existing groups to be

stopped or changed will be brought back to SLT for decision

3.4 Place Based Partnership

3.4.1 A PBP Steering Group consisting of ICS member representatives has developed an initial proposal for Place within Dorset (Appendix C). The paper proposes that there will be 2 Places within the Dorset ICS aligned to the two Local Authority Health and Well-Being Boards. The PBPs will be developed along national guidelines and be adapted and adopted for the Dorset Places.

3.4.2 Further engagement work is required with Place partners to ensure that genuine partnerships, based around communities and populations, are created, which are more than an amalgamation of NHS organisations. By 1st April 2022 PBPs must be defined and established. However, the substance and development of PBPs so that they are the driver of reducing health inequalities and improving the health and well-being of Dorset's communities will be imperative and perpetual.

3.5 Implications for Dorset County Hospital

3.5.1 The creation of statutory Integrated Care Systems with a purpose of joining up delivery and focusing on improving health inequalities and the wider health and well-being of populations is closely aligned to and reflected in the DCH Strategy.

3.5.2 The ICS legislation continues a direction of travel set over recent years at a national policy level of consolidating decision-making at a system level and diluting the autonomy of Foundation Trusts, such as DCH.

3.5.3 Small changes to FT Licenses and the role of Governors are being drafted which will place greater emphasis on collective decision making which places the needs of the population at the forefront of FT decision-making, and, legislation will enable capital budgets to be set at a system level. Subject to the Provider Collaborative proposals it is anticipated that some decision-making authority is delegated from the Trust Board to the Provider Collaborative.

3.5.4 The DCH Strategy identifies clearly states that it is in DCH's overall interests for a thriving and effective Integrated Care System to be operating.

4. Recommendations

4.1 It is recommended that:

- Note the ICS Development Programme progress
- Note and comment on the proposed Integrated Care Partnership proposal
- Note, comment and endorse the Provider Collaborative proposals
- Note and comment on the Place Based Partnerships proposals

DRAFT V2.0

DORSET INTEGRATED CARE SYSTEM (ICS): INTEGRATED CARE PARTNERSHIP (ICP) PROPOSAL

1. Purpose and structure of the paper

This paper has been written following a development session of the Our Dorset System Partnership Board on 9th September which, via a co-design approach, considered the initial design and formation of the Integrated Care Partnership (ICP).

Integrated Care Partnerships are a new addition to the local public sector landscape. The intention is to ensure that the ICP becomes a valued contributor to and facilitator of the work that all partners and the existing forums play in improving the health, well-being and safeguarding of our communities.

The purpose of the paper is to propose an outline design for the ICP for ICS partners to consider and comment on. The design and proposals will evolve through further co-production between ICS partners prior to 1st April 2022.

The proposals set out in this paper have been informed by:

- Discussions at the System Partnership Board (Appendix B)
- The Health and Care Bill
- The Integrated Care Systems Design Framework and associated guidance including but not limited to, Thriving Places, Working in Partnership with the Community, What Good Looks Like for Digital
- Integrated Care Partnership engagement document: Integrated Care System implementation

The paper covers:

- The Purpose of the Dorset Integrated Care System (replicated from agreed ICB Paper)
- The Landscape and importance of recognising the vital role of other existing forums
- The Purpose and Aims of the Dorset ICP
- Principle Functions and Responsibilities of the ICP
- ICS Strategy Development
- Relationships with Integrated Care Board and Health and Well-being Boards
- Chair and Membership
- Secretariat
- Next steps

2. Purpose of the Dorset Integrated Care System (ICS)

The Dorset ICS is being designed to achieve four fundamental purposes:

- Improving population health and healthcare.
- Tackling unequal outcomes and access.
- Enhancing productivity and value for money.
- Helping the NHS to support broader social and economic development.

These are consistent with the national guidelines and the legislation currently proceeding through Parliament. When referring to "population health", this includes people of all ages from children to older adults.

Dorset ICS has set out its vision and purpose namely.

Our Vision: **Working together to deliver the best possible improvements in health and wellbeing.**
Our Purpose: **To transform the planning and delivery of local health and care services**

3. The Landscape and importance of recognising the vital role of other existing forums

Integrated Care Partnerships are a new addition to the local public sector landscape. The intention is to ensure that the ICP becomes a valued contributor to and facilitator of the work that all partners and the existing forums play in improving the health, well-being and safeguarding of our communities.

The proposals in this paper do not seek to replicate or replace the statutory responsibilities or roles of partners or other joint committees and forums.

As the ICP is developed and evolves all ICS partners will wish to ensure that it complements the wider roles of ICS partners and that it does not operate in isolation or duplicate the role of other statutory bodies.

4. The Purpose and Aims of the Dorset ICP

ICPs are a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. The ICP will provide a forum for NHS leaders and local authorities (LAs) to come together, as equal partners, with important stakeholders from across the system and community. Together, the ICP will *generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable*.

The ICP should aim to enhance partnerships to *enable* the system to best support their local communities and address issues which no one part of the system can address alone, including:

- Improving healthy life expectancy;
- Supporting people to live fulfilling and independent lives for longer;
- Improving people's overall wellbeing;

- Addressing health and wellbeing inequalities.

The ICP will be the successor to the Our Dorset System Partnership Board (SPB) and will seek to build on the foundations, successes and strengths of the SPB.

Specifically, the Aims of the Dorset ICP are to:

- Provide a forum for discussion and debate of key system issues
- Setting the ICS priorities through the Integrated Care Strategy
- Focus on facilitating agreement between partners on key health and well-being issues and responses
- Identifying key outcomes and making a difference for all the people of Dorset ensuring the experience of service users and patients remain at the centre of all we do
- Set the culture and tone for the ICS through leading by example
- Openly discuss difficult issues with a focus on what is best for the population
- Provide constructive challenge to the established ways of working
- Ensure that the needs of our people, places and communities are genuinely understood

4.2 ICP Culture Development

A culture development programme will be developed for the ICP which will aim to improve the ability of the ICP to meet its Purpose and Aims.

5. Principal functions and responsibilities

The ICP is a statutory committee of the ICS, not a statutory body, and as such its members can come together to take decisions on the Integrated Care Strategy, but it does not take on functions from other parts of the system and nor does it hold any statutory authority to hold partners to account.

The ICP is expected to highlight where coordination is needed on health and care issues and *challenge partners to deliver the action required*. These include, but are not limited to:

- helping people live more independent, healthier lives for longer
- taking a holistic view of people's interactions with services across the system and the different pathways within it
- addressing inequalities in health and wellbeing outcomes, experiences and access to health services
- improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
- improving the life chances and health outcomes of babies, children and young people
- improving people's overall wellbeing and preventing ill-health

The ICP will be responsible for developing an Integrated Care Strategy in collaboration with people and communities and is able to challenge partners on delivery of that IC Strategy.

6. Integrated Care Strategy

It will be a statutory requirement for ICPs to develop an Integrated Care Strategy (IC Strategy) to address the broad health and social care needs of the population within the ICP's area, which may include determinants of health such as employment, environment, and housing issues. ICBs and LAs will be required by law to *have regard* to the IC Strategy when making decisions, commissioning and delivering services

The IC Strategy will aim to set out the ICP's vision and priorities to develop a consistent narrative and vision for the improvement of health and well-being across Dorset. In developing the IC Strategy the ICP will take account of existing Health and Well-Being strategies and Joint Strategic Needs Assessments and any relevant partner strategies.

Once the IC Strategy is produced it is expected that other relevant partner strategies and plans will be consistent with the IC Strategy vision and priorities and that they reflect and seek to implement relevant parts of the IC Strategy.

ICBs and LAs will be required by law to have regard only to the ICP strategy when making decisions, commissioning and delivering services.

Effectively, the IC Strategy will inform and influence other relevant strategies and plans across Dorset within a continuous cycle of development.

The Health and Well-Being Boards may seek to translate the IC Strategy into a place specific health and well-being strategies and plans which in turn may influence the strategies and plans of Place-Based Partnerships and Providers.

The ICP will need to engage with a range of stakeholders including representatives of local people and the community and voluntary sector to develop the IC Strategy. Accordingly, the IC Strategy development will not commence until after the establishment of the ICB and ICS.

7. Relationships with Integrated Care Board and Health and Well-Being Boards

Health and Wellbeing Boards (HWB) are legislated for at place level, bringing together the NHS, LAs and wider partners to develop strategies for places and Joint Strategic Needs Assessments (JSNAs) for their populations. These are mandatory requirements and essential for improving the health and wellbeing of local populations at the place level.

ICPs, on the other hand, are designed to support partnerships and integrated working across places, at system level, specifically looking at broad health and care experiences and outcomes that cannot be solved by one organisation or place alone.

ICPs should complement the ongoing activities of HWB(s) by promoting integration from the place-level to the system-level. HWB(s) will have local and place-based insight that will be incredibly valuable to the ICP when looking at and developing a strategy to address cross-cutting, long-term health and care challenges.

7.1 Place-Based Partnerships

ICPs should work closely with place-based partnerships to support and promote integrated working from the place to the system level. Place-based partnerships and ICPs will bring together similar statutory and non-statutory partners but ICPs should focus on collecting the experiences and expertise of these partners to address health and care challenges that span across places and organisations.

The place-based partnership workstream will be bringing forward proposals which set out the format of the two PBPs within the Dorset Integrated Care System. These two PBPs will seek to reflect the the east and west of the County of Dorset and will broadly be aligned to the BCP Council and Dorset Council areas, whilst recognising the fluidity of boundaries

The functions and responsibilities of PBPs will be developed over the coming months with a view to the PBPs increasingly taking on responsibility for population health management and service delivery.

8. Governance and Operation

8.1 Chair

It is important that there is agreement between the two statutory members of the ICP on the Chair. It is equally important that there is broad consensus amongst all ICP members.

The Chair will not be selected by virtue of other positions held but rather because the individual is deemed to have the appropriate values, skills and experience to meet the purpose and needs of the ICP at the point of selection.

Initially, it is proposed that the Chair of the ICP will be the current System Partnership Board Chair and the Chair Designate of the Integrated Care Board.

This will ensure continuity from the current System Partnership Board and coordination between the ICB and ICP during the establishment period.

Two Deputy Chairs should be appointed reflecting the ethos of the ICP and its commitment to equal partnership. For example, where the Chair is from the ICB the Deputy Chairs may be the two Chairs of the Health and Well-Being Boards

It is recommended that this is formally reviewed around the anniversary of the establishment of the ICP, or earlier if requested by one of the statutory members.

Formal agreement of the appointment(s) will be required from both the ICB and the Local Authorities. Each partner may decide the nature of the formal agreement in line with their own constitutions and governance.

Remuneration for the role will be considered on an appointment by appointment basis, with formal approval from statutory members. Members who are remunerated for their roles on other partner bodies, such as ICB or LAs will not be remunerated for ICP membership.

8.2 Membership

ICPs should be dynamic and evolve as the needs of local communities change and partnerships mature and therefore Membership will be reviewed regularly and evolve according to the needs and challenges of the system and the effectiveness of the ICP. For example, as Provider Collaboratives evolve there may be no need for all NHS Providers to attend.

Initially the following Membership is proposed as per Appendix 1.

8.3 Wider Public Engagement and Transparency

In addition to Patient and Public Representative Members, the ICP will be transparent and accountable to the local community, by meeting in public with minutes and papers made available online.

Private sections to formal meetings will be permitted to enable confidential discussions, however, these should be by exception and avoided where at all possible. Development style sessions would not be public.

Patient or Service User stories will be encouraged at meetings of the ICP. The ICP may seek to reflect on the difference which good quality integrated care may have had on the story.

We will work in accordance with the 10 principles for working in partnership with people and communities.

8.4 Frequency of Meetings

The ICP will endeavour to meet on a quarterly basis, with a minimum of 2 formal ICP meetings per annum.

The ICP may decide to meet on an informal basis as frequently as agreed necessary by the statutory members

8.5 Quoracy

There must be a minimum of the Chair, one ICB representative and one representative from each Local Authority to constitute a formal ICP meeting.

There will be no voting.

8.6. Annual Plan and Review

The ICP will develop, approve and publish an Annual Plan and Review (after year 1) which will include:

- the planned frequency of formal meetings and development sessions
- a forward plan of items requiring consideration
- what it will do to deliver each of the Aims in the year ahead
- plans for culture and OD development to improve the ability of the ICP to meet its Aims
- Key priorities for the year ahead
- Secretariat hosting and funding
- A review of Membership
- a review of the previous years activity and effectiveness, reflecting on the achievement of Purpose, Aims and general effectiveness

9. Secretariat Function

It is the responsibility of the statutory partners of the ICP to agree how the ICP would be best resourced. They should consider the resources required to provide a secretariat function to the committee, develop and deliver the integrated care strategy and actively promote integration across the system

The Secretariat function will provide a management and coordination function for the ICP. Hosting and funding will be agreed on an annual basis as part of the Annual Plan

Specifically, the Secretariat will support the administration and functioning of the ICP, including providing support for the Chair and ensuring the ICP is fulfilling its duties and obligations.

The Secretariat will not provide a delivery function for the ICP. Delivery will be via partnership members. For example, the ICP has responsibility for developing the ICP Strategy. The Secretariat will ensure the ICP oversees the development but will not be responsible for developing and producing the ICP Strategy.

An ICP Partnership Manager will oversee the ICP Secretariat. This role will be supported by an ICP Support Officer. These may be joint roles with ICB or LA Officer roles (e.g. An individual with responsibility for ICP and Health and ICB or Health and Well-Being Board business).

10. Next Steps

Following discussion at System Partnership Board and System Leadership Team this proposal will be updated to reflect key feedback.

It is not anticipated that the design or format of the ICP is frozen or fixed at a point in time, rather that the ICP format will continue to evolve through further co-design and co-production.

There are a number of particular areas which will need to be considered over the coming months, including but not limited to:

- It is recognised that further work is required to understand in more depth the interfaces of the ICP within the Dorset public sector landscape and to ensure there is clarity of roles and responsibilities
- Further work is required to determine the VCSE, academic and other representatives
- The details of the secretariat will need to be finalised
- A plan for the development of the Integrated Care Strategy will need to be developed

Following further co-production an update will be provided to SPB and SLT prior to the formal establishment of the ICS.

APPENDIX 1

ICP		
Organisation/Sector	**Roles**	**No.**
ICP Chair	-	**1**
Bournemouth Christchurch and Poole Council	CEO Cabinet/Portfolio Holder H&WB Board Chair	**3**
Dorset Council	CEO Cabinet/Portfolio Holder H&WB Board Chair	**3**
NHS Integrated Care Board	Chair CEO Chief Medical Officer or Chief Nursing Officer	**3**
Primary Care	PCN/Place Leads	**2**
Dorset Police	Chief Constable	**1**
Dorset and Wiltshire Fire Service	Chief Fire Officer	**1**
Dorset HealthCare University NHS FT	Chair CEO	**2**
Dorset County Hospital NHS FT	Chair CEO	**2**
University Hospitals Dorset NHS FT	Chair CEO	**2**
South West Ambulance Service Foundation Trust	Exec Representative	**1**
Healthwatch Dorset	TBD	**1**
Voluntary Sector Alliance Rep	A pool of voluntary and community sector representatives will be drawn from the members of the VCSE task and finish group who are co-designing the VCSE alliance	**4**
Wessex AHSN	CEO or delegate	**1**
Higher Education Representative	To be selected from Dorset Higher Education Institutions on rolling basis	**1**
Public and Community Engagement	Chair of the Our Dorset Public Participation Group	**1**
Public and Community Engagement	Lead representative for the Our Dorset Digital Public Engagement Group	**1**
Dorset Local Enterprise Partnership	TBD	**1**

Appendix 2 - SPB

ICP Discussior

SPB Notes (

Appendix 3 - Guidance '5 Expectations'; Dorset ICP Proposal Check

Expectation	What that means	Dorset ICS Proposal Check
ICPs are a core part of ICSs	Equal partnership , influential in setting ambitious strategies Dynamic relationship between ICB and ICP Create mechanisms for constructive challenge	ICB and LA reps on ICP. Requirement for agreement on Chair Chair of ICB also Chair of ICP. Review in place Membership enables challenge Meeting in public and privately
ICPs create space to develop and oversee strategies to improve outcomes	Long-term, outcome focussed – e.g. prevention, care closer to home, reducing health inequalities and enhanced personalisation Look beyond traditional ICS boundaries for solutions and join-up with wider services – e.g. housing, education, employment, transport etc	Aims of Dorset ICP focussed on outcomes Membership of public and patients Membership beyond traditional boundaries
ICPs will support integrated approaches	Integrated provision, strategic plans, budgets for more budget pooling, more joined-up service provision, more streamlined care pathways	Aims promote integration. ICP Strategy will drive integration
ICPs will be rooted in needs of people, communities and places	Champion subsidiarity of decision-making, ensure HWB and JSNA plans inform Strategy Public health, place-based representation, VSCE sector and independent representatives of people and communities	Membership of VSCE orgs, beyond just 'umbrella' organisations, HWB as place reps, along with place patient/public reps
ICPs should take an open and inclusive approach	Collective accountability; creating culture, behaviours and leadership, collaborative and open workplace cultures, population-focused decision making Actively engaging – meeting in public with open minutes and papers	Meetings in public Express focus on culture within aims

Our Dorset
Your Local NHS and Councils Working Together

ESTABLISHING PROVIDER COLLABORATIVES

Recommendations paper

DRAFT V0.1

Contents

1. Purpose of this paper

1.1. This paper has been written following a series of engagement sessions with key members of the Dorset ICS which via a co-production approach considered the design and formation of provider collaboratives

1.2. The purpose of the paper is to set out the outline design for the provider collaboratives for partners to consider and comment on. Following this input the design will be refined and agreed though Our Dorset System Leadership Team for approval and to the System Partnership Board for endorsement.

1.3. The proposals set out in this paper have been informed by:

- The Health and Care Bill
- The Integrated Care Systems Design Framework
- Working together at scale: guidance on Provider collaboratives

1.4. This paper sets out a series of draft recommendations for discussion to inform the final design for Provider collaboratives for Dorset

2. ICS Background

2.1. In November 2020 NHS England and NHS Improvement published Integrating care: Next steps to building strong and effective integrated care systems across England. It described the core purpose of an ICS being to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

2.2. It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes
- collaboration between partners, both within a place and at scale, is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- local flexibility, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

2.3. Reflecting insight drawn from local systems, the document outlined the key components to enable ICSs to deliver their core purpose, including:

- strong place-based partnerships between the NHS, local councils and voluntary organisations, local residents, people who access service their careers and families, leading the detailed design and delivery of integrated services within specific

localities (in many places, long established local authority boundaries), incorporating a number of neighbourhoods
- provider collaboratives, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

3. What Are Provider Collaboratives?

3.1. Provider collaboratives are formal partnership arrangements involving at least two trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience
- Improve resilience by, for example, providing mutual aid
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value.

3.2. Provider collaboratives work across a range of programmes and represent just one way that providers collaborate to plan, deliver and transform services. Collaboratives may support the work of other collaborations including clinical networks, Cancer Alliances and clinical support service networks.

3.3. Providers may also work with other organisations within place-based partnerships, which are distinct from provider collaboratives. Place-based partnerships co-ordinate the planning and delivery of integrated services within localities and alongside communities, while provider collaboratives focus on scale and mutual aid across multiple places or systems.

4. Benefits of Provider Collaboratives

4.1. By working effectively at scale providers can properly address unwarranted variation and inequality in access, experience and outcomes across wider populations, improve resilience in smaller trusts, and ensure that specialisation and consolidation occur where this will provide better outcomes and value. Meeting these challenges is essential to delivering recovery from the pandemic and can only be achieved by providers working together with a shared purpose.

4.2. The specific programmes of work that provider collaboratives have developed to achieve these benefits vary, but clinical leaders and their teams across different providers often consider potential benefits across three areas:

- **Clinical services**, which may include:
    - - standardising protocols, policies and pathways; for example, agreeing referral and assessment criteria to ensure patients are seen in the right place at the right time
    - - expanding access to appropriate and timely health services to ensure that the needs of underserved groups are considered over whole care pathways
    - - delivering service transformation in line with NHS Long Term Plan priorities
    - - designing new models of care
    - - jointly managing clinical demand and capacity

- - increasing staff flexibility to work between sites through aligned contracts, processes and cultures.

• **Clinical support services**, which may include:

- - sharing pharmacy, radiology or similar services
- - supporting pathology and imaging networks in sharing pathology and imaging services, as appropriate
- - sharing patient records to create a more seamless patient experience.

• **Corporate services**, which may include:

- co-ordinating or consolidating, for example, HR, procurement or analytics
- sharing data and informatics
- deploying joint quality improvement and change management frameworks.

5. The National Ask

5.1. All trusts providing acute and mental health services, including specialist trusts, are expected to be part of one or more provider collaboratives by April 2022, working together to agree plans and deliver benefits of scale. Community trusts, ambulance trusts, and non-NHS providers should be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved.

5.2. Systems and their constituent providers have flexibility to decide how best to arrange provider collaboratives, recognising that some providers, including community and ambulance trusts, may need to work across multiple collaborations and/or place-based partnerships and need to consider how best to devote their resources. The specific arrangements should be driven by the purpose – that is, individual providers should come together in provider collaboratives in ways which make sense to achieve benefits of scale, provide resilience and deliver system priorities.

5.3. Whether provider collaboratives are well established or in the early stages of development, it is expected that by April 2022, ICS leaders, trusts and their system partners, with support from NHS England and NHS Improvement regions, as appropriate, will:

- identify the shared purpose of each collaborative and the specific opportunities to deliver benefits of scale and mutual aid
- develop and implement appropriate membership, governance arrangements and programmes (or reflect on this where collaboratives are already in place)
- ensure purpose, benefits and activities are well aligned with ICS priorities.

6. Engagement

6.1. A significant programme of engagement has been held with Key stakeholders across the system including NHS FT CEO's, NED's and NHS Provider Representatives, to view seek the design principles and test out the various options for consideration. Regional NHSE teams and legal views has also been sought to ensure alignment to the legislative and national policy and requirements.

Summary of local views

- Provider collaboratives should drive transformation of services

- We should avoid having too many collaboratives, as they will increase administration costs and complex arrangements will hinder effective decision making
- Consolidate existing groups where possible
- We need to connect people & teams together to build the ownership, it's all about relationships and trust.
- We need to ensure the Patient Voice central in provider collaboratives development

7. Method of Approach

7.1. The Provider Collaboratives Workstream plans to break down the programme into 3 phases distinct phases

- **Phase 1 – Establishing the right structure**
- **Phase 2 – Developing shared decision making**
- **Phase 3– Thriving Collaboratives**

Phase 1 – Establishing the right structure

7.2. Due to the significant operational pressures in the system the ICS programme Steering Board took the decision to deliver the minimum requirements for ICS's for April 2022.

7.3. For provider collaboratives this means establishing the minimum governance arrangements to both; be compliant with legislation and to ensure there is a stable platform to develop thriving provider collaboratives from.

7.4. Phase 1 will look at establishing the governance arrangements for provider collaboratives in order to for partners to begin making joint decisions, developing shared transformation plans and lay the foundations to create future accountability and risk/benefits sharing arrangements.

Phase 2 – developing shared decision making

7.5. Phase 2 of the provider collaboratives work will focus on developing a shared plan, outlining key delivery priorities for the provider collaborative and outline the ambition for integration between partners.

7.6. A programme of leadership development will be initiated to grow the maturity of the collaborative to support better joint decision making and explore how partners can be accountable

7.7. This phase will also begin to explore the opportunities for joined up shared services and support functions, building on the work being pioneered though digital and other local collaboratives

7.8. Phase 2 will explore out of area arrangements for provider collaboratives, developing opportunities to collaborate across the region aligned to patient flows.

7.9. Dorset already supports four formal provider collaboratives at pathway level within Mental Health Services: Forensics, CAMHS, Veterans and eating Disorders. These provider collaboratives represent good examples how partnership groups can mature over time into more formal arrangements to better integrate, share decision making, resources and accountability.

7.10. Phase 2 of the provider collaboratives work will explore which other system groups, clinical networks and communities of practice could be developed into more mature provider collaboratives.

7.11. A collaboration mapping exercise has already been started to begin to identify groups that could benefit from becoming a provider collaborative and those existing groups that could be accelerated to deliver benefits at scale quicker.

Phase 3– Thriving Collaboratives

7.12. Phase 3 will focus on developing thriving collaboratives, establishing formal mechanisms for accountability, allowing risks and benefits to be shared across partners, support delegation of some commissioning functions from the ICB and implementing the ambitions of the collaborative as set out in the roadmap in phase two

7.13. Phase 3 will see the formalisation of additional collaboratives at a pathway/service level where it makes sense to do so and drive benefits at scale across those pathway.s

8. Options for Consideration

8.1. This section aims to explore the variety of options available to Dorset ICS in establishing provider collaboratives in line with the new legislation and national policy for April 2022 and within scope of phase 1 of the programme. The views expressed in the sections below are as a result of the engagement with key Dorset stakeholders, informed by research and advise form legal and NHSE teams. following areas are covered within this section

- Purpose & Function
- Governance models
- Membership
- Decision making
- Other Considerations
- Alignment of delivery priorities

Purpose & Function

8.2. In comparison to other ICS's around the country the Dorset ICS relatively small, only having 3 FTs and already good partnership working between all providers. Though conversations with regional and legal teams, it is suggested that the provider collaborative arrangements for Dorset are kept simple, as fragmenting already good system decision making into many multiple provider collaboratives would be a step backwards for Dorset.

8.3. Through local engagement, it is recommended that Dorset forms a provider leadership function in order to:

- Drive the transformation of services across the whole of Dorset
- Tackle the system's priority areas of common concern and develop and deliver a shared agenda
- Establish a strategic single voice for providers
- Develop maturity in relationships and decision making between providers
- Reduce administrative burden on providers in running multiple smaller structures

- Develop accountability at the topmost provider levels
- Create the governance arrangements that will allow movement funding and resources between providers to better delivery and transformation of services
- Be able to take on delegated commissioning responsibility for some services from the ICB

8.4. ***Recommendation: A Provider leadership Function should be established to allow strategic decision making and create a platform to be able to align other partnerships and collaboratives***

8.5. Though engagement with the Dorset ICS Chief Executive Officers Group, two options for Provider Leadership functions were proposed to be evaluated

- A Single Dorset-wide Provider Collaborative
- Two Provider Collaboratives, one focussing on In-Hospital services and one on Out of Hospital services

Single Dorset-wide provider collaborative

8.6. A single provider collaborative would provide a strategic platform for joint decision making and represent a unified provider voice at the ICB. A Dorset wide collaborative would enable a more strategic conversation to take place regarding deploying resources to the system's biggest problems and allow for better movement of finance and workforce across different service areas. It would allow for a single shared provider deliver and transformation plan to be established and clear line of accountability

8.7. A single provider collaborative would also enable better accountability at the topmost level allowing for inter-organisation risk and benefit sharing arrangements and a better platform to take on potential future delegation of some commissioning functions from the ICB. A single collaborative would also reduce the administrative burden and time commitments by partners

8.8. However, a single provider collaborative would be less likely to have the particular focus that a theme specific collaborative (ie in hospital and out of hospital focused collaboratives) would. Whilst conversations would be at a strategically high level to better configure each organisations approach to deliver, there is potential for the smaller operational decisions to be overlooked in favour of the bigger priorities.

Two Provider Collaboratives, one focussing on In-Hospital services and one on Out of Hospital services

8.9. Under two provider collaboratives, better focus on the specific issues of in hospital and out of hospital services could be established, allowing for more detailed discussion.

8.10. Having a more granular lens on the priorities would allow faster decision making with each specific area and could enable better mutual aid conversations around some of the lower level priorities

8.11. However, separating the decision making would reduce opportunities for moving resource across different pathways, reducing ability to disinvesting one part of the system in order to drive benefits in another. Establishing two provider collaboratives

would also fragment the provider voice potentially creating gaps between services and duplication where some services span both areas.

8.12. Provider representatives within the engagement felt that whilst the two collaboratives would have different focusses all providers contribute to the delivery and transformation of both in out of hospital services. Therefore, the same providers would want to be present in each group and therefore would be a bigger strain on their time compared to a single collaborative. A theme specific model would also Increases administration on providers having to manage multiple groups.

8.13. Through discussion with representatives from provider organisations, it was unanimously felt that a single Dorset-wide provider collaborative would help deliver both the national aims and the local requirements and that the first task of the established provider collaborative will be to determine short, medium and long term priorities in line with the ICB strategy (which could have specific aims regarding in and out of hospital services) and outline the ambition for desired future state of the provider collaboratives within Dorset.

8.14. ***Recommendation: to support the development of a single Dorset-wide provider***

Governance Models

8.15. Provider Collaboratives across the country have taken various different forms, the guidance is very permissive regarding what delivery models should be established and allow for systems to develop their provider collaboratives in a way that most benefits the system.

8.16. NHSE has identified three main models that NHS providers have typically used to form collaboratives under existing legislation. The models are not mutually exclusive; they can be combined or work in parallel, and one may evolve into another.

- **Provider leadership board model**: chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners. This model can also make use of committees in common, where committees of each organisation meet at the same time in the same place and can take aligned decisions. To ensure effective oversight of the provider leadership board, trusts should consider how to involve their non-executive directors in providing scrutiny and challenge.
- **Lead provider model**: A single NHS trust or foundation trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required. Alongside the contract between the commissioner and NHS lead provider, the NHS lead provider enters into a partnership agreement with other collaborative members who contribute to the shared delivery of services.
- **Shared leadership model**: Members share a defined leadership structure in which the same person or people lead each of the providers involved, with at least a joint chief executive. This model can be achieved by NHS trust or foundation trust boards appointing the same person or people to leadership posts. In the case of NHS trusts, this model can also be achieved by the board of one trust delegating certain

responsibilities, consistent with the remit of the provider collaborative, to a committee which is made up of members of another trust's leadership team. Under either of the above approaches each provider's board remains separately accountable for the decisions it takes (even if aligned). Nevertheless, alignment of decision-making can be supported by using shared governance (such as committees in common).

8.17. The way that functions are delegated, and decisions taken, will depend partly on the type of provider. Under current legislation, each NHS foundation trust delegates to a committee of its own directors, and the committee considers issues together with committees of other collaborative members to take aligned decisions and achieve consistency – often called committees in common. NHS trusts take a similar approach, but an NHS trust can delegate functions to non-directors who can exercise those functions on committees that include others who are not employees of the NHS trust.

8.18. Depending on the model selected, will determine the work required and scale of the implantation, models of loser collaboration require less implantation and planning than more complex integrations. Once the model is agreed a detailed delivery plan will be produced outlining the specific deliverables and timescales for implementation

8.19. Whilst NHSE have provided 3 common models for implementation, other delivery models are available. The diagram below highlights a range of different models that could support the establishment of provider collaborative models

Loose Arrangements → **Tight Agreements**

Loose Collaboration	Provider Leadership Board – Individual Basis	Provider Leadership Board – Committees in Common	Contractual Joint Venture	Corporate Joint Venture	Lead Provider	Shared Leadership Model	Single Provider/ Merger
- Leadership Group - Terms of Reference - Principles of Working Together / Collaboration - "Coffee shop chat" - No ability for any decisions to be made, advisory only - Enables a more strategic approach to collaboration	- Leadership Board - MoU/Collaboration Agreement - ToR for the Board - Transactional (less than CIC) - Individuals from each member organisation attend with delegated functions from their organisation. - Individuals use same information to discuss relevant matters and meet in common. - Individuals then make decision for their own organisation. - Aligns decision making but does not share decision making	- Leadership Board - MOU/Collaboration Agreement - ToR for each organisations committee mirrors ToR of other member organisations - Transactional - Each member creates its own committee with delegated functions - Committees meet in Common and use same information to make decisions for their organisations. - Ability to make organisationally binding decisions but not jointly - Enables a strategic approach to collaboration	- Contractual agreement which mimics corporate joint venture approach - Principally is a mechanism to enable service delivery - Can permit joint decision making within contractual agreement	- Options advice would be needed on corporate Vehicles and Powers - Heads of Terms - Articles of Association / LLP Agreement / Constitution - Members Agreement - Services Agreement - Principally is a mechanism to enable services delivery - Can permit joint decision making within JV agreement	- Main Contract held by a single lead NHS provider - Lead providers then Sub Contracts with other NHS and non-NHS providers - Bidding Agreement / Consortium - Heads of Terms - Principally is a mechanism to enable services delivery - Can permit joint decision making within sub-contractual agreement	- Defined leadership structure - Same person or people lead each provider involved - Boards of NHSTs or FTs appoint same person to multiple posts - Enables shared decision making but on a single organisational basis	- Governance and legal advice required to determine feasibility - Will need to demonstrate patient benefit - Heads of Terms - Due Diligence Questionnaire - Due Diligence Report - Interim Management Agreement - Transaction Agreement - Dissolution Order / Transfer Order

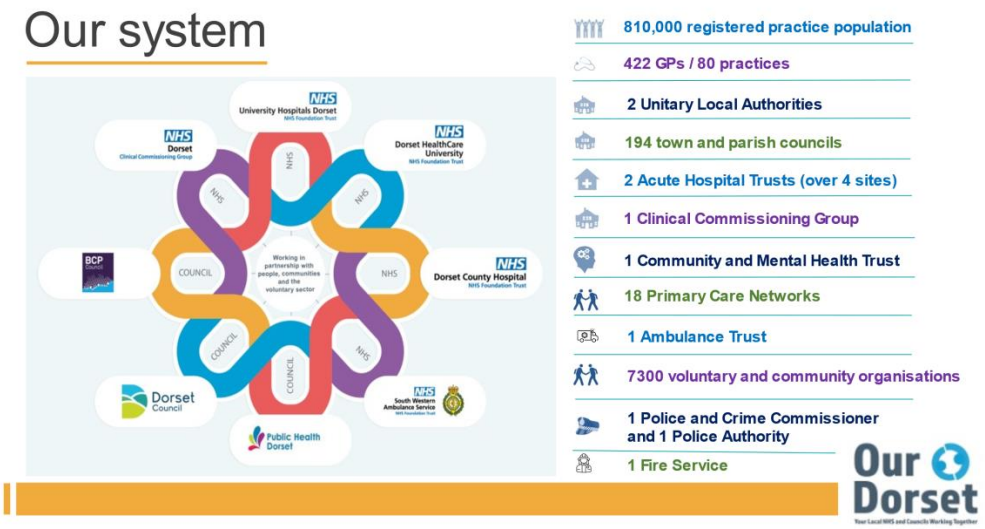
8.20. ***Recommendation: that a shared leadership board (individual basis) model be established where CEO's (or named exec leads) are delegated the authority to make decisions on behalf of their organisation***

8.21. A Committees in Common approach was discussed with provider representatives and dismissed due to increased administrative procedures that are required. Taking lessons from the recent UHD merger work, a committees in common approach would take a significant period of time to embed effectively, require high levels of administration and

create an additional layer of complexity that could slow down decision making in the bedding in period, rather than improving it.

8.22. It is suggested that as part of phase 2, the provider collaborative will explore the appetite for increasing the maturity of the collaborative and therefore the governance model can mature and adapt over time inline with the ambition

Membership



Partners

8.23. ***In order to be compliant with legislation and national policy, all trusts providing acute and mental health services, including specialist trusts, are expected to be part of one or more provider collaboratives by April 2022. therefore, for Dorset the following minimum organisational memberships is recommended:***

- ***Dorset County Hospital***
- ***Dorset Healthcare***
- ***University Hospitals Dorset***

8.24. Community trusts, ambulance trusts, and non-NHS providers should also be part of provider collaboratives where this would benefit patients and makes sense for the providers and systems involved. SWAST is a key provider with the Dorset system but it is recognised that they will be required in a range of provider collaboratives and place based partnerships across the southwest and therefore should be able to attend as required

8.25. ***It is recommended that SWAST should also be included in the membership of the provider collaborative and attend as required***

Primary Care Involvement

8.26. Primary care networks (PCNs), serving the patients of the constituent general practices, play a fundamental role improving health outcomes and joining up services. They have a close link to local communities, enabling them to identify priorities and address health

inequalities. Joint working between PCNs and secondary care is crucial to ensure effective patient care in and out of hospital. Therefore, it is vital primary care is represented within the provider collaborative and able to jointly make decisions with the other partners.

8.27. Work is underway within the CCG's Primary Care Commissioning Team to explore development of a forum for primary care leaders to come together and provide representatives into the various ICS governance arrangements. The Provider Collaboratives workstream will link in with this work to

8.28. ***Recommendation that a primary care representative is included in the minimum membership of the provider collaborative***

8.29. The provider collaboratives workstream was also asked to explore the feasibility of a primary care specific provider collaborative to look at delivery of Primary care at scale. This work overlaps with work to develop a primary care alliance, and additional work is required establish feasibility. An update will provided to SLT on the progress of these conversations

Other Members

8.30. It is also suggested that members representing other key providers within the Dorset ICS are also included. In particular, **local authorities** representing of social care provision, Voluntary Community Social Enterprise **(VCSE)** sector representatives and **independent sector** Provider (ISP) representatives should also be included.

8.31. Further work is needed to determine how these groups should be engaged and how decision making, and financial accountability could work with a wider partner groups

8.32. ***Recommendation that in principle membership of provider collaboratives also includes social care, VCSE ad ISP representatives are included, (recognising further work and engagement is needed to determine specific roles and responsibilities of these partners within the governance arrangements)***

Provider Collaboratives representation in the ICB

8.33. Provider collaboratives will also be represented in the integrated Care Board (ICB) as a voting member, with the Provider Collaborative Chair representing the interests of the provider collaborative at the ICB meetings.

8.34. Initial conversations indicate that one of the members of the provider collaborative should hold the position of chair for the collaborative. Once membership of the collaborative is confirmed, an expression of interest process will be initiated with members, and it is suggested that the designate ICB Chair and Chief Officer review and confirm the appointment

Decision making

8.35. The Provider collaborative will report directly into the ICB with the chair representing the collective views of the collaborative

8.36. In order to make decision, in the provider collaborative, members will need to be delegated the authority form their organisations/ sectors to act on their behalf, and

therefore will need CEO/exec level members. The scope of decisions that the collaborative can make will need to be set out in a collaborative agreement.

8.37. The Provider Collaborative will provide assurances to the ICB and Trust boards/organisational accountable bodies around the decision-making process,

8.38. The Collaborative will produce a shared delivery plan outing key priorities and structure of transformation programmes/initiatives, joint finance, estate and resource plans, and sustainability plans.

8.39. It is recommended that existing priority transformation groups (such as UEC board, elective care board, HomeFirst board, Dorset cancer partnership board etc) are realigned to the provider collaborative and from April 2022, will report into it. A proposal of existing groups to be stopped or changed will be brought back to SLT for decision

Other Considerations

- Partnership groups and existing collaborations/collaboratives
- Shared support Services
- Out of Area/regionalised provider collaboratives

9. Next Steps

- Seek comments and feedback on paper and refine proposals - October 2021
- Formal Agreement of proposals at SB & SLT - November 2021
- Development of detailed delivery plan – November 2021
- Implementation of phase 1 governance arrangements for April 2022 & realignment of existing governance arrangements

10.Summary of Recommendations

- Recommendation: A Provider leadership Function should be established to allow strategic decision making and create a platform to be able to align other partnerships and collaboratives
- Recommendation: to support the development of a single Dorset-wide provider
- Recommendation: that a shared leadership board (individual basis) model be established where CEO's (or named exec leads) are delegated the authority to make decisions on behalf of their organisation
- In order to be compliant with legislation and national policy, all trusts providing acute and mental health services, including specialist trusts, are expected to be part of one or more provider collaboratives by April 2022. therefore, for Dorset the following minimum organisational memberships is recommended:
    - Dorset County Hospital
    - Dorset Healthcare
    - University Hospitals Dorset

10.1. It is recommended that SWAST should also be included in the membership of the provider collaborative and attend as required

10.2. Recommendation that a primary care representative is included in the minimum membership of the provider collaborative

10.3. Recommendation that in principle membership of provider collaboratives also includes social care, VCSE ad ISP representatives are included, (recognising further work and engagement is needed to determine specific roles and responsibilities of these partners within the governance arrangements)

10.4. It is recommended that existing priority transformation groups (such as UEC board, elective care board, HomeFirst board, Dorset cancer partnership board etc) are realigned to the provider collaborative and from April 2022, will report into it. A proposal of existing groups to be stopped or changed will be brought back to SLT for decision

DORSET ICS: PLACE BASED PARTNERSHIPS DESIGN & ENGAGEMENT PROPOSAL

1. Purpose and structure of the paper

National guidance adopted as a foundation with adaptation by Dorset ICS system partners

This paper has been written following an action from the Dorset Integrated Case System (ICS) Place Based Partnerships (PBP) Programme Steering group. The is Steering Group is chaired by the Director at Place, Dorset Council and is the decision-making body of the programme. The PBP programme is part of the wider ICS programme. Its membership represents system partners, details are at Appendix 1.

The purpose of the paper is to invite partners to consider and comment on the design for PBP in Dorset and the proposed engagement and approval process and the delivery plan. This paper will be refined to reflect feedback received.

The proposal has been informed by:

- PBP Steering Group meetings
- System Partnership Board development session
- Dorset Health & Well Being Board development session
- Bournemouth, Christchurch and Poole Health & Well Being Board development session
- Health and Social Care bill
- The Integrated Care Systems Design Framework
- Thriving Places - Guidance on the development of place-based partnerships as part of statutory integrated care systems

The paper covers:

- Defining the geography of Place in Dorset
- The functional design of PBP in Dorset
- The organisational form of PBP in Dorset
- The plan to April 2023

2. Defining the geography of Place in Dorset

There will be 2 Places within the Dorset ICS

2.1 Guiding Principles

• There is no single approach to defining how, and at what scale, partners should come together to work in an ICS. Place-based partnerships should start from understanding people and communities and agreeing shared purpose before defining structures.

• Effective partnerships are often built 'by doing' – acting together and building collaborative arrangements to support this action as it evolves.

• Governance arrangements must develop over time, with the potential to develop into more formal arrangements as working relationships and trust increase.

• Partnerships should be built on an ethos of equal partnership across sectors, organisations, professionals and communities.

• Partners should consider how they develop the culture and behaviours that reflect their shared values and sustain open, respectful and trusting working relationships supported by clearly defined mechanisms to support public accountability and transparency.

2.2 Places in Dorset

As far as possible, the footprint of place should be based on what is meaningful to local people, has a coherent identity and is where they live their lives – such as a town, city, borough or county. The footprint for place-based partnerships must be defined collaboratively, to ensure that it is a meaningful forum for engaging partners to deliver joint actions. The LGA et al in Shifting the centre of gravity recommend:

"Place-based systems should be established following local discussion and considering the role of all the partners who contribute to health and care in a place, including housing, employment and training, and emergency services."

After consideration, it is proposed that Dorset ICS has 2 Places. These Places make sense to our partners and population. The Place boundaries will follow the Local Authority and Police Authority boundaries, broadly split into BCP and Dorset. This means that most PCNs/Neighbourhoods also fall into one Place as do the NHS acute Trusts.

3. Proposed functional design of Place Based Partnerships in Dorset

National guidelines on key functions will be adapted and adopted for the Dorset Places

Place Based Partnerships work within an ICS to support the following aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

Places and Neighbourhoods are ideally positioned to help tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

To work most effectively, Places will undertake the following functions.

3.1 Health and care strategy and planning at Place

A shared vision for Place with local priorities

The PBP will have a common understanding of its population, and an agreed shared vision, including local Place priorities for the delivery of health, social care and public health services at place. The place vision and local priorities will be developed in response to the needs of communities at neighbourhood and place. They will build on existing plans where relevant, such as the Joint Health & Wellbeing Strategy, drawing on insights from Joint Strategic Needs Assessment. The Dorset Intelligence & Insight Service (DiiS) will provide insight to the performance at Place for assurance and improvement.

Building on its vision and local priorities, the place-based partnership will have a role in informing and developing the integrated care strategy agreed by all partners in the ICP. Partners at place will also be responsible for delivering these system-wide plans where relevant.

The 2 Places will work together to provide a single voice with common strategic goals but delivered in differing ways to meet the needs of the local communities. They will also have a mechanism for collaboration and boundary management.

3.2 Service planning & integration

A trusted partner to deliver commissioned services

The PBP will align the commissioning of NHS and local government services around shared objectives and outcomes, involving relevant partners, people and communities. This includes formal joint commissioning arrangements, where NHS and local authority budgets are delegated to a shared decision-making structure and planning decisions are made via a single process.

The PBP providers of health and social care will play an active role in parts of the commissioning process. In particular, place-based partners will work collaboratively to monitor the delivery of services as part of the planning cycle, including sustainability, climate change, quality monitoring, reviewing performance using a DiiS ICS dashboard and outcomes. Place will connect to and integrate with other ICS work streams that rely on Place for delivery, including; workforce & OD, education, digital services & business intelligence and travel.

3.3 Operational management & delivery

Working together to tackle common challenges

PBP will agree to align and share resources, particularly when addressing common issues and opportunities; school visiting, childhood obesity, homelessness, prevention at scale for example. PBP will report performance, escalate exceptional issues that cannot be addressed locally and submit proposals grounded locally. In addition, PBP will act as a central hub for other workstreams to connect to. It will support delivery and help refine how best to delivery locally to PCNs/Neighbourhoods.

3.4 Service transformation

There will be collaborative structured change programmes to improve

Integration and coloration will be a core function of Place: Particularly in the delivery of health, social care and public health services around the needs of the population. Reviewing performance, using the DiiS and taking corrective and improvement action will be a key part of service delivery; partners will work together to identify and resolve most local issues locally. PBP will transform services using a culture of innovation & improvement.

3.5 Engaged people, communities and groups

Our people will have a voice

The PBP will engage with a wide range of people, communities and groups to leverage and invest in community assets and support for improved wellbeing. Partnerships will work with voluntary, community and social enterprise (VCSE) sector partners to understand where there are opportunities to develop service provision to support communities to build resilience and independence. This may also include working with community partners to influence health and wellbeing in the community, including housing associations, education providers and local businesses.

3.6 Population health management & Public Health

The PBP will build on existing population health & public health intelligence and develop the analytical capabilities at-scale. Insight from the DiiS will be used to support care redesign locally, building on existing expertise across the place and system. This is a key component of a quality improvement strategy, prevention and approach to addressing health inequalities.

3.7 Promote health and wellbeing

The PBP will work proactively local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability. This may include aligning plans with public health and other local government strategies and plans. This could include improving the quality of housing and the built environment, skills development and employment support services, promoting active transport and improving the natural environment, climate change and air quality. The NHS and local government may consider opportunities to leverage their role as 'anchor institutions' to support economic opportunity and skills development in their communities, building on existing research.

Figure 1 Dorset Integrated System - Place Based Partnership functions

4. The organisational form of PBP in Dorset

Dorset's 2 Places will build on existing and new forms to support the aims of the ICS

The organisations that will come together to deliver the PBP functions is proposed below. This should be seen as the first of many refinements as we learn and evolve together. The proposal is subject to support and endorsement from suggested organisations.

BCP and Dorset Health & Wellbeing Boards, in close collaboration with the ICP & ICB will lead on Health and care strategy and planning.

There will be regular meetings for each Place. While attendance is to be confirmed, it is expected all stakeholders will be represented. The meeting will predominately manage locally issues locally. It will also share direction received from the HWB boards and ICB, and take updates, escalation items and proposals from the Neighbourhoods. The meeting will be informed by the performance dashboard and use it to generate improvement actions.

There will be 2 new Place & Neighbourhood management & delivery teams. The team will directly support the BCP and Dorset HWB boards and their constituent Neighbourhoods. It will be the hub for Place activity, made up of partners with connections into the ICB, ICS work streams that provide services at Place, the emerging VCSE alliance, people, communities and groups. The teams will lead on service planning & integration, operational management & delivery, service transformation and engagement with people, communities and groups. The team will have direct links to Population health management & Public Health. How these teams are resourced and managed will be addressed post-approval of this paper.

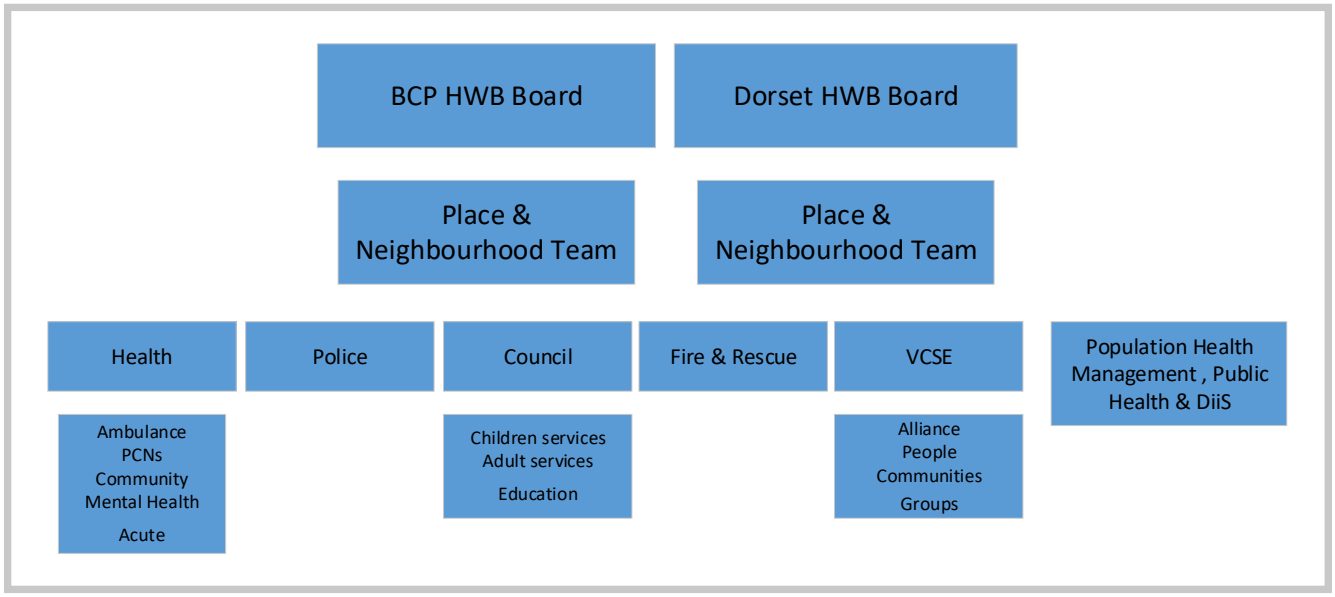


Figure 2 Dorset Integrated Care System - Place Based Partnership form

5. Proposed delivery plan

The Delivery plans to January 2022 and March 2022 are firm. The plan to April 2023 indicates the anticipated main areas of effort.

5.1 To 10 February 2022

Subject to endorsement of this paper, the BCP and Dorset HWB boards will be engaged to capture their feedback and requests for refinement, with a view to securing their support. Depending on the amount of feedback, this may need to be moved to 31 March 2022.

There will be an engagement event for all stakeholders towards the end of November 2021 to present the latest iterations of functions and form. With feedback, the paper will be further refined into a final draft.

On 13 December 2021, the final draft will be presented to the PBP Steering group for approval. If approved, the paper will go to the PDG programme board, Senior Leadership Team and finally the System Partnership Board for approval 10 Feb 22.

The aim is for PBP form and function to be approved by the boards by end of January 2022.

5.2 To 31 March 2022

- Places Defined
    - Boundaries defined
    - Members
    - Roles & Responsibilities
    - Governance
    - Plan
- Neighbourhoods Defined
    - Boundaries defined
    - Members
    - Roles & Responsibilities
    - Governance
    - Plan
- Building on this foundation paper, the detail of functions and form will be developed for approval.
- Resourcing and management for the 2 new Place & Neighbourhood management & delivery teams will be agreed.

5.3 To April 2023

The PBP meetings commence and start to develop their agenda and governance.

The new Place & Neighbourhood management & delivery teams will be created and start to build their capacity and capability.

The Place & Neighbourhood management & delivery teams will start to connect with the BCP and Dorset HWB boards and their constituent Neighbourhoods. The other ICS programme work streams, the emerging VCSE alliance, people, communities and groups.

Identify and support existing work and service change initiatives that affect Place.

Work will begin with Population Health Management, Public Health and DiiS to develop a dashboard that reports the health & Wellbeing at Place.

Paul Lewis MBE
Dorset ICS Place Based Partnerships Programme lead

Appendix 1: Place Based Partnerships Steering Group Membership as of November 2021

NAME	ROLE	ORG	GROUP
Adam Harrold	Director of Operations	Office of the Police & Crime Commissioner	Steering
Alex Sharp	Senior Clinical Lead - Dorset	SWASFT	Steering
Christian Verrinder	Associate Medical Director	Dorset CCG	Steering / working
John Sellgren	Director of Place	Dorset Council	Steering
Kelly Ansell	Service Director - Communities	BCP Council	Steering
Marc House	Area Manager	Dorset & Wiltshire Fire & Rescue	Steering
Mark Callaghan	Chief Superintendent	Police BCP	Steering
Matthew Metcalfe	Director of Finance and Strategic Development	Dorset Healthcare	Steering
Mufeed Niman	GP	South Coast Medical Group	Steering
Nick Johnson	Deputy Chief Executive Officer	DCHFT	Steering
Nicky Lucey	Chief Nursing Officer	DCHFT	Steering
Paul Lewis	Head of Transformation & Improvement	Dorset CCG	Steering / working
Richard Renault	Chief Strategy & Transformation Officer	UHD	Steering
Sally Sandcraft	Director of Primary and Community Care	CCG	Steering
Sam Crowe	Director of Public Health	Dorset Council	Steering / working
Sara Froud	Practice Mgr - Blackmore Vale Partnership	The Vale PCN	Steering
Stewart Dipple		Dorset Police	Steering
Sue Wilkins	Business Development Director	Shore Medical GP Partnership	Steering
Theresa Leavy	Exec Dir for People - Children Mngmt Team	Dorset Council	Steering

Meeting Title:	Trust Board Meeting
Date of Meeting:	24th November 2021
Document Title:	**Trust Strategy Update**
Responsible Director:	Nick Johnson – Deputy CEO
Author:	Ciara Darley – Transformation Programme Manager

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

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

Purpose of the Paper	To provide Trust Board with an update on the Trust Strategy as part of a bi-annual review process							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	Further to the ad-hoc strategy update to Trust Board in September this report has been provided to commence the bi-annual reporting to Trust Board on the implementation of the Trust Strategy. Significant progress has been made since the last report on: • creating a new Board Assurance Framework; • finalising the strategic outcome measures, • establishing the Strategy and Transformation Senior Leadership Group and SLG working group • developing a final draft of the strategic delivery plan • progressing the development of the Clinical and People Strategies							
Action recommended	The Committee is recommended to **NOTE** the update.							

Governance and Compliance Obligations

Legal / Regulatory	~~Y~~/N	
Financial	~~Y~~/N	Not directly
Impacts Strategic Objectives?	Y/~~N~~	
Risk?	~~Y~~/N	Not directly – strategic risks will be developed as part of refreshed BAF
Decision to be made?	~~Y~~/N	
Impacts CQC Standards?	~~Y~~/N	Not directly
Impacts Social Value ambitions?	~~Y~~/N	Embeds SV ambitions as part of Trust Strategy and aligns to SV Pledge
Equality Impact Assessment?	~~Y~~/N	EIAs for any key strategic programmes and initiatives arising

Quality Impact Assessment?	~~Y~~/N	QIA for any key strategic programmes and initiatives arising from the strategy

Board of Directors
DCH Strategy Implementation Bi-Annual Update

1. Introduction

This paper has been developed to provide members of the Board as part of the newly established bi-annual update on implementation of the Trust Strategy.

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

2. Background

Key to achieving the ambitions set out within the Strategy means ensuring that implementation is adequately planned in collaboration with those who will be instrumental to its delivery. Following publication, work has been undertaken to ensure that a proper monitoring body is established to oversee and guide implementation, with the correct information available to assure the Board that changes are having the desired impact. As such, a delivery plan and dashboard are in production, with the process reporting bi-monthly into the Strategy and Transformation Senior Leadership Group (SLG).

This is being completed in parallel to two further noteworthy Strategies which are in production; the Clinical Strategy and People Strategy. These two enabling strategies will help to fulfil some of the key deliverables outlined within the Corporate Strategy and are expected to be completed in March 2022, following a period of Trust wide engagement. Finally, work is underway to ensure that risks to the strategic objectives are adequately identified, monitored and controlled via an updated Board Assurance Framework.

The following sections provide an update on the implementation activities described above and an understanding of the next steps.

3. Key Areas

3.1 Strategy and Transformation Senior Leadership Group (SLG)

The Strategy and Transformation SLG meeting commenced in September to provide a forum to monitor the implementation of the Trust Strategy.

The Strategy recognises that the way in which Dorset County Hospital (DCH) plans and delivers care must change if the organisation is to be sustainable in future, therefore there are a number of longer-term change initiatives currently underway. Prior to the commencement of this new SLG, these initiatives were being developed and initiated without oversight to ensure management, coordination and prioritisation, which is crucial due to the number of

interdependencies and limited resources to deliver. The Strategy and Transformation SLG now provides this oversight.

In November, a Working Group was also established to support both the members of SLG and those who wish to present proposals for consideration. It brings together key leads from across the Trust to discuss proposals, ensuring they are aligned to the Strategy and are developed considering all key aspects, such as Finance, Workforce, IT, Quality and Estates. This provides Senior Leaders with confidence that proposals are effectively worked up prior to SLG and also provides a safe environment for those who have developed the proposal to learn and get the most from their efforts.

3.2 Development of the Strategy Delivery Plan

The Trust Strategy provides a view of what our Trust will look like in future and sets out the aims and actions which help us to achieve these ambitions. To bring this to life, a Strategy Delivery Plan is in draft. It captures the deliverables under the Strategic Themes of People, Place and Partnership and acts as a snapshot to understand the key activities and timescales for delivery.

It was the ambition that the delivery plan will be a collaborative document and therefore the first draft has been shared with leads from across the Trust for feedback and comment regarding the design and content. The plan is also shared with members of Strategy and Transformation SLG at every meeting to demonstrate progress and request further comment and opportunities for collaboration. It is anticipated that the first draft will be completed for sign-off by the December meeting.

Alongside the Delivery Plan, the Strategy Dashboard is also in production and has been shared with members of the Strategy and Transformation SLG for comment. The ‘People’ measures will be aligned to the People Performance Dashboard with guidance from HR Leads. The ‘Place’ and ‘Partnership’ metrics will also link to ongoing quality reporting, providing the hook between their measures and the dashboard.

The agreed outcome measures and metrics for the dashboard are as follows:

People	• Friends and Family Test • Workforce Race Equality Standard • Workforce Disability Equality Standard • Quality Improvement Metrics • Gender Pay Gap • Recruitment and Retention
Place	• Quality (CQC) • Reduced admissions per 100k population • Increased number of patients treated remotely • Increased clinical space available • Increased number of locally employed people and local spend

	• Reductions in health inequalities
Partnership	• Improving patient experience • Improving waiting times and access to planned services • Increasing productivity and efficiency measures • A thriving ICS

3.3 Board Assurance Framework

There was a need to ensure that the Board Assurance Framework was updated to align to the Strategy. In the first instance, risks were carried over from the existing BAF to see if the template and contents were fit for purpose. Following discussions with the Executive Team, it was felt that the aims under the three strategic themes could be further developed into measurable objectives which would allow the risks to be better identified and aligned. At this stage there was also the opportunity to review the BAF template with a number of examples presented for comment. It was felt that the example from NHS Providers could work for DCH and therefore has been developed with the strategic objectives for input by Risk Owners.

The newly revised BAF has been submitted to the November Risk and Audit Committee for further comment and input.

3.4 Enabling Clinical and People Strategies

The Trust Clinical and People Strategies are key enablers to the delivery of the Trust Strategy.

A Project Team was established and has been focused on supporting ten engagement events across the two clinical divisions. Each Divisional Triumvirate and Care Group has
been invited to attend an externally facilitated away day to encourage strategic thinking which will help to inform both the development of the Clinical and People Strategies, but also individual departmental strategies and planning. The away days commenced on the 4th October and are due to run until the 23rd November 2021. Planning is in place to arrange a Feedback Session on the 2nd December 2021 to bring both Divisions and our Support Services together to share outputs and provide a further opportunity for engagement across divisional boundaries. Throughout the engagement period, findings and key themes are being collated to help form the basis of the Clinical and People Strategies, which are due to go to Trust Board in March 2022.

4. Progress and Next Steps

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

	Q1 2021/22	Q2 2021/22	Q3 2021/22
Strategy approval from Trust Board	✓ Delivered		
Develop materials to support and promote Trust Strategy		✓	

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

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

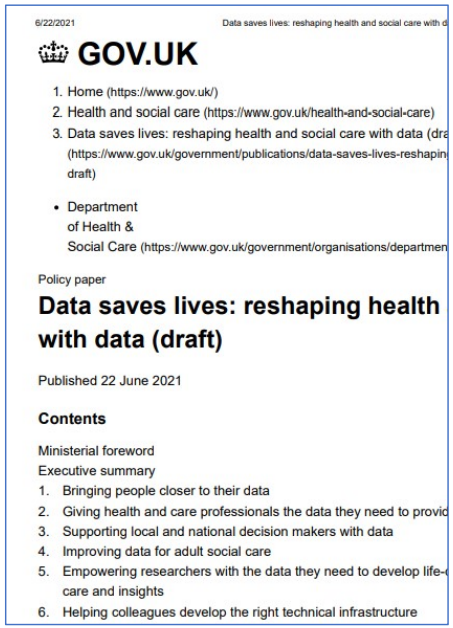
- Continued review of the Key Lines of Enquiry from the Well-Led Framework to ensure that we are successfully embedding the Strategy
- Continued focus on the role of the Strategy and Transformation SLG
- Approval of the Strategy Delivery Plan as a working document
- Completion and approval of the Strategy Dashboard
- Approval of the refreshed Board Assurance Framework and embedding within the Trust
- Completion of the Trust Clinical and People Strategies – planning for delivery starting in Q1 2022
- To establish the strategic planning cycle, ensuring alignment to the corporate planning cycle supported by The Head of Corporate and Strategic Planning – employment starting in Dec 2021

5. Recommendation

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

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

Dorset Intelligence & Insight Service (DiiS)



6/22/2021 Data saves lives: reshaping health and social care with d

GOV.UK

1. Home (https://www.gov.uk/)
2. Health and social care (https://www.gov.uk/health-and-social-care)
3. Data saves lives: reshaping health and social care with data (dra (https://www.gov.uk/government/publications/data-saves-lives-reshapin draft)

- Department of Health & Social Care (https://www.gov.uk/government/organisations/departmen

Policy paper

Data saves lives: reshaping health with data (draft)

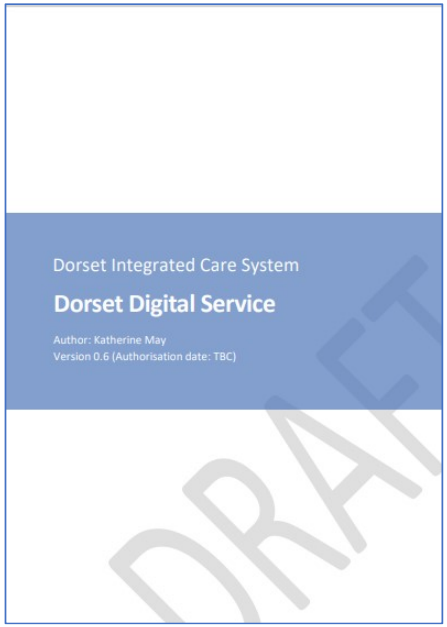
Published 22 June 2021

Contents

Ministerial foreword
Executive summary
1. Bringing people closer to their data
2. Giving health and care professionals the data they need to provid
3. Supporting local and national decision makers with data
4. Improving data for adult social care
5. Empowering researchers with the data they need to develop life- care and insights
6. Helping colleagues develop the right technical infrastructure

NHSE – Data Saves Lives

ICS – Dorset Digital Service



Dorset Integrated Care System

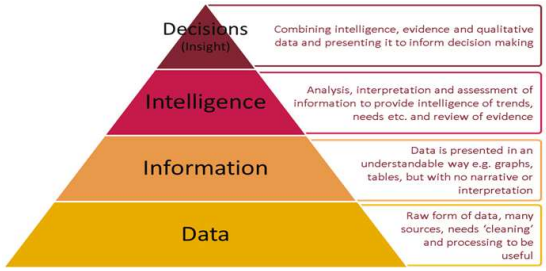
Dorset Digital Service

Author: Katherine May
Version 0.6 (Authorisation date: TBC)

DRAFT

Outstanding care for people in ways which matter to them

Dorset County - Business Intelligence



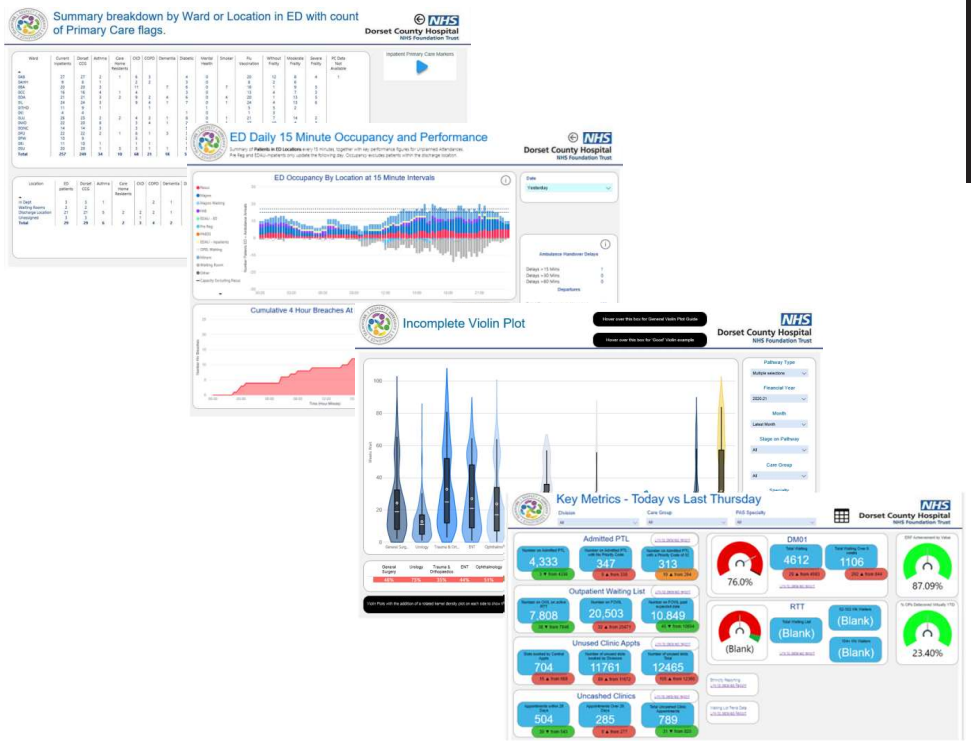
"To put accurate and timely intelligence at the heart of all **decision making**.

By providing intelligence that's accurate, accessible in real time and configurable to meet different needs, ultimately resulting in the provision of targeted and reliable data where and when needed to support the delivery of safe and compassionate care."

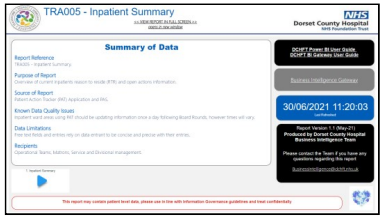
Outstanding care for people in ways which matter to them

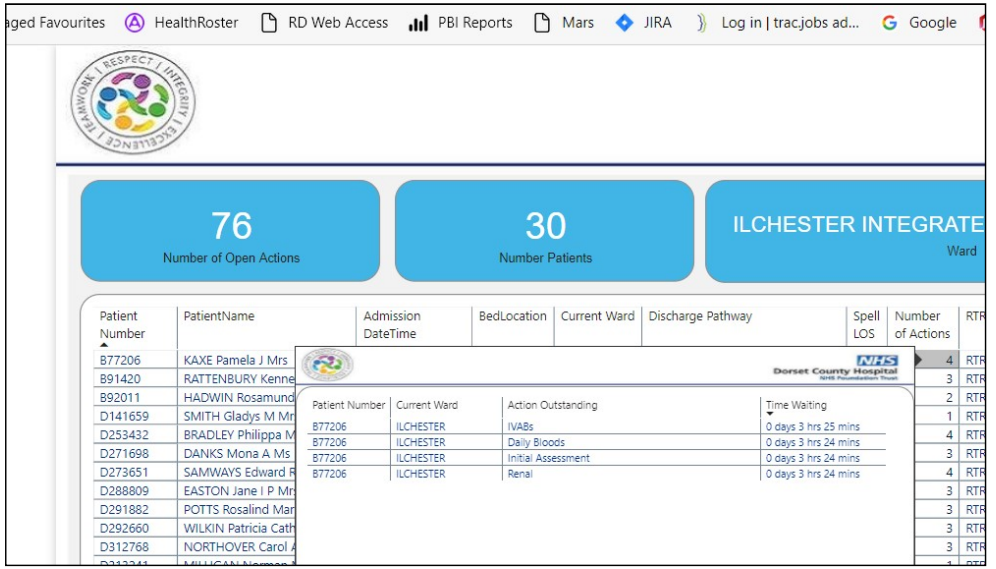
DCH from Information Team to BI Service

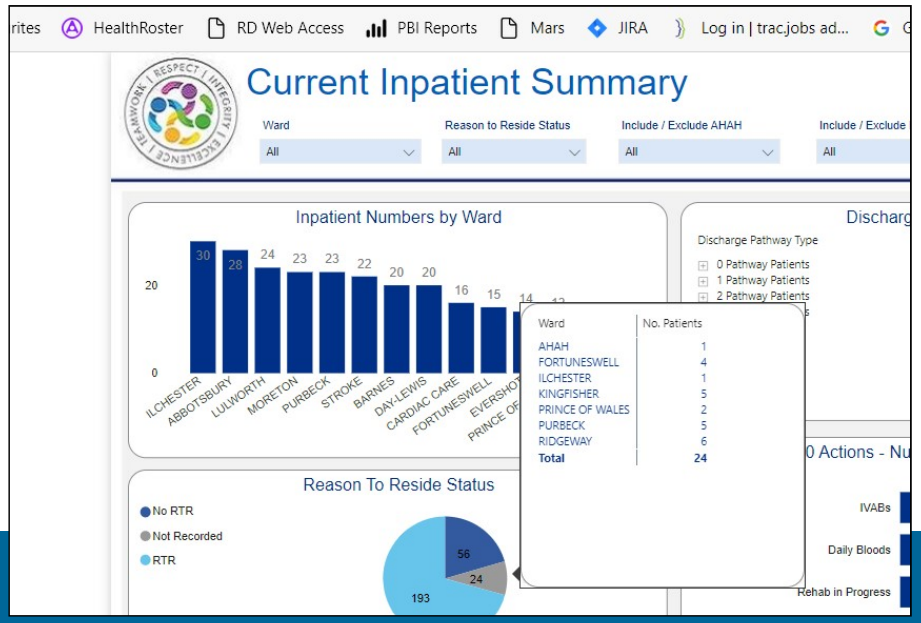
- Team restructure – focus on Business Partnering
- Trust BI Gateway Launch
- Trust BI Champions network Launch
- Consume Primary care data into Trust
- ESR/Workforce Data automated data transfer
- DCH Analysts embedded in centre of excellence
- Learning Sessions across UHS and DCH teams
- Created roles funded across DCH and ICS
- Collaborative leadership across teams



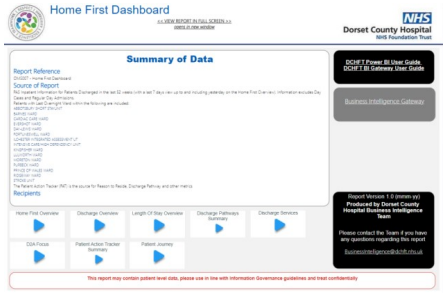
DCH Patient Action Tracker/Home First

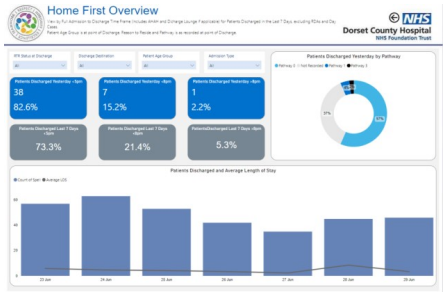


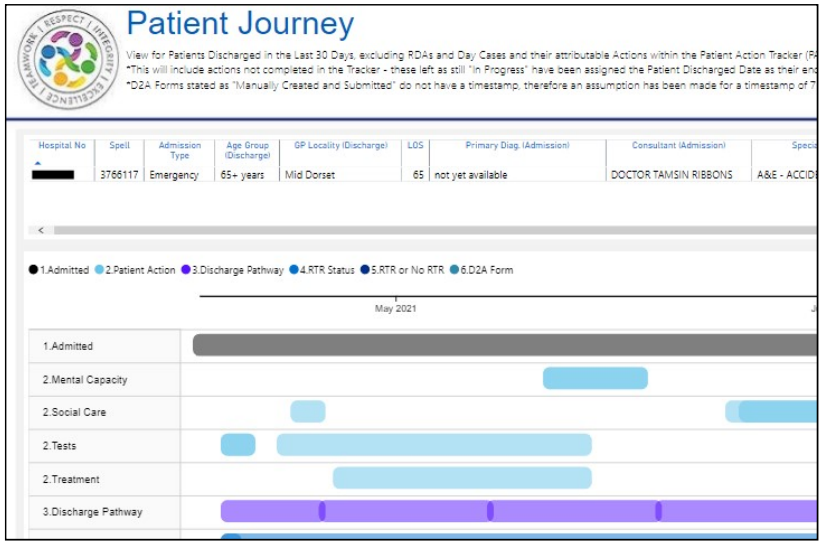


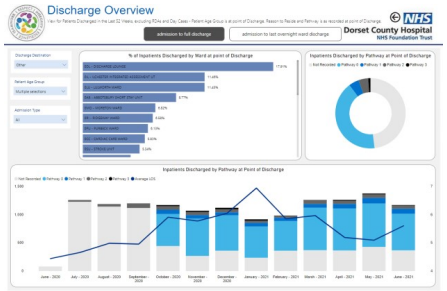


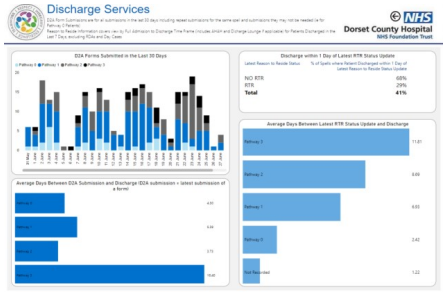
DCH Patient Action Tracker/Home First



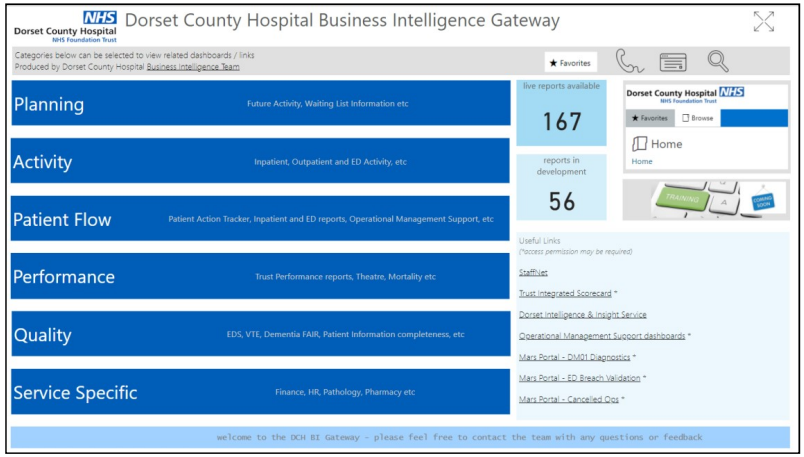


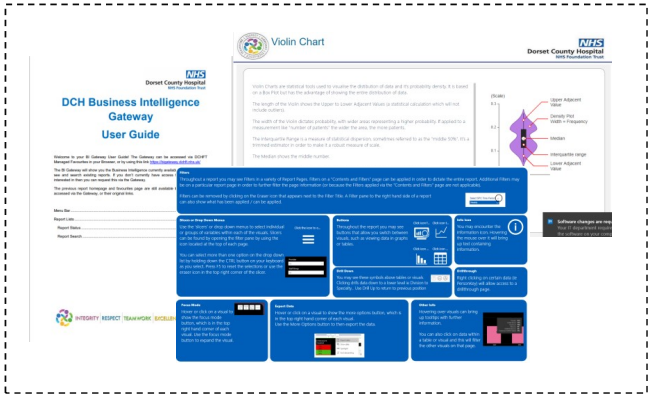


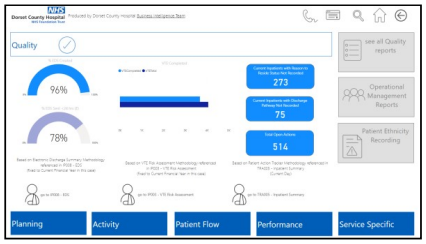


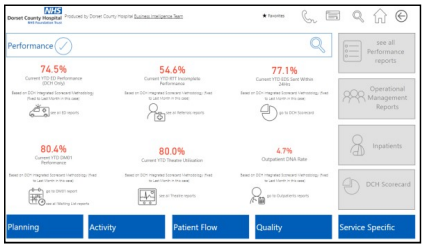


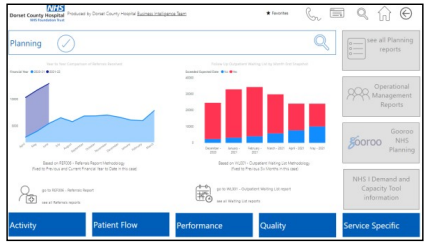
DCH BI Gateway



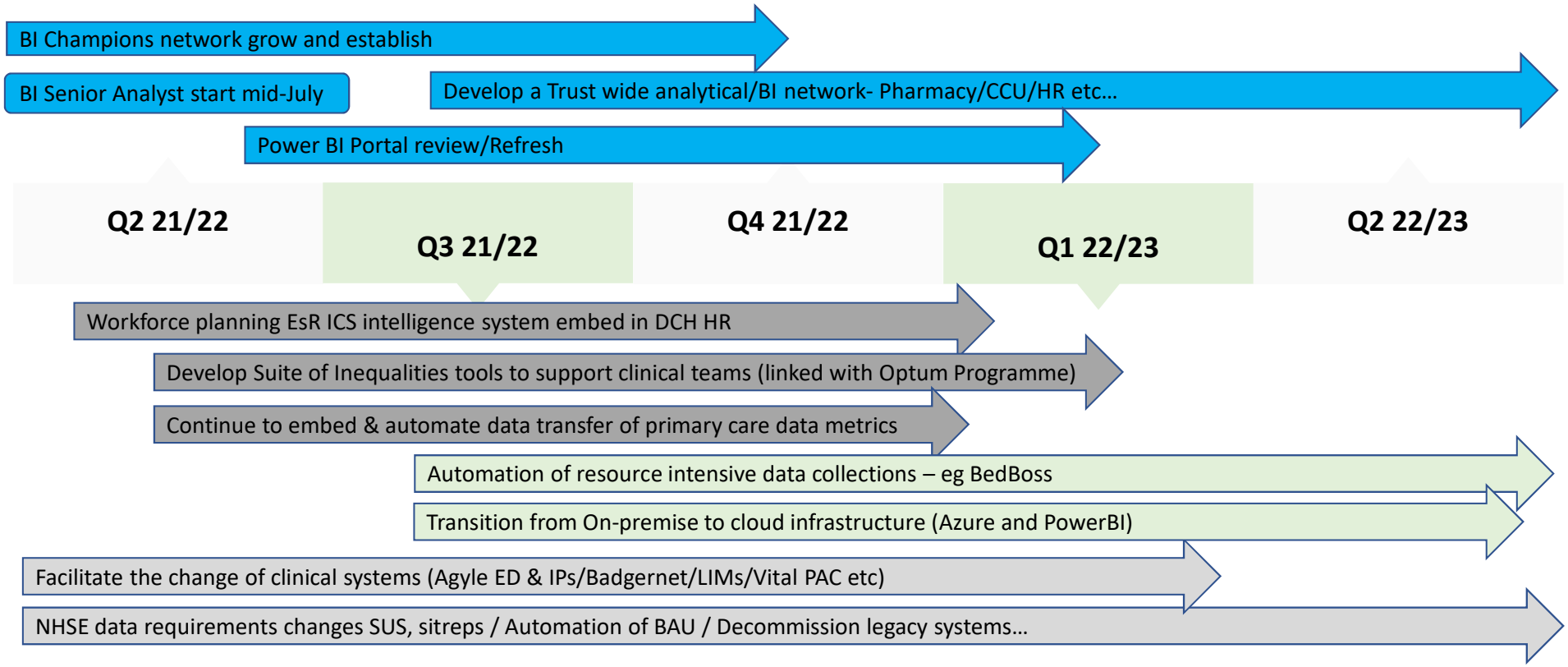








The Next Year…



transparity

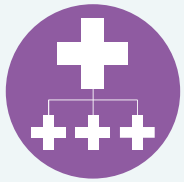
transformation • partnership • clarity

Welcome to the DiiS

The Dorset Intelligence & Insight Service (DiiS) is a collaborative service to deliver a live, linked health and social care dataset across Dorset Integrated Care System (ICS). The aim is to make health and social care data open, easy to access, and available to create actionable insights. It is being used to support data-led service improvement, planning and decision making at a system and organisational level – and more recently during Dorset's COVID-19 response. We've been working together from the start with partners, community groups, and industry to provide analytics to deliver better health and wellbeing outcomes for Dorset people.

The DiiS is being used every day by health and care professionals across Dorset to make evidence-based decisions to improve the health and wellbeing of our population. This has been in particular evidence during the COVID-19 pandemic, where the DiiS has become a tool at the forefront of Dorset's analytical response linking data from primary care, acute and community providers on a near real time basis. Other examples of this include:

- Case finding/Targeting for individuals or cohorts (including secure re-identification of patients or service users to those who manage their care)
- Population Health Management: the ability to group by medical, mental health, demographic and socio-economic markers to identify points of earlier intervention in the pathway
- Provision of wider population-based insights to enable the use of social prescribing

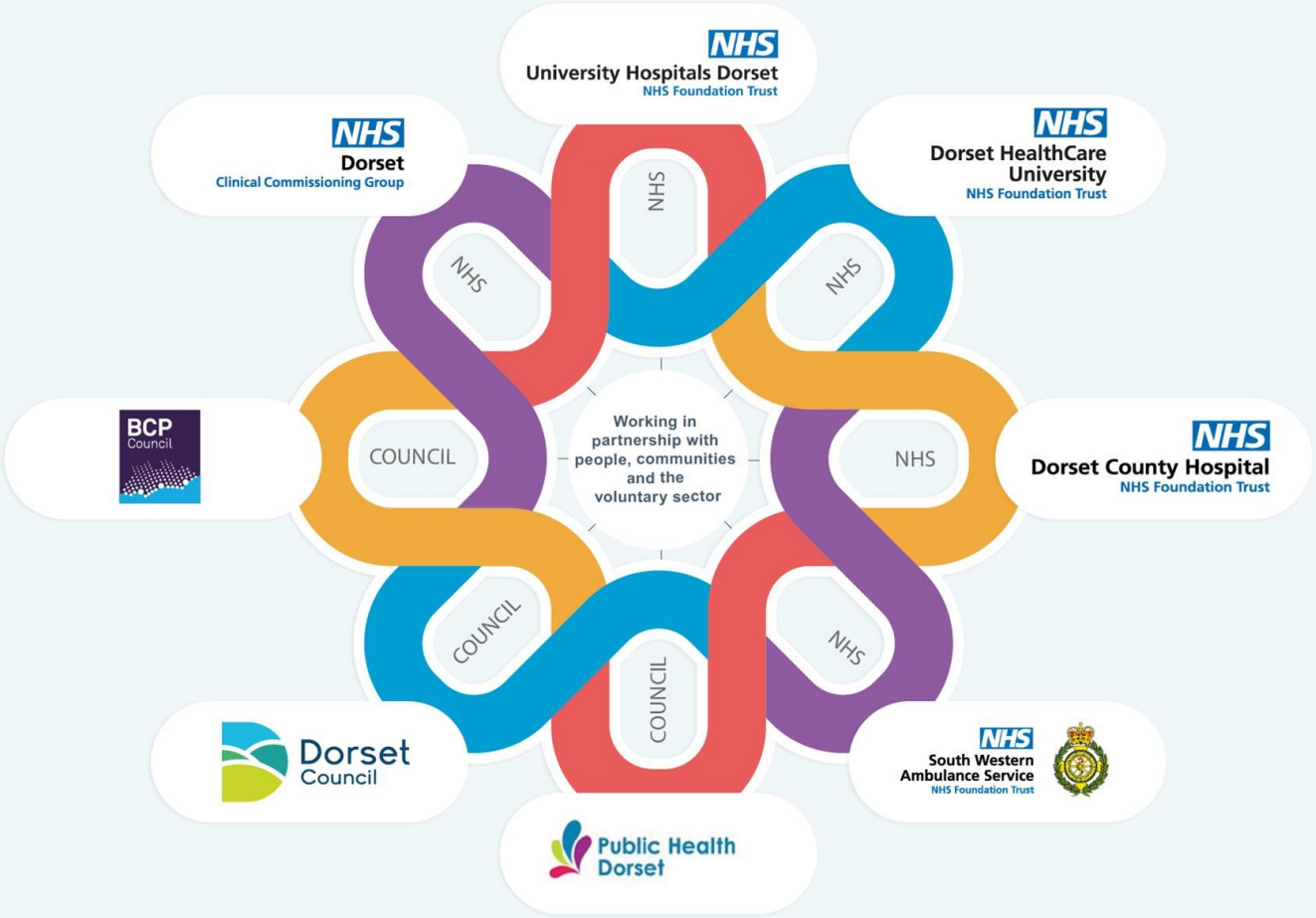


18
primary care networks

77
GP practices

810,000
registered population

Dorset Integrated Care System and Partners



&

NHS England

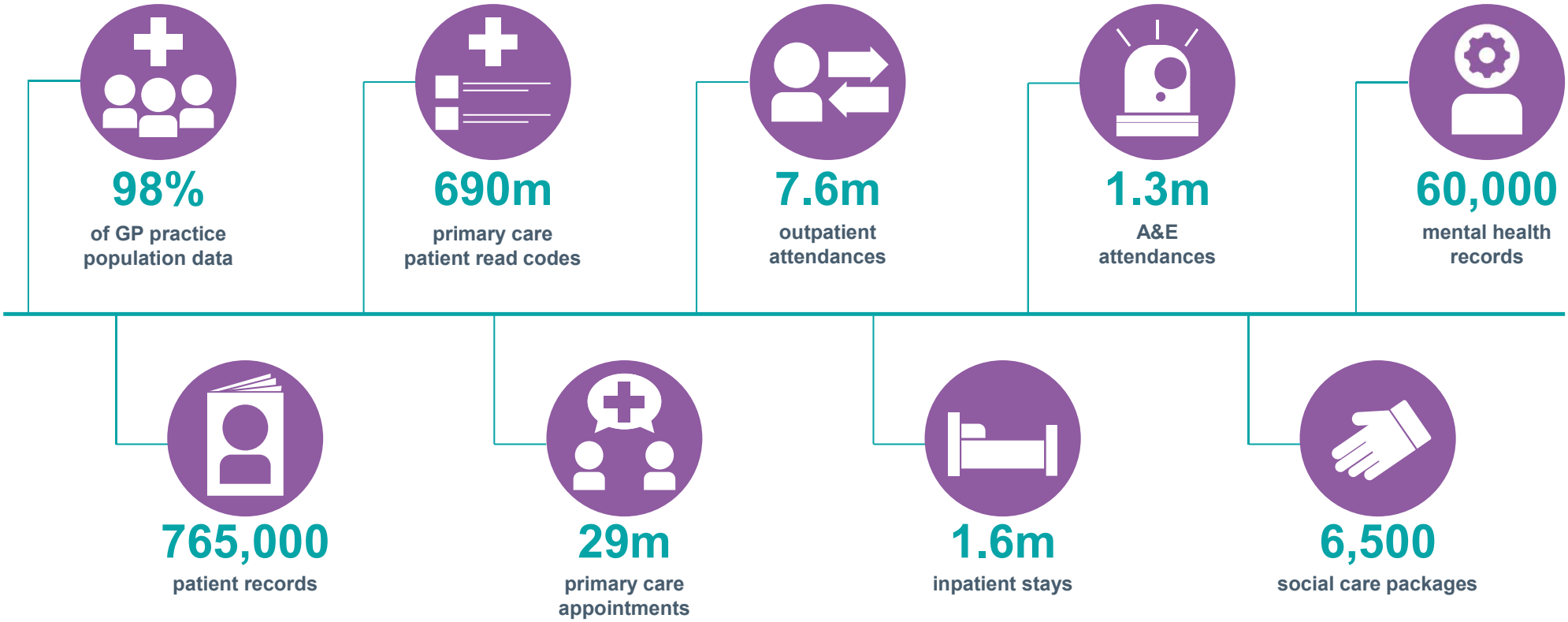
DORSET & WILTSHIRE FIRE AND RESCUE

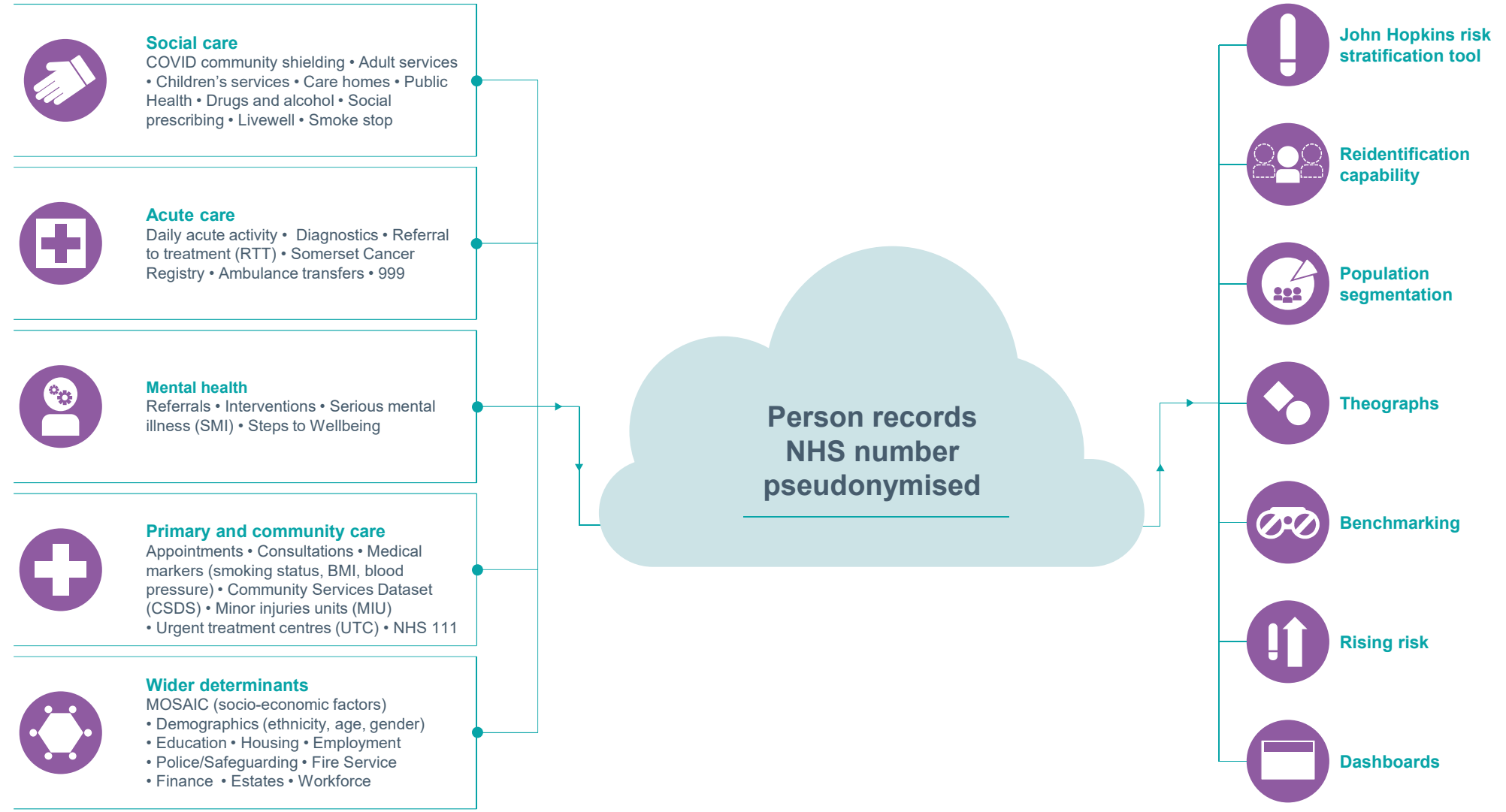
Dorset Police

Microsoft

acg JOHNS HOPKINS

Live linked datasets




Social care
COVID community shielding • Adult services • Children's services • Care homes • Public Health • Drugs and alcohol • Social prescribing • Livewell • Smoke stop
Acute care
Daily acute activity • Diagnostics • Referral to treatment (RTT) • Somerset Cancer Registry • Ambulance transfers • 999
Mental health
Referrals • Interventions • Serious mental illness (SMI) • Steps to Wellbeing
Primary and community care
Appointments • Consultations • Medical markers (smoking status, BMI, blood pressure) • Community Services Dataset (CSDS) • Minor injuries units (MIU) • Urgent treatment centres (UTC) • NHS 111
Wider determinants
MOSAIC (socio-economic factors) • Demographics (ethnicity, age, gender) • Education • Housing • Employment • Police/Safeguarding • Fire Service • Finance • Estates • Workforce
Person records NHS number pseudonymised
John Hopkins risk stratification tool
Reidentification capability
Population segmentation
Theographs
Benchmarking
Rising risk
Dashboards

How DiiS supports PHM

The DiiS is being used every day by health and care professionals across Dorset to make evidence-based decisions to improve the health and wellbeing of our population.

- Tool at the forefront of Dorset's COVID-19 analytical response linking data from primary care, acute and community providers on a near real time basis
- Case finding / Targeting for individuals or cohorts (including secure re-identification of patients or service users to those who manage their care)
- Population Health Management: the ability to group by medical, mental health, demographic and socio-economic markers to identify points of earlier intervention in the pathway
- Provision of wider population-based insights to enable the use of social prescribing

How DiiS supports PHM

"Improving the health of Dorset's population will depend not only on clear vision, leadership and high quality services but on embedding a strong and consistent Population Health Management approach. This must be developed at all levels of our ICS – whether this be at primary care network, integrated health and care partnership or at ICS level. We will at all times look to improve care, identify gaps in care and target populations who will benefit from a risk stratified approach to the way we look after people, embedding service redesign and quality improvement to improve outcomes. This will be achieved through the development of new care models in our evolving Primary Care Networks and the wider system that support them. The Dorset executive is committed to embedding this approach, building on the success of the first pilot areas and rapidly rolling out the development programme to all newly formed PCNs and the wider system."

– Sam Crowe, PHM SRO & Director of Public Health and Dr Karen Kirkham, ICS Clinical Executive Lead

For more information, on PHM, visit https://nhsdorsetccg.sharepoint.com/sites/iwp/SitePages/PHM.aspx

The Vale Primary Care Network (PCN)

The Vale recognised that overall health is determined by a range of social, economic and environmental factors, and that social prescribing could address and support individual needs in a holistic way by asking 'What matters to you most?'. They also identified that 30% of clinical appointments were related to one or more non-clinical need(s). During the initial COVID-19 lockdown, they looked at their team of Social Prescribers and how they could work closely with key partners in a proactive approach.

Weekly Huddle

Clinicians, link workers, self-management coaches and social prescribers discussed and reviewed cases.

Segmentation

Using the DiiS COVID-19 Insights report they ran searches for people with significant risk factors. The data was segmented using criteria including social vulnerability, mental health and long-term health conditions.

Intervention

They designed a different intervention for each group. For example, for those at low risk but with a history of mental health issues they texted out contact details of relevant support groups, helplines and websites.
They asked their frailty Advanced Nurse Practitioners to contact those with significant Covid-19 health risk to identify any current unmet clinical needs whilst the Social Prescribing team contacted a group with low Covid-19 risk and social vulnerability to offer a conversation about their current support needs.

From a cohort of 94 contacted, 75% received a social prescribing offer with a recorded outcome; these were people who had not approached any services themselves and most were struggling with the impact of lockdown.

"Looking at how we can deploy our community teams to focus their workload to get best value and outcomes. Historically there has been no evidence or data to inform us of who needs care, when, how and why. By using the data, we can now target populations in a proactive manner and hopefully improve outcomes possibly measured by a reduction in segmental drift."

– Local GP

How DiiS supports PHM

COVID-19 Risk Groups

Data updated: 01/03/2021

Local Authority: All

Primary Care Network: All

Practice N: All

Reset Page

Link to Risk Group and Mental Health Criteria Definitions

Link to Socio-Economic Criteria Definitions

Filter by CC

Covid F

COVID

Filter table by patient variables:

COPD | Diabetes | CKD Stage 3-5 | In a care residence

Risk Group Matrix:

Risk Group Name	Very High Covid Risk (Shielded)	High Covid Risk LTC	Low/Med Covid Risk LTC	No Covid Risk	Total
Mental Health Risk and Social Vulnerability	1,130	464	914	1,144	**3,652**
Mental Health Risk	4,135	2,114	7,016	14,278	**27,543**
Social Vulnerability	5,170	4,792	9,463	7,304	**26,729**
Increased Risk of Serious Illness	2,821	3,311	13,803	4,136	**24,071**
No Mental Health Risk, Social Vulnerability or Serious Illness Risk	37,711	39,972	182,781	459,189	**719,653**
Total	**50,798**	**50,568**	**213,728**	**485,503**	**800,597**

COVID-19 R

- hover ove

Group 5 V

Weymouth

Poole Cent

Sh

Poole Nort

Bournemo

How DiiS supports PHM

Cross cohort considerations for further tailoring of care offer

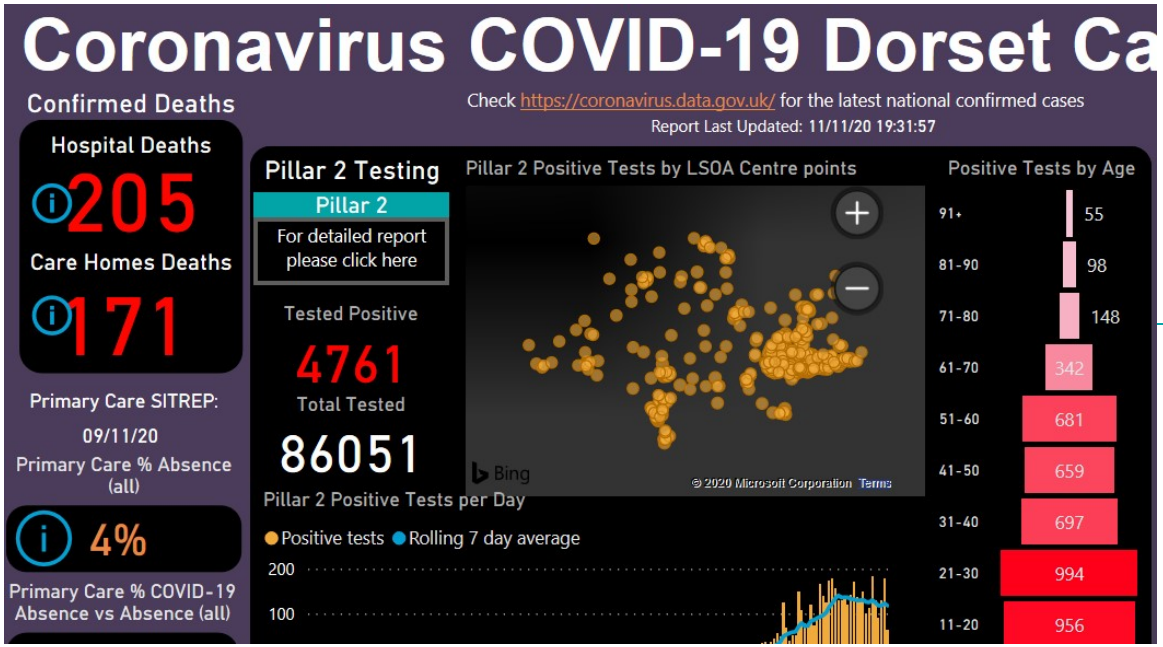
- English not first language
- Digital literacy, access
- Key worker?
- Caring responsibilities, who? How?
- Crowded or poor quality

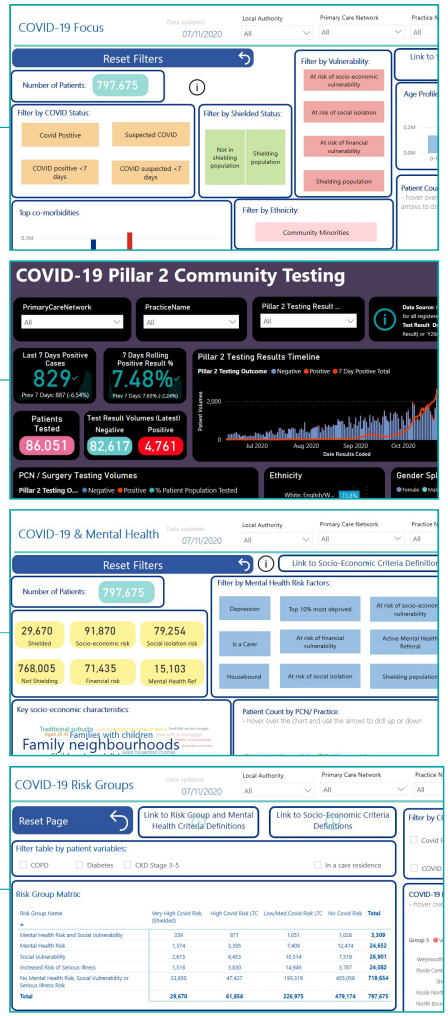
Covid Care Models matrix	No specific Covid risks	Single high risk (local)	Multiple
All / no specific vulnerabilities	• Whole population messaging on social distancing, health and well-being support and exercise • Maintain social distancing • Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• Practice nurse check in by phone • Holistic care planning/care plan virtual review/LTC patient APP • Sign posting to tele health options national/local for particular conditions e.g. Help Diabetes management web	• Proactive Remot blood sugars, we APP • Virtual Group co Somerset LTP pa
Mental health	• National websites, apps helplines (guided by Nat Covid workstream) • Leaflet drop • Town council helpline • Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• e check in wellbeing worker • planning in partnership with patient (and carer where relevant) • Health champion virtual groups • Social prescribing signposting to Dorset MIND for online group support. and access to The Vale First Contact MH practitioner., Steps to Wellbeing.	• Clinician for initi management / • Holistic MDT care patient (and ca • Health Champio Café online for c • Social Prescribin practitioner., Ste
Social vulnerability	• Leaflet drop • Town council helpline • Social prescribing wellness call from Help & Care or local SP practitioner. Social Prescribing to Help and Kindness website for pan-Dorset support directory.	• Practice nurse check in • Care coordinator assigned • Holistic care planning in partnership with patient (and carer where relevant) • Practice Nurse for initial contact, then care coordinator with MDT • Social prescribing support signposting to Livewell Dorset/Age Concern	• Clinician for initi management • Holistic MDT care patient (and ca • LA team to supp remote tech fro • Health champio management.
Social vulnerability + mental health	• Social prescriber assigned to conduct Wellness Calls	• Practice nurse check in • Health and wellbeing worker	• Clinician for initi

Social prescriber resource targeted to where most needed

How DiiS supports the COVID-19 response

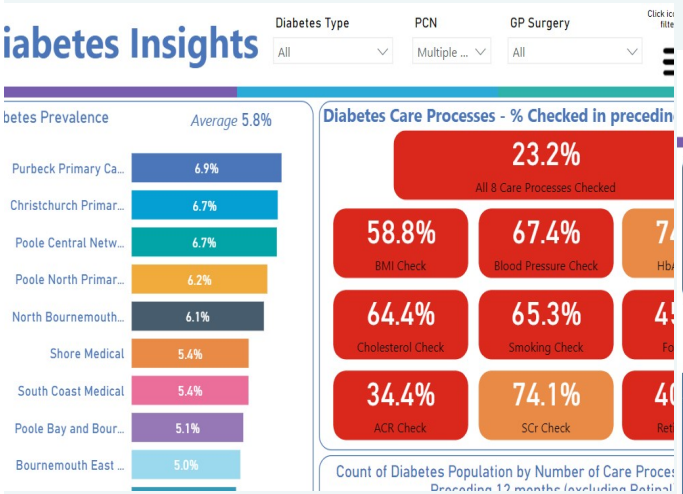
Automated, live data provides a system–wide view of COVID cases, across acute, community and primary care settings, enabling us to better understand the spread of the disease locally and model capacity and demand. Analytics focusing on vulnerable or at risk populations, including those with mental health conditions, has helped clinical colleagues to identify specific groups who may benefit from a directed, pro-active approach. Using this data they have focused their workforce on these groups dependent on social as well as clinical need.

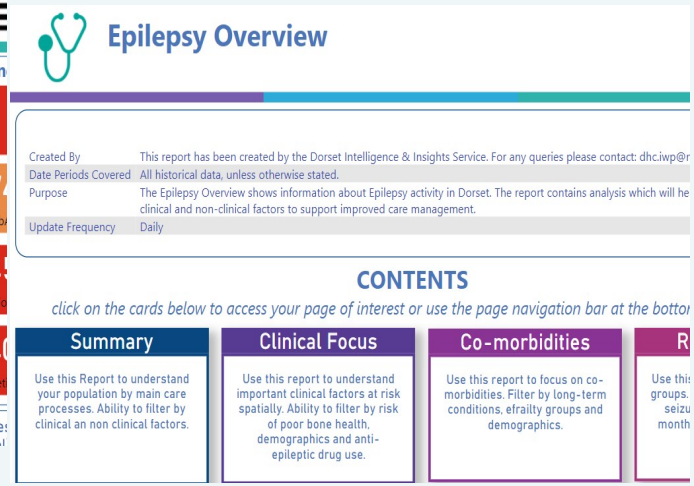


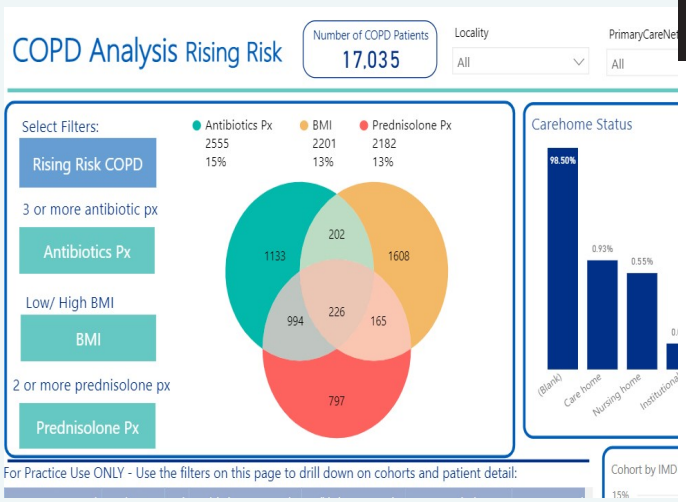


"Perfect. The COVID insights are really helpful… to identify groups… and then identify those individual patients."

How DiiS supports cross-system working

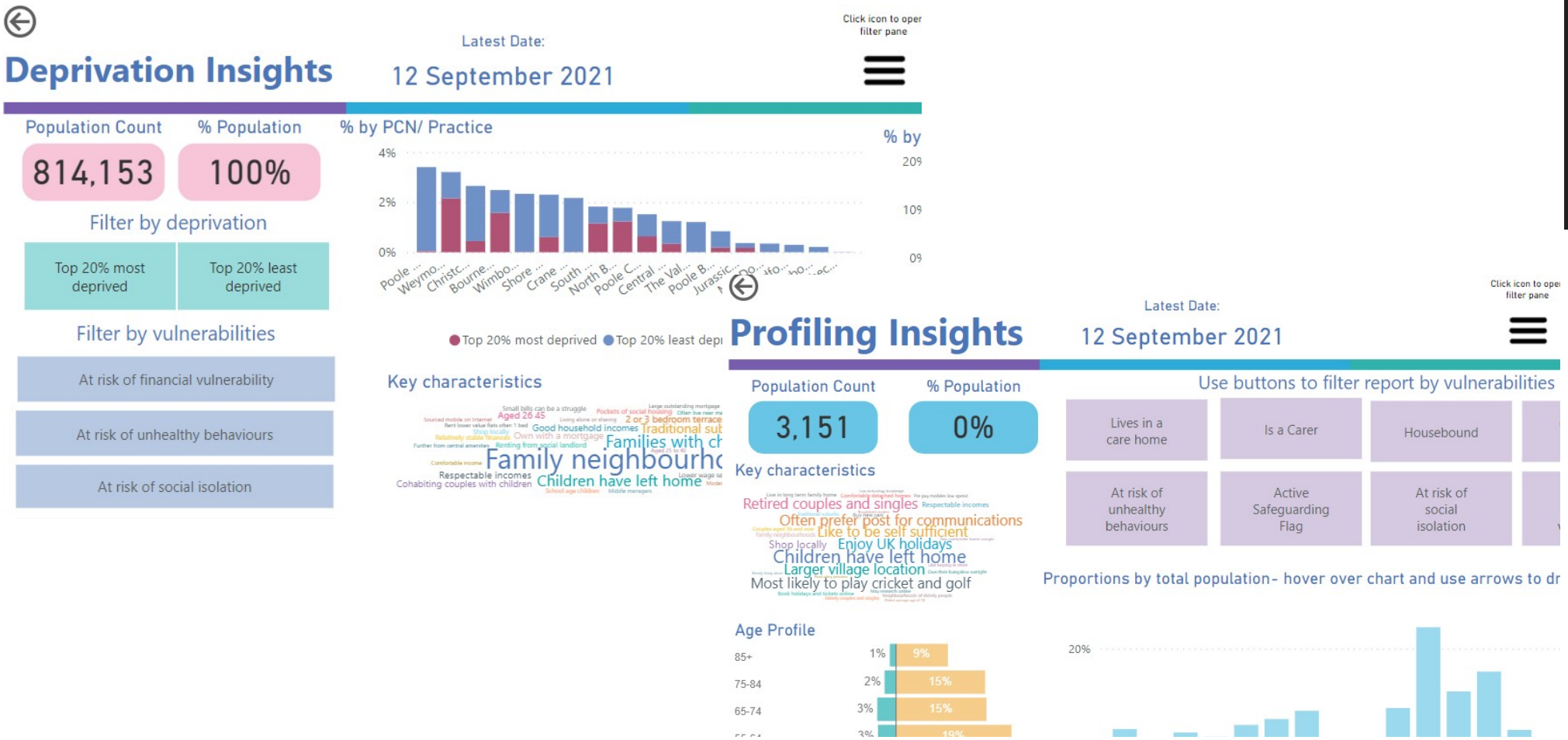




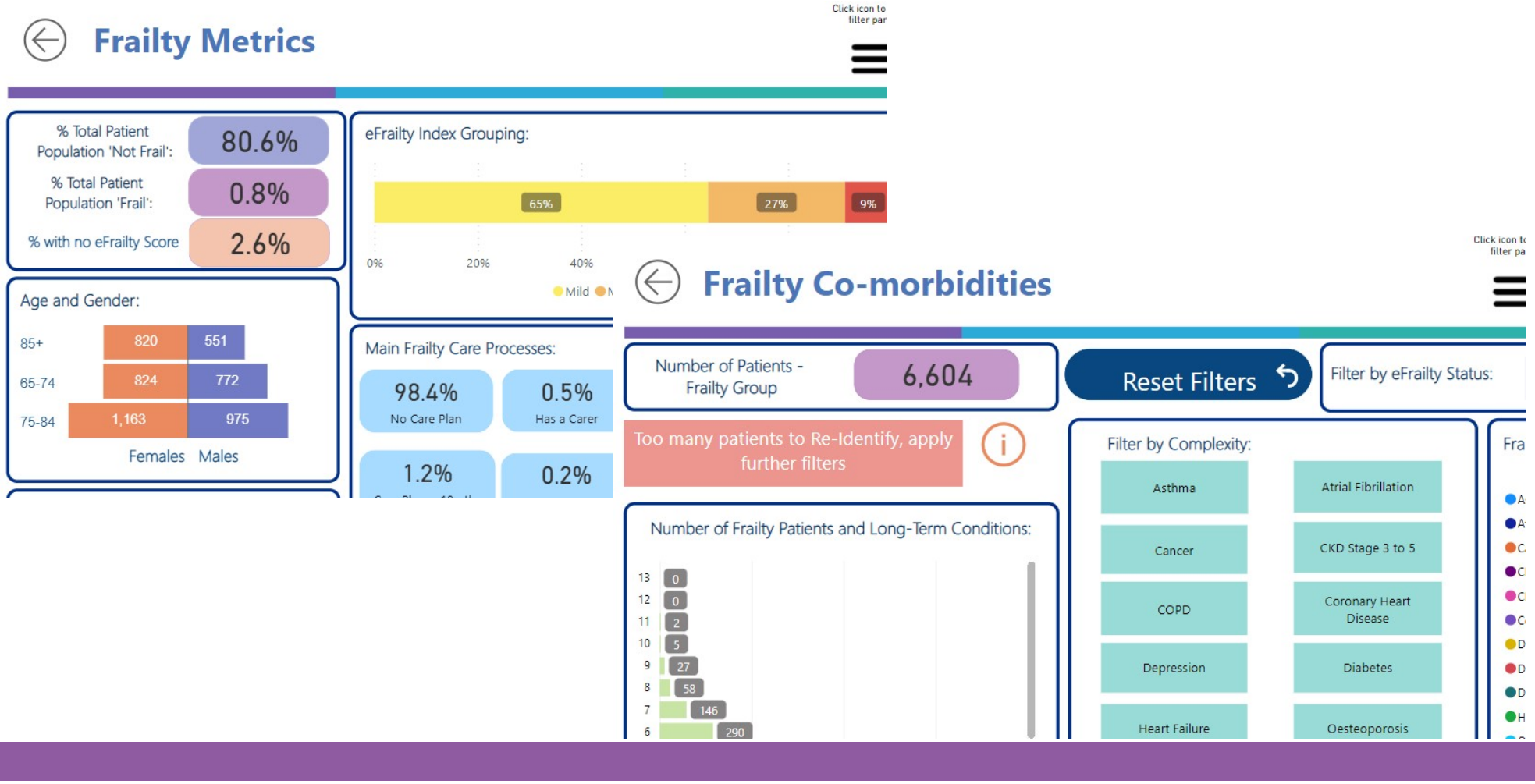


High Intensity Users

Deprivation and Profiling focus



Focussing on Frailty



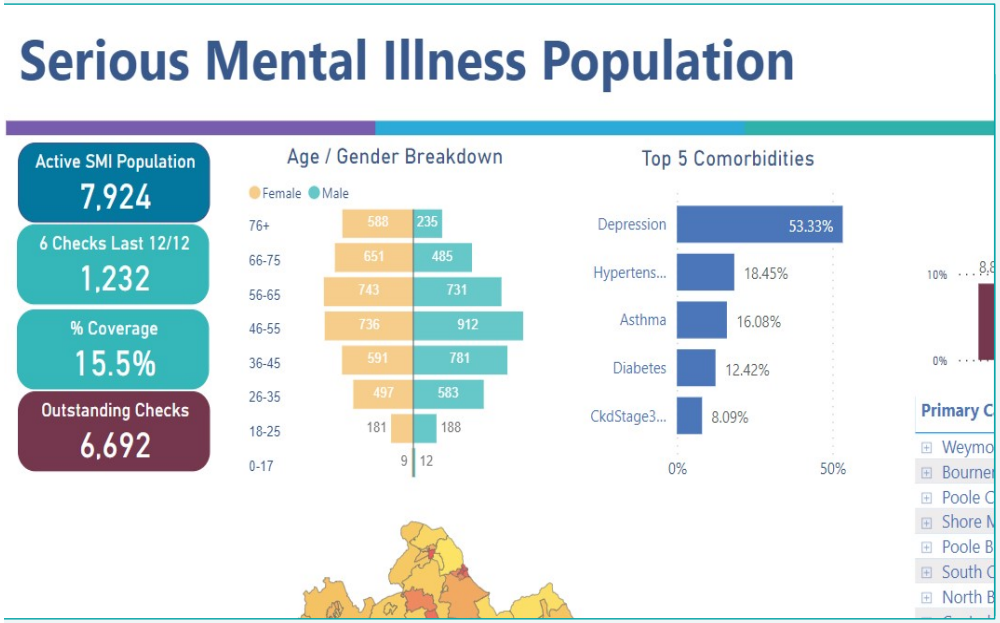
Prediction of Rising Risk for Proactive Interventions

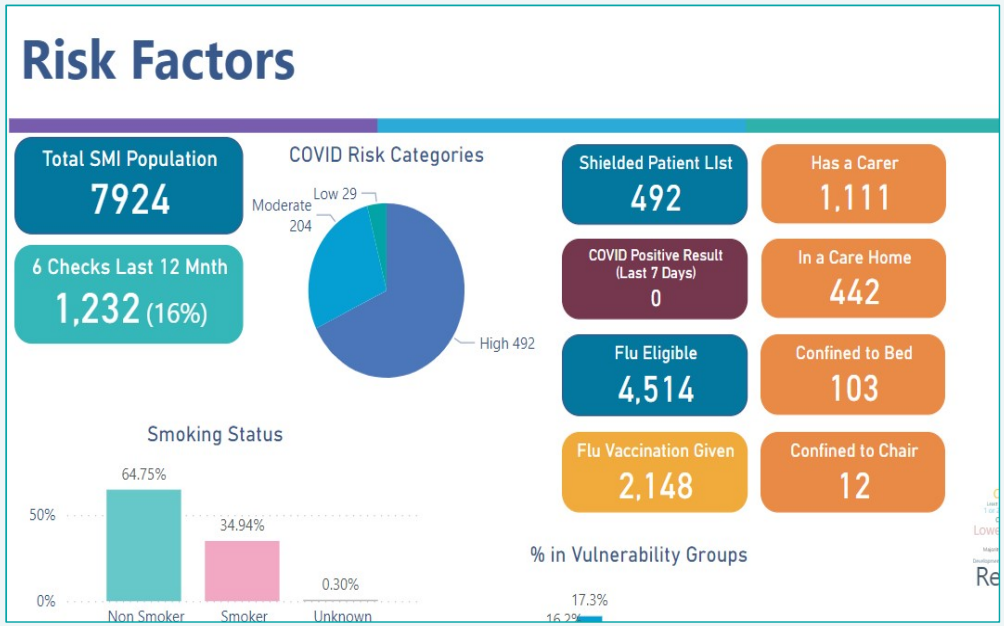
Filter by risk

- >50% Risk of Inpatient Hospitilisation
- >50% Risk of Emergency Hospilisation
- High/ Very High Mortality Risk

Person Key	EFI Group	EFI	IP Hospitalisation <12mths	Inpatient Probability	Latest Mortality Risk Group	Latest Mortality Risk Score	Change in Mortality Score
512436	Severe	0.11	78%	51%	5 Very High	84	14
200052	Severe	0.14	81%	50%	5 Very High	89	9
217069	Severe	0.06	80%	44%	4 High	74	8
447742	Severe	0.06	68%	39%	4 High	70	9
63554	Severe	0.09	82%	38%	5 Very High	86	11
643383	Severe	0.09	89%	37%	5 Very High	93	1
710024	Severe	0.09	86%	35%	5 Very High	84	4
826775	Severe	0.11	85%	35%	4 High	72	15
747073	Severe	0.06	77%	34%	4 High	67	0
694225	Severe	0.08	82%	34%	5 Very High	99	5
463478	Severe	0.08	75%	32%	5 Very High	99	2
163314	Severe	0.08	66%	32%	4 High	74	4
713033	Severe	0.06	72%	32%	5 Very High	86	10
831236	Severe	0.06	61%	31%	5 Very High	89	12
89205	Severe	0.16	89%	29%	5 Very High	100	16
668924	Severe	0.06	70%	29%	4 High	60	1
218285	Severe	0.09	68%	27%	5 Very High	89	18
1167968	Severe	0.14	62%	27%	5 Very High	89	-2
636395	Severe	0.14	71%	26%	5 Very High	96	12
618989	Severe	0.06	56%	25%	5 Very High	84	11
1184335	Severe	0.06	89%	25%	4 High	75	3
247202	Severe	0.08	48%	25%	4 High	65	3
283933	Severe	0.09	71%	25%	5 Very High	95	8
469564	Severe	0.09	62%	24%	5 Very High	89	2
396213	Severe	0.09	51%	24%	5 Very High	78	4
848336	Severe	0.09	69%	24%	5 Very High	105	1
942821	Severe	0.08	67%	23%	4 High	72	-2
1173722	Severe	0.11	51%	22%	5 Very High	81	10
768218	Severe	0.09	64%	22%	5 Very High	92	16

How DiiS supports mental health



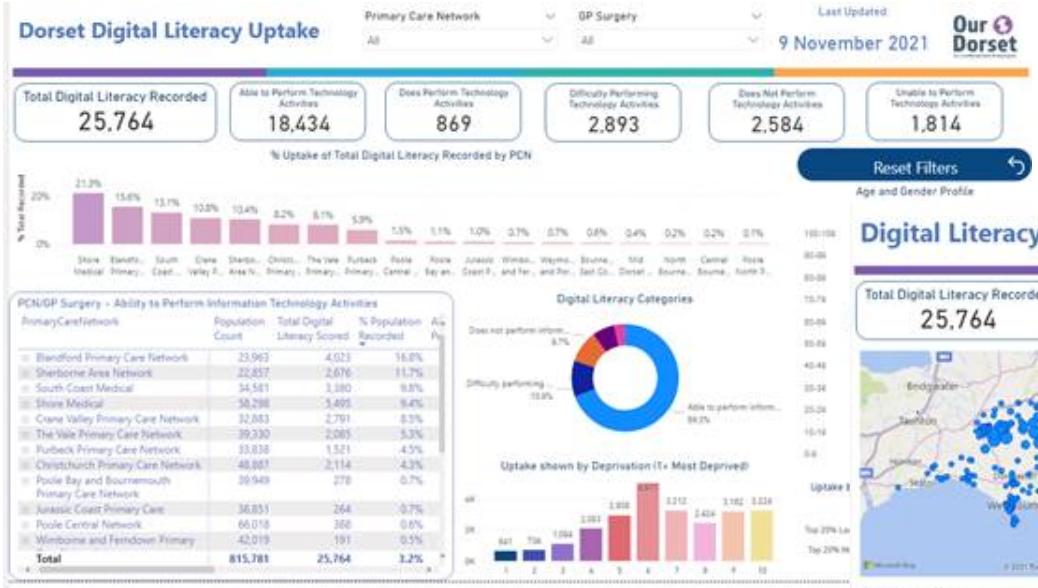


"Exploration of the link between physical health with mental health problem and how a care plan can help manage these two more effectively and prevent mental health deterioration then causing deterioration in physical health/diabetes and vice versa."

– Local GP

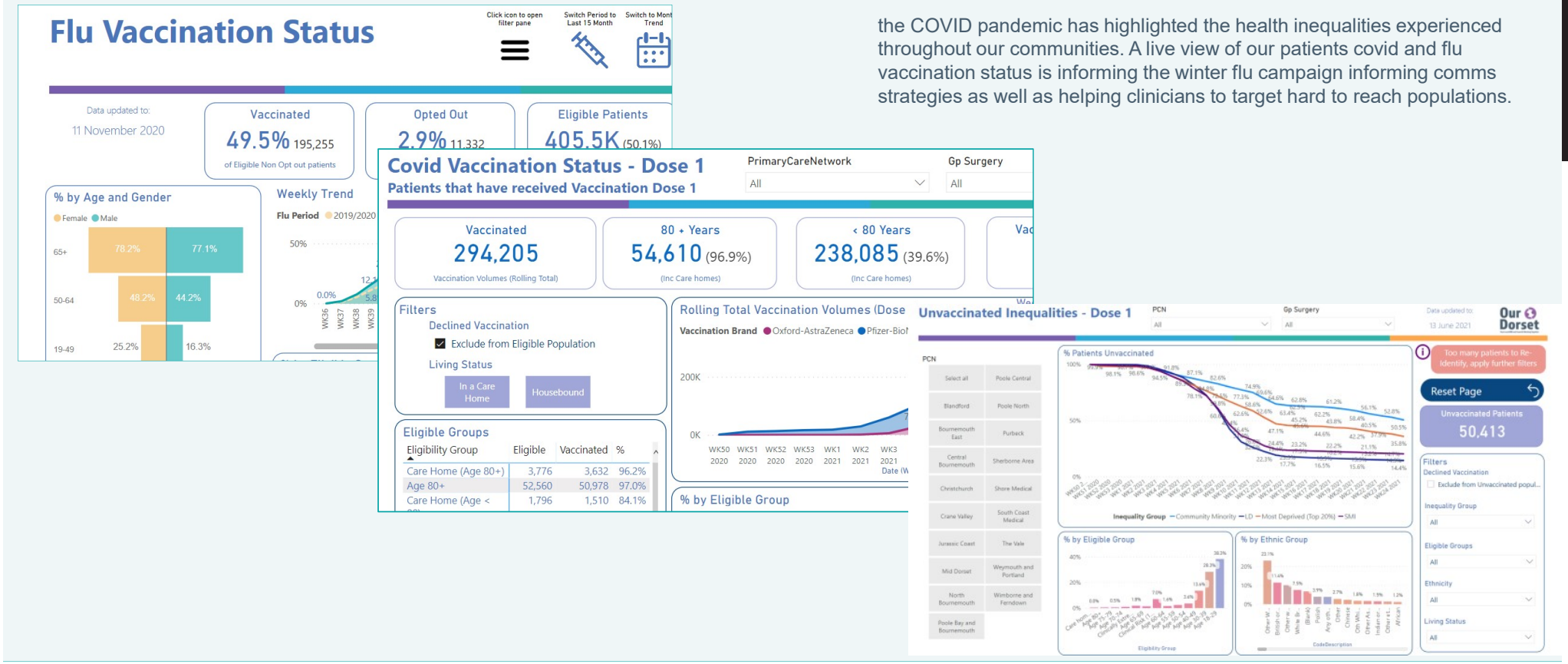
Risk Stratification, Access and Outcomes

Measuring Patient Digital Literacy



How DiiS supports the COVID-19 response

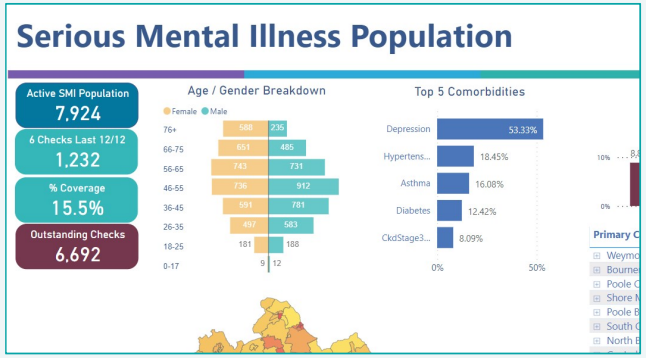
"The depth and quality of data now available in one place is astounding."

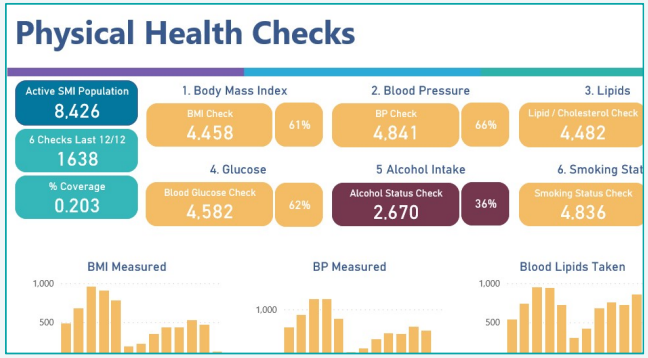


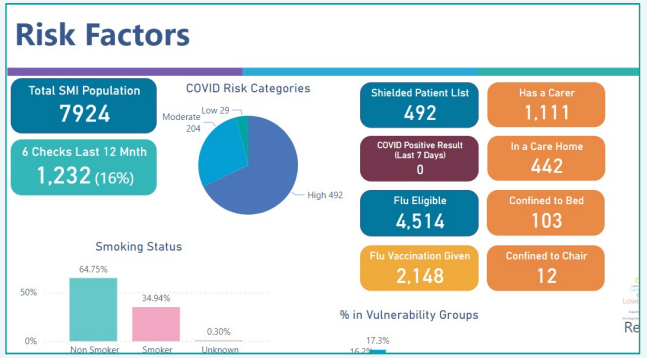
the COVID pandemic has highlighted the health inequalities experienced throughout our communities. A live view of our patients covid and flu vaccination status is informing the winter flu campaign informing comms strategies as well as helping clinicians to target hard to reach populations.

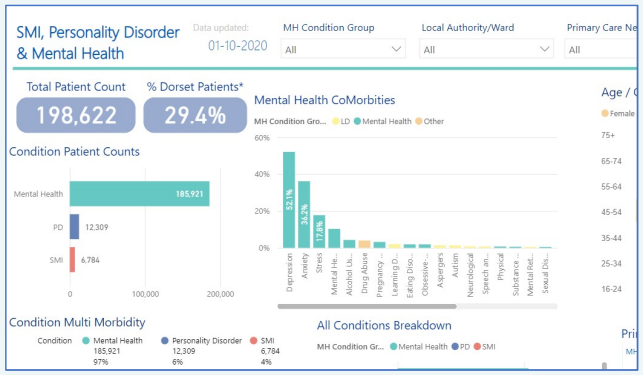
How DiiS supports mental health

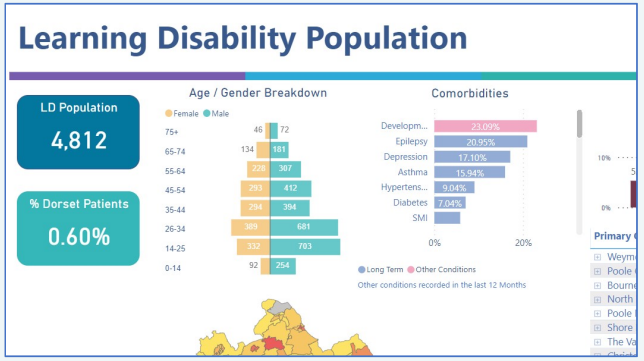
Using live data from primary care, we are able to view our population who have various mental health conditions including serious mental illness, in a variety of ways. The data can be segmented by demographics, geography and associated long term conditions. We can also monitor other physical clinical markers amongst this cohort and ensure we are viewing our people holistically, rather than through one particular medical lens.











"Exploration of the link between physical health with mental health problem and how a care plan can help manage these two more effectively and prevent mental health deterioration then causing deterioration in physical health/diabetes and vice versa."

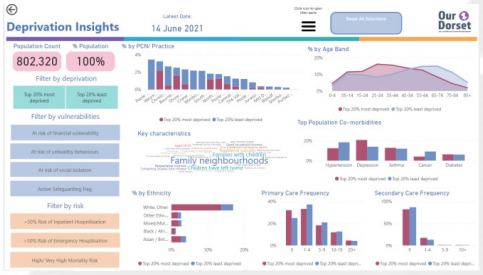
– Local GP

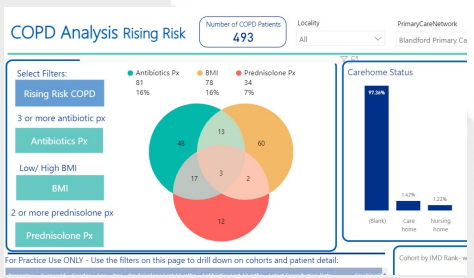
How DiiS supports COPD

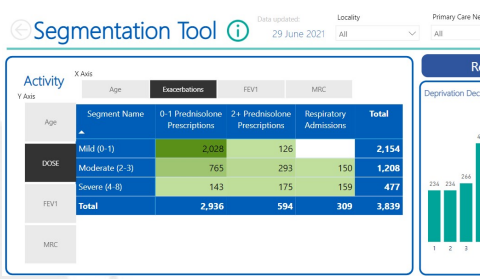
Population Health Needs Assessment and understanding of burden of Disease

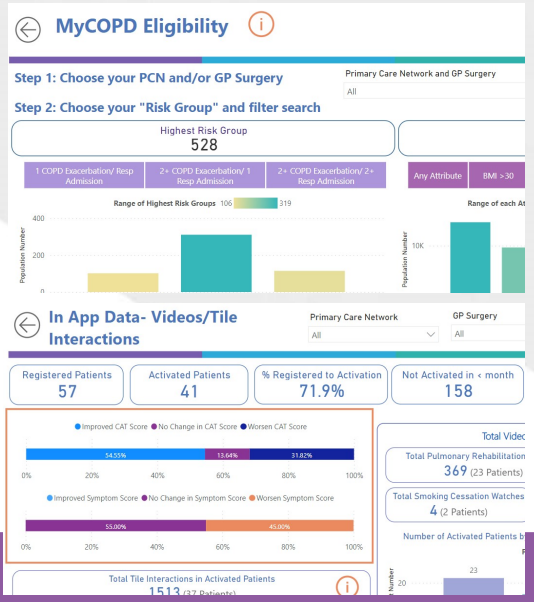
Identify rising risk and stratify/segment into risk categories

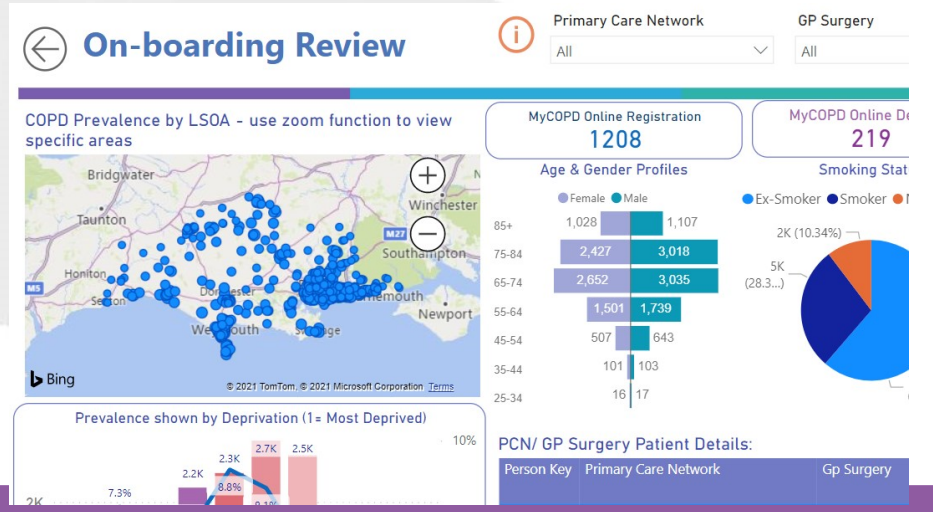
- High Risk – co design pathway with acute physician
- Medium risk – pulmonary rehab
- Low Risk - Referral to digital self management app (MyCOPD)



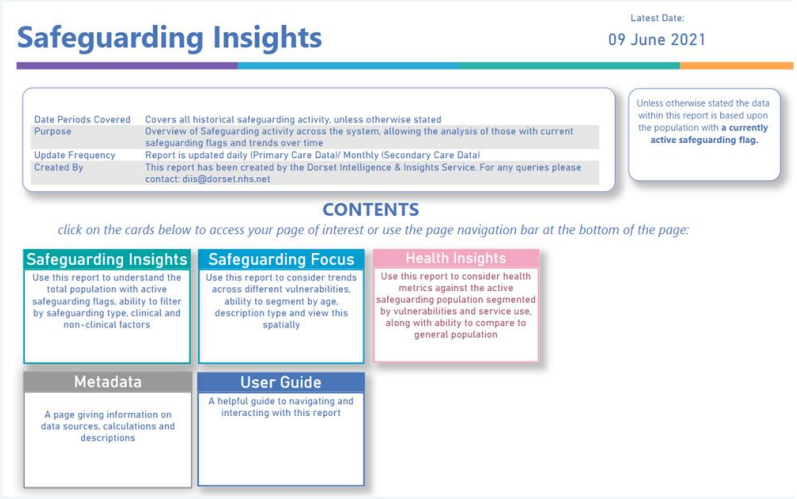


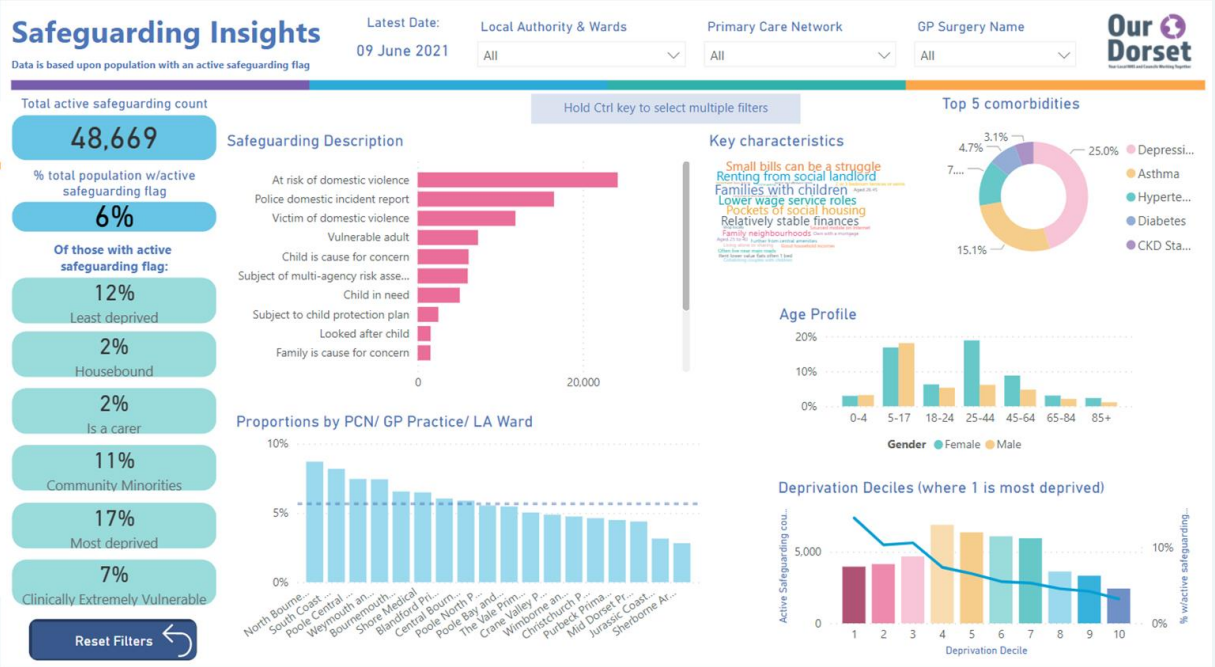






How DiiS supports Safeguarding

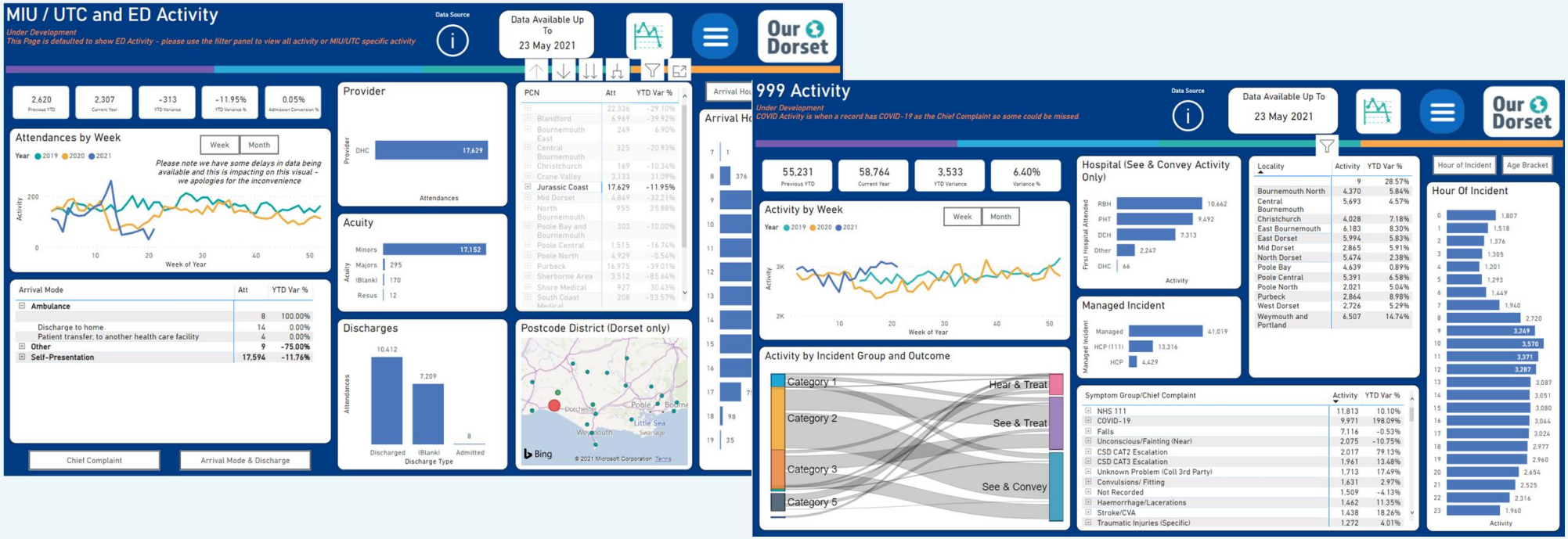




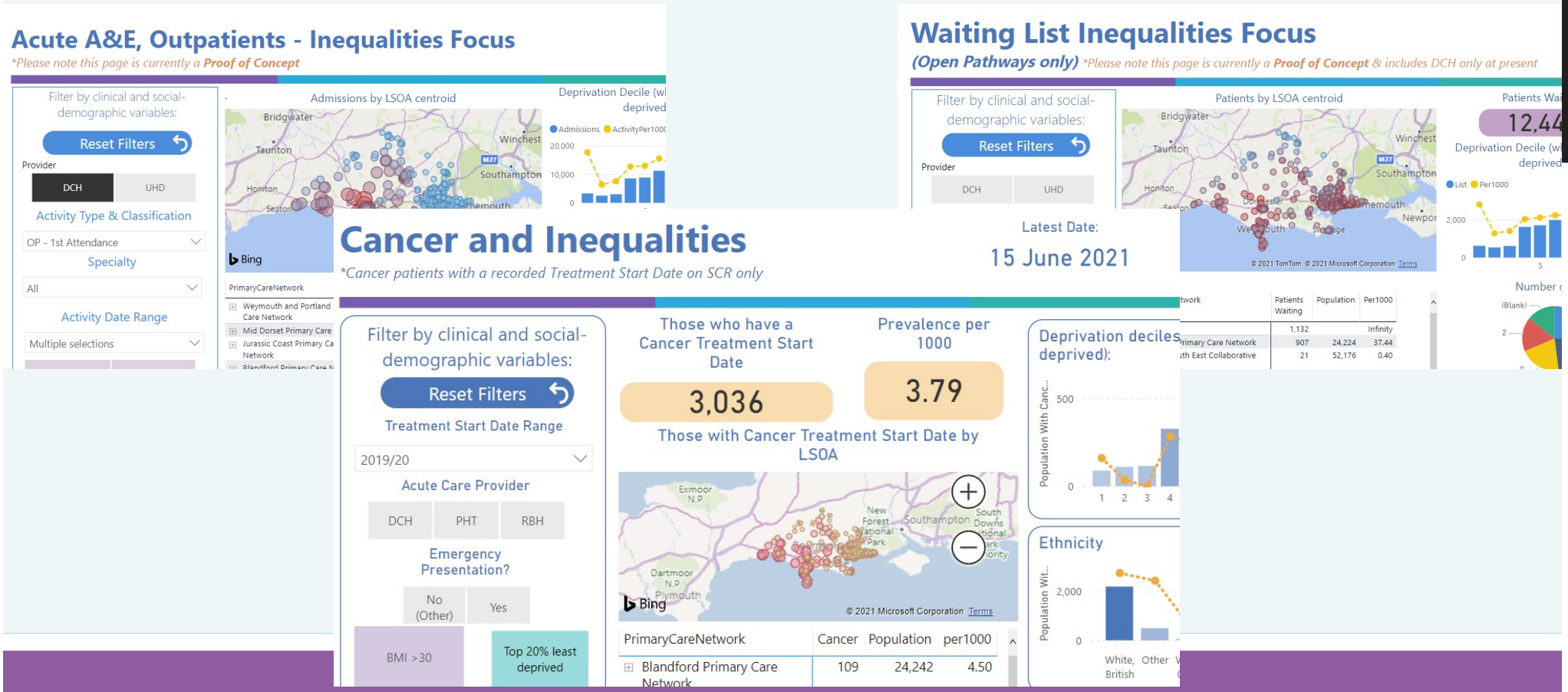
"The opportunities for us all working together I believe can significantly improve safeguarding and innovate the way we work" - Liz Plaistow, Head of Safeguarding, CCG

How DiiS supports Urgent & Emergency Care

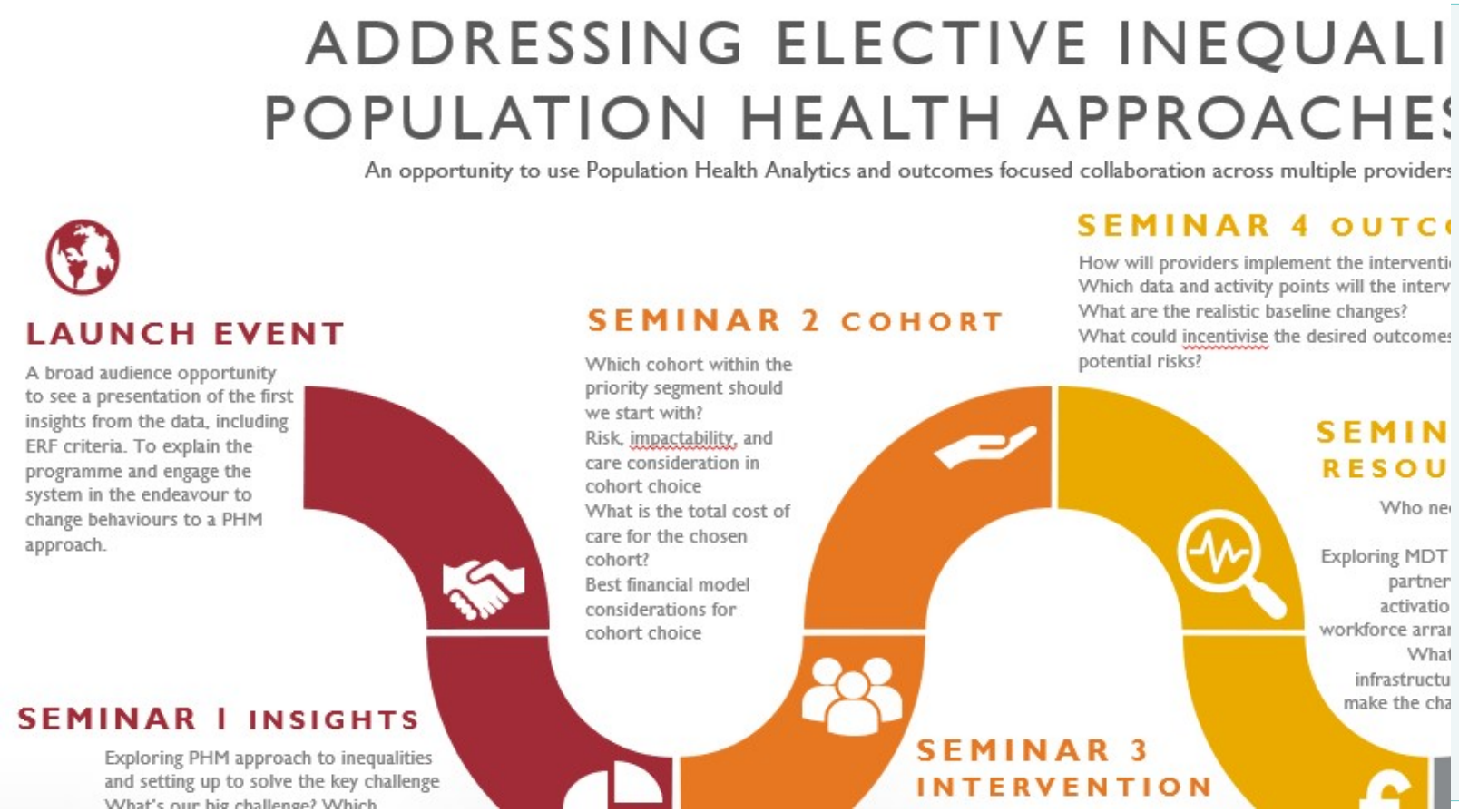
Current reporting enables the understanding of System activity and relationship with SWAST, further developments are in hand to provide a population health overview on activity and outcomes for patients moving through the UEC pathways.



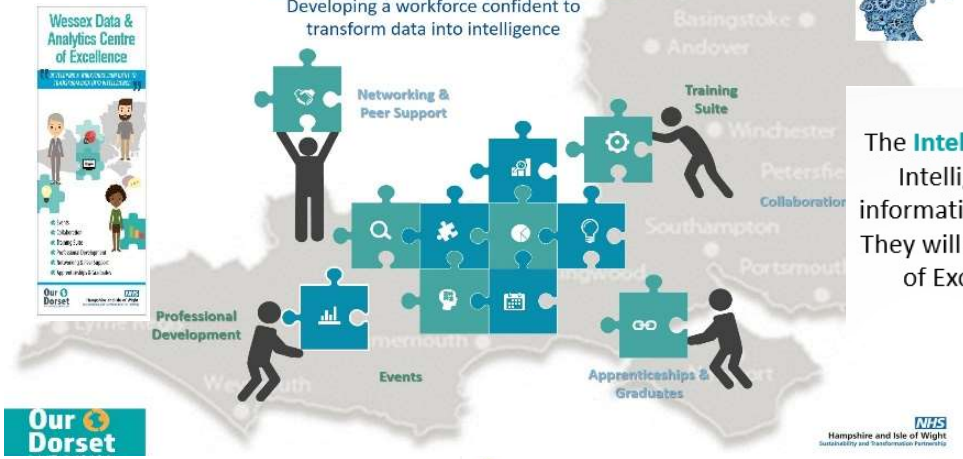
How DiiS supports the inequalities agenda

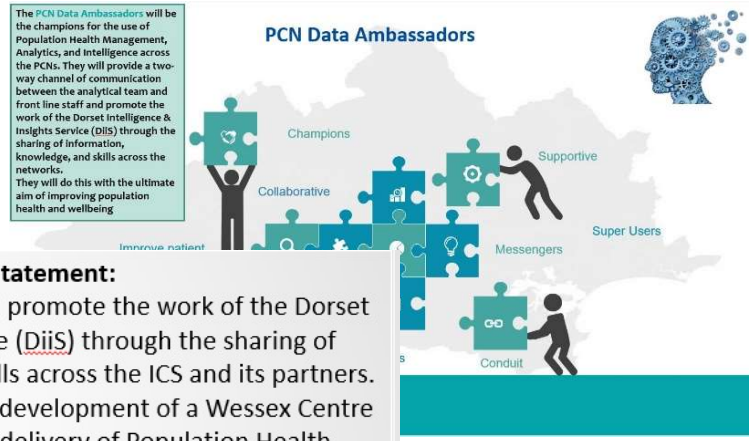


How DiiS supports the inequalities agenda



Data & Analytics Centre of Excellence





Mission Statement:

The **Intelligence Champions** will promote the work of the Dorset Intelligence & Insights Service (DiiS) through the sharing of information, knowledge, and skills across the ICS and its partners. They will be instrumental in the development of a Wessex Centre of Excellence to support the delivery of Population Health Management.

Our Dorset

Your Local NHS and Council Working Together

For more information on the DiiS, visit
https://nhsdorsetccg.sharepoint.com/sites/iwp
Or contact us on
James.woodland@dorsetccg.nhs.uk

Meeting Title:	Board of Directors
Date of Meeting:	24th November 2021
Document Title:	**Workforce Disability Equality Standard 2021**
Responsible Director:	Dawn Harvey, Chief People Officer
Author:	Julie Barber, Head of Organisational Development

Confidentiality:	No – publicly published
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	18/10/2021	

Purpose of the Paper	This report sets out our 2020/21 data and action plan against the Workforce Disability Equality Standard (WDES) metrics							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The WDES is the national framework through which Trusts measure their performance against ten key metrics. These comprise workforce metrics (1-3), Staff Survey metrics (4-9) and a metric based on Board representation (10). Overall, the organisation has improved or remained consistent in five metrics and decreased in four, and mixed results for Metric 4 (4a (i) – positive, 4a (ii) & (iii) and 4b – negative). Data is shown at Annex A. The rolling WDES action plan has been replaced with our Equalities Plan & Priorities, a comprehensive suite of staff development activities and plans aimed at developing inclusive behaviours and practices across the organisation. This is shown at Annex B.							
Action recommended	The Board Meeting is recommended to: 1. **NOTE** the Workforce Disability Equality Standard data and action plan, and next steps. 2. **DISCUSS** the contents and implications 3. **APPROVE** the document to be published on 31/10/21							

Governance and Compliance Obligations

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

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

Introduction

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

The WDES is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts. This supports closer scrutiny of the progress we make and outcomes we achieve. Non-compliance with the WDES would create risks for the organisation in terms of reputation, but more importantly, in terms of the wellbeing of the overall workforce. In the spirit of transparency and continuous improvement, national health organisations adopted the WDES in autumn 2020.

The WDES is a data-based standard and uses a series of ten measures (metrics) to improve the experiences of Disabled staff in the NHS. All the metrics draw from existing data sources (recruitment dataset, staff records, NHS Staff Survey, local HR data) with the exception of one; metric 9b asks for narrative evidence of actions taken, to be written into the Trust's WDES annual report.

The ten key metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9) and a metric based on Board representation (10).

The 2020-21 WDES data for Dorset County Hospital is based on staff who have a disability recorded on the Trust's Electronic Staff Records and we currently have data indicating 3.35% of our workforce have a disability.

Overview of changes since 2019/20 data

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

Overall, the organisation has improved or remained consistent in five metrics and decreased in four, and mixed results for Metric 4 (4a (i) – positive, 4a (ii) & (iii) and 4b – negative). The data is attached at **Annex A** and the WDES Action Plan (Equalities Plan and Priorities) is shown at **Annex B.**

Metrics where we have seen positive changes or data has remained consistent

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

The number of staff identifying as having a disability has increased very slightly from 2.9% in 19/20 to 3.35% in 20/21- an increase of 0.45% across the overall workforce.

Due to the low percentage of staff recorded with a disability on ESR (3.35%), it was not possible to draw any conclusions from the data. This low percentage also presented a risk of identifying individuals at particular grades, so the majority of the data for Metric 1 has been presented as overall figures.

We know from our 2020 Staff Survey that 32% of respondents stated they have a physical or mental health condition or disability which is expected to last more than 12 months. Our Equalities Plan & Priorities will support increased disclosure over time.

A breakdown of workforce data for 2020-21 is shown at Annex A.

Metric 4a: *Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse*

(i) From patients/service users, their relatives or other members of the public

This data shows an improvement for both Disabled and non-disabled staff for the year and a reduction in the disparity to -2%. Whilst the improvement is welcomed, this still represents an unacceptable statistic and remains an area of focus for attention.

Metric 5: *Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion*

The data shows very little change (-0.1%) and a reduction in disparity. The Trust's Staff Survey results for this metric for Disabled and non-disabled staff remain higher than the national average for Acute Trusts.

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

Metric 6: *Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties*

The data shows a decrease for Disabled staff of 3.4% resulting in 30.8% saying they have felt pressurised to come to work, which is still unacceptably high.

Metric 9: *NHS Staff Survey and the engagement of Disabled Staff*

Part (a): The engagement score for Disabled staff, compared to non-disabled staff

This metric has remained static for both Disabled and non-disabled staff, although we still have a small disparity gap of -0.4% which needs to be reduced further.

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

We answered 'yes' to this question, citing that prior to 31/3/21 activity commenced to establish a Staff Network for staff with disabilities and long-term health conditions. The Trust's 'Without Limits' staff network launched in the early part of 21/22.

The new network has already made positive strides towards improving the experience of Disabled Staff. Examples include:

(a) a systematic review to check hearing loops are working across the Trust, after it found that many were not
(b) Improving awareness around the Access to Work scheme is underway after issues were raised in the EDI Steering Group
(c) Improving communication pathways for reasonable adjustments and Access to Work is also underway with a view to clear protocols and information being in place

Metric 10: *Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:*

(a) By Voting Membership of the Board
(b) By Executive membership of the Board

Whilst disability data on voting and executive membership was not reported last year so cannot be compared, it can be noted that 26.67% of the Board have not declared their disability status in 20/21, which is an improvement on 31% for 19/20.

Metrics where we have seen negative changes

Metric 2: *Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts*

Our likelihood ratio of 1.10 in 2019/20 has increased to 1.38 in 2020/21 which is disappointing and indicates the continuing need to improve the situation. A review of recruitment and selection processes, procedures and training for recruiting managers is underway as part of the Inclusive Recruitment work stream of our Transforming People Practices Programme.

Metric 3: *Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.*

Our likelihood ratio of 21.25 in 2019/20 has increased to 23.34 in 2020/21. Although this relative likelihood suggests there may be a problem, as there is only 1 Disabled and 1 non-disabled member of staff in the capability process, this suggests there are no underlying issues.

A review of disciplinary policies and procedures is underway as part of the Inclusive Recruitment work stream of our Transforming People Practices Programme.

Metric 4a: *Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse*

(ii) From Managers

This data shows an increase of 2.4% from last year, with 20.7% of disabled staff saying they had experienced harassment, bullying or abuse from managers. This also resulted in the disparity between Disabled and non-disabled staff widening to -12%. This remains an area of focus for attention and the Trust welcomes the fact that more staff feel able to express their views.

(iii) From other colleagues

This data shows an increase of 6.0% from last year, with 32.1% of disabled staff saying they had experienced harassment, bullying or abuse from other colleagues. This also resulted in the disparity between Disabled and non-disabled staff widening to -13%, which has nearly doubled in two years. This remains an area of focus for attention.

It is worth reminding ourselves that whilst our ESR shows that 3.35% of staff have a disability, metrics 4-9a are taken from our Staff Survey where 32% of staff have declared themselves to be Disabled (or to have a long-term condition), so these figures represent a significant number of staff reporting unacceptable behaviour.

Metric 4b: *Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it*

44.1% of Disabled staff said that they reported incidents – this is a 2.5% drop from the previous year. Non-disabled staff had increased reporting incidents, resulting in a disparity of +0.8%. All staff will continue to be encouraged to report incidents and a number of priority work programmes *(shown at Annex B)* focus attention on challenging unacceptable behaviour and reporting routes.

Metric 7: *Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work*

Satisfaction has decreased for both Disabled staff and non-disabled staff, and in both cases percentage levels are close to the national average for Acute Trusts. Satisfaction levels are lower for Disabled staff with a disparity of -11.6%, indicating further work is required in this area.

Metric 8: *Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work*

This shows a reduction on last year, with the current score of 75.5% being equal to the average across Acute Trusts. A review of staff policies and procedures and improved awareness in this area is included in the Equalities Plan and Priorities shown at Annex B.

Next steps

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

The WDES is a driver for the Trust to improve our disability declaration rates on ESR and our Without Limits staff network provides an additional platform for the voices of Disabled staff to be heard.

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

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

The WDES findings will be shared with the Without Limits Staff Network to test if there is anything missing from our Action Plan, to further improve the experience of Disabled staff across the Trust.

All NHS Trusts are required to publish WDES data by 31st October 2021.

Annex A - WDES National Metrics Report

Detailed below is the organisation's WDES data which was submitted in August 2021 covering the period 1 April 2020 – 31 March 2021.
Where data is available, year-on-year comparisons have been made.

Metric 1: Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. (Data source: ESR)

N.B. Due to the low percentage of staff recorded with a disability on ESR (3.35%), it was not possible to draw any conclusions from this. This low percentage also presented a risk of identifying individuals at particular grades, so the majority of the data for Metric 1 has had to be presented as overall figures.

1a - Non-clinical workforce

AfC Bands 1 - VSM	Disabled Staff #	Disabled staff %	Non-disabled staff #	Non-disabled staff %	Unknown #	Unknown %	Total
TOTAL	38	3.3%	899	79.0%	201	17.7%	1138

1b – Clinical workforce

AfC Bands	Disabled Staff #	Disabled staff %	Non-disabled staff #	Non-disabled staff %	Unknown #	Unknown %	Total
Cluster 1 Bands 1-4	32	3.3%	812	84.4%	118	12.3%	962
Cluster 2-4 Bands 5-VSM	52	3.8%	1133	82.7%	264	19.3%	1370
TOTAL	84	3.5%	1945	80.7%	382	15.8%	2411

1c – Medical & Dental Workforce

Consultants Non-consultants career grade Medical & dental trainee grades	Disabled Staff #	Disabled staff %	Non-disabled staff #	Non-disabled staff %	Unknown #	Unknown %	Total
TOTAL	15	2.76%	354	65.07%	175	32.17%	544

1d – Overall Workforce

	Disabled Staff #	Disabled staff %	Non-disabled staff #	Non-disabled staff %	Unknown #	Unknown %	Total
Overall workforce	137	3.35%	3198	78.13%	758	18.52%	4093

This metric indicates an increased percentage (0.45%) in staff with a disability in the overall workforce, from 2.9% in 19/20.

Metric 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment & ESR data)

Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting	**Relative likelihood in 2019-20**	**Relative likelihood in 2020-21**	A figure below 1.00 indicates that Disabled staff are more likely than non-Disabled staff to be appointed from shortlisting
	1.10	1.38	

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

Relative likelihood of Disabled staff compared to non-Disabled staff entering	**Relative likelihood in 2019-20**	**Relative likelihood in 2020-21**	A figure above 1.00 indicates that Disabled staff are more likely than non-Disabled staff to enter the formal capability process
	No likelihood figure provided in 19/20 but calculations indicate 21.25	23.34	

Metric 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

(Data source: Q.13a-d, NHS Staff Survey)

4a: % of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	**2018**			**2019**			**2020**		
	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)
(i) Patients/service users, their relatives or other members of the public	26.8	23.3	-3.5	26.9	23.8	-3.1	23.5	21.5	-2.0
(ii) Managers	19.4	8.2	-11.2	18.3	8.1	-10.2	20.7	8.7	-12.0
(iii) Other colleagues	24.0	17.1	-6.9	26.1	17.5	-8.6	32.1	19.1	-13.0
4b: % of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	37.0	52.1	-15.1	46.6	39.8	**+6.8**	44.1	43.3	**+0.8**

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion

(Data source: Q.14, NHS Staff Survey)

2018			2019			2020		
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
89.1	91.7	-2.6	86.3	92.4	-6.1	86.2	89.0	-2.8

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

(Data source: Q11e, NHS Staff Survey)

2018			2019			2020		
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
30.8	21.1	-9.7	34.2	18.0	-16.2	30.8	21.4	-9.4

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

(Data source: Q5f, NHS Staff Survey)

2018			2019			2020		
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
33.6	49.8	-16.2	40.4	53.0	-12.6	37.8	49.4	-11.6

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

(Data source: Q.26b, NHS Staff Survey – *this question only includes the responses of Disabled staff*)

2018	2019	2020
77.9%	81.2%	75.5%

Metric 9: NHS Staff Survey and the engagement of Disabled Staff

Part (a): The engagement score for Disabled staff, compared to non-disabled staff

2018			2019			2020		
Disabled Staff	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**	**Disabled Staff**	**Non-disabled staff**	**Difference (+/-)**
6.7	7.3	-0.6	6.9	7.3	-0.4	6.9	7.3	-0.4

(Data source: NHS Staff Survey)

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes.**

We were asked to provide at least one practical example of current action being taken in the last 12 months to engage with Disabled staff:

Prior to 31/3/21 activity commenced to establish a Staff Network for staff with disabilities and long-term health conditions. Network launched in the early part of 21/22.

(Data source: WDES Submission, August 2021)

Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

(Data source: WDES Submission, August 2021)

Snapshot as at 31/3/21	**Disabled %**	**Non-disabled %**	**Disability unknown %**
Total Board members	0.00	73.33	26.67
By Voting Membership of the Board	0.00	71.43	28.57
By Non-Voting Membership of the Board	0.00	100.00	0.00
By Executive Membership of the Board	0.00	83.33	16.67
By Non-Executive Membership of the Board	0.00	66.67	33.33
Difference (Total Board – Overall Workforce)	-3%	-5%	8%
Difference (Voting membership – Overall Workforce)	-3%	-7%	10%
Difference (Executive membership – Overall workforce)	-3%	5%	-2%

Whilst disability data on voting and executive membership was not reported last year so cannot be compared, it can be noted that 26.67% of the Board have not declared their disability status in 20/21, which is an improvement on 31% for 19/20.

Annex B – WDES Action Plan (Equalities Plan and Priorities)

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

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

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

Measures of Success

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

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

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

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

Meeting Title:	**Board of Directors**
Date of Meeting:	24th November 2021
Document Title:	**Board Assurance Framework**
Responsible Director:	Nick Johnson – Director of Strategy, Transformation & Partnerships. Deputy CEO.
Author:	Ciara Darley – Programme Manager, Transformation & Improvement

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

Prior Discussion							
Job Title or Meeting Title		**Date**		**Recommendations/Comments**			
Risk and Audit Committee		16/11/2021					
Purpose of the Paper							
Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Summary** There is a requirement for the Trust Board to understand the Trust's strategic objectives and the principle risks that may threaten the achievement of these objectives. The Board Assurance Framework (BAF) provides a structure and process that enables the organisation to focus on those risks that might compromise achieving its most important strategic objectives; and to map out both the key controls that should be in place to manage those objectives and confirm the Board has assurance about the effectiveness of these controls. The Trust Strategy was updated earlier this year to review the future direction for the organisation. Engagement to develop the strategy highlighted that the mission and vision continue to reflect the future ambition, and three new strategic themes were introduced to help focus this ambition - People, Place and Partnership. In line with the revised strategic focus, it was necessary to update the BAF to ensure that risks which threaten the achievement of the strategy are identified with the appropriate management mechanisms. In reviewing the BAF there was a further opportunity to critically review and revise the previous template to ensure an effective and user-friendly framework moving forwards. A number of Strategic Objectives were developed to sit under each theme and the template was updated to reflect these objectives, based on the example outlined from the NHS Providers Board Assurance: Toolkit for Health Sector Organisations. A first draft of the updated BAF has been enclosed for review and comment to allow for further development moving forwards. The principle risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix. All Executives were asked to review and provide updates where appropriate to the relevant BAF items.						
Action recommended	The Board is requested to: • To discuss the updated Board Assurance Framework • To provide comments for further development; and • Note the high-risk areas						

Governance and Compliance Obligations

Legal / Regulatory	Y/~~N~~	
Financial	Y/~~N~~	The Board Assurance Framework includes risks to long term financial stability and the controls and mitigations the Trust has in place.
Impacts Strategic Objectives?	Y/~~N~~	The Board Assurance Framework outlines the identified risks to the achievement of the Trust's objectives. Failure to identity and control these risks could lead to the Trust failing to meet its strategic objectives.
Risk?	Y/~~N~~	The Board Assurance Framework highlights that risks have been identified and captured. The Document provides an outline of the work being undertaken to manage and mitigate each risk. Where there are governance implications to risks on the Board Assurance Framework these will be considered as part of the mitigating actions.
Decision to be made?	~~Y~~/N	
Impacts CQC Standards?	Y/~~N~~	It is a requirement to regularly identify, capture and monitor risks to the achievement of the Trusts strategic objectives.
Impacts Social Value ambitions?	~~Y~~/N	
Equality Impact Assessment?	~~Y~~/N	
Quality Impact Assessment?	~~Y~~/N	

BOARD ASSURANCE FRAMEWORK - SUMMARY
DATE: xx/xx/xx

Summary Narrative

Risk Heatmap

		1
CONSEQUENCE SCORE		Rare
5	Catastrophic	5
4	Major	4
3	Moderate	3
2	Minor	2 PL1.9
1	Negligible	1

Key

Letters:	
PE	PEOPLE
PL	PLACE

Risk Ref:	Responsible Director	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Strength of Control	Assurance/ Evidence	Strength of Assurance	Target Risk Score
People Objective 1										
We will look after and invest in staff, developing our workforce, creating collaborative and multidisciplinary teams to support outstanding care and equity of outcomes										
PE 1.1	DH	**Risk description:** Failure to balance wellbeing needs of staff with service delivery and recovery **Risk owner:** CPO	4	4	16	• People strategy • People performance dashboard • People Committee reports • People recovery steering group • Targeted wellbeing support • Wellbeing offer • System & national wellbeing offers	Good	• People strategy (development) • People Dashboard - PCC • PCC reports • FPC reports • Divisional performance reviews • Quarterly people pulse survey • National staff survey • FTSUG reports • Staff listening exercises • Exit interviews	Good	12
PE 1.2	DH	**Risk description:** Failure to attract and retain the right people with the right skills puts more pressure on existing teams **Risk owner:** CPO	5	4	20	• People strategy development • Implementation of workforce business partner model • System attraction strategy • Resourcing function business case • Career pathways • CESR academy proposition • Locally employed doctor appraisal and development • Pilot site for national stay and thrive initiative & international nurse experience deep dive • OD team • Development of flexible & temporary staffing function • Inclusive leadership programme • Transforming people practices programme • Values based recruitement -HCA workforce	Good	• People strategy (development) • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitement control panel • System workforce plan	Good	15
People Objective 2										
We will create an environment where everyone feels they belong, they matter and their voice is heard										
PE 2.1	DH	**Risk description:** Not creating a culture and environment where ALL stay feel valued, heard and that they belong impacting attraction, availability and retention **Risk owner:**	4	3	12	• People strategy • EDI roadmap – culture transformation programme (inclusive leadership development, transforming people practices work streams) • Staff networks x 5 • FTSUG and champions • People performance dashboard as cultural barometer • Exit interviews	Good	• People performance Dashboard - PCC • PCC workplan • PCC deep dives • Divisional performanve reviews • EDI steering group • Exec sponsors for staff networks • Quarterly pulse survey • National staff survey • Junior dr survey	Good	8
People Objective 3										
We will improve safety and quality of care by creating a culture of openness, innovation and learning										
PE 3.1	DH/NL	**Risk description:** People not feeling safe to speak out about safety and care quality **Risk owner:** CPO/CNO	4	2	8	• Trust strategy • Trust values • People strategy • Implementation of just & learning culture principles • Raising concerns policy • Whistleblowing policy • Trust induction • Leaderhip & management development • FTSUG and champions • Safety walkabouts • Ward accreditation framework • Incident reporting	Good	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whisteleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix	Good	4
PE 3.2	NJ	**Risk description:** Operational pressures will stifle will and capacity for innovation **Risk owner:**	3	4	12	• Quality Improvement and Innovation Programme overall supports importance and value of innovation and learning and provides resource support • QSIR Training protected and supported by division • Transformation and Improvement team providing support • Research and Innovation strategy and plan • Engagement in Academic Health Science Network • Divisional Performance Meetings with focus on innovation	Good	• S&T SLG reporting on QI programme and progress • Research and Innovation Governance • Divisional Performance Meetings	Good	6
PE 3.3	DH	**Risk description:** Operational pressures reduce capcity for learning **Risk owner:**	4	3	12	• People strategy • Appraisal policy • Medical appraisal • Study leave policy • Mandatory training KPI's • Practice education team • PCC reporting • Quality committee reporting • PCC and QC risk sharing & triangulation	Good	• Mandatory training KPI's • Appraisal KPI's • Monthly performance review • PCC reports • QC reports • Medical and nursing revalidation • System education workstreams	Good	8
PE 3.4	AH	**Risk description:** Not being an exemplar site for clinical research and innovation **Risk owner:** Medical Director	3	2	6	• Strong clinical research and innovation programme. • Research Strategy in place for 2019-22 with plans to review in 2022.	Good	• Reports to Quality Committee through the Urgent and Integrated Care division - with annual reporting to Board.	Good	6

Risk Ref:	Responsible Director	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Strength of Control	Assurance/ Evidence	Strength of Assurance	Target Risk Score
Place Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual										
PL 1.1	NL	**Risk description:** Inability to recruit or retain sufficiently skilled clinical staff to meet the demand of patients then will not be able to meet care standards required so will not meet the strategic ambitions on quality, personalised care and financial objectives. **Risk owner:**	4	5	20	See People objective • Recruitment and retention policies and work streams • International recruitment • Wellbeing support • Maximise use of opportunities through Health Education England and NHSE/I funding streams • Maximise where able apprenticeships • Workforce planning and innovation with redesign of roles to enable clinicians to practice at the top of their licence • Increased opportunities for supported training places Controls non-HR/OD: • Protocols and policies for clinical care • Quality improvement work to streamline care or improve effective patient care • Compliance with national standards to support patient care • Engagement with service users to assist in re-design effective and efficient care to maximise workforce efficiencies • Sub-board oversight of standards delivery and interventions as part of strategic objectives	Good	• Sub board reports: PCC; QC & RAC • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT/Networks • Corporate risk register actions and tolerated/managed risk	Strong	8
PL 1.2	NL	**Risk description:** If the population demand is over the ability to create and deliver capacity that meets the constitutional standards and quality standards outline under the CQC regulatory framework then the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met. **Risk owner:**	4	4	16	• Capacity planning • Commissioning of capacity • Clinical pathways design and system working for sustained capacity • Estates strategy • Workforce planning including job planning • Quality improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives • ICS governance framework • Clinical networks to support pathway design and resources based on population need	Good	• Sub-board committee FPC; QC & PC • Estates master plan and associated business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSE/I) • Benchmarking data: clinical networks; GIRFT	Strong	8
PL1.3	AT	**Risk description:** Not achieving national and constitutional performance and access standards **Risk owner:**	4	4	16	• Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement • Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - triggers for intervention/support • Provider assurance framework/Finance and Performance Committee	Good	• Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee • Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board)	Good	
PL 1.4	AT	**Risk Description:** Not having effective Emergency Preparedness, Resilience and business continuity plans **Risk owner:** Head of EPRR	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE	Good	• Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	
PL 1.5	AT	**Risk description:** Emergency Department admissions continuing to increase per 100,000 population **Risk owner:** Chief Operating Officer	4	5	20	• Reframed Urgent and Emergency care Boards and ICPCS Boards objectives linked to the Boards delivery plan. CEO is the system SRO care and health inequalities. • Performance Framework reporting - triggers for intervention/support • Redesign through ED15 to increase estate and flow within current dept including commitment to increased workforce • Increase to 7 day SDEC offer across medicien and surgical specialties • Clinical and People Strategies addressing emergency flow Home First Board work streams • Internal Home First work streams - 7 day discharge services, strengthened front door multi-agency response, PAT	Good	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting Home First Board and workstream documentation Home First (DCH) documentation Divisional reporting via Performance Meetings, FPC, Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	12
PL 1.6	AT	**Risk description:** Occupied bed days continue to increase per 100,000 population **Risk owner:** Chief Operating Officer	3	4	12	• Home First Board membership • Urgent and Emergency Care Board - CEO is SRO and COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. • VSCE support front door and discharge response Clinical and People Strategies for front door response	Requires Improvement	Home First Board papers UECB papers Disional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	9
PL 1.7	AT	**Risk description:** Having No Reason to Reside patients pathways 1-3 for periods greater than 1 day **Risk owner:** Chief Operating Officer	3	4	12	• Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management • Home First Board membership • Urgent and Emergency Care Board - CEO is SRO and COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. • VSCE support front door and discharge response Clinical and People Strategies for front door response	Requires Improvement	Home First Board papers UECB papers Disional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	C3xL3=9
PL 1.8	AT	**Risk description:** Not achieving an integrated community health care hub based on the DCH site **Risk owner:** Chief Operating Officer	4	4	16	• Proactively working in partnership at 'place' with Integrated Community and Primary care Portfolio, West integrated Health and Care partnership, and Primary care networks South Walks - Proof of Concept for partnership working in 'place' based care	Good	• Transformation (SLG) Reporting and Strategic updates to Board and ICPCS portfolio Board to SLT. South Walks reporting through Elective Care Board and FPC	Requires Improvement	9
PL 1.9	AT	**Risk description:** Not achieving a minimum of 35% of our outpatient activity being delivered away from the DCH site **Risk owner:** Chief Operating Officer	2	1	2	• Outpatient Improvements (within Elective Care Board Programme) Clinical and People Strategies (including physical capacity required)	Good	• Reports to SLG and through to Board via Strategy updates	Good	2
PL 1.10	AH	**Risk description:** Not maintaining the Trusts Summary Hospital-Level Mortality Indicator within the 'as expected' range. **Risk owner:** Chief Medical Officer	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to PPC	Requires Improvement	• Regular reports to Hospital Mortality group,Quality Committee and Board.	Good	8
Place Objective 2: We will build sustainable infrastructure to meet the changing needs of the population										
PL 2.1	NJ	**Risk description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver **Risk owner:** Strategic Estates Project Director	5	3	15	• Full Programme Structure in place with dedicated team • NHP Project Board, Clinical Assurance Group, • Finance and Performance Committee into Trust Board	Good	• NHSEI SOC Approval; NHSEI NHP Deep Dive re. OBC	Good	10
PL 2.2	NJ	**Risk description:** If we do not embed appropriate business case approval processes then plans will not be sustainable so we will not be able to meet the needs of patients and populations **Risk owner:** Deputy Director of Finance	4	4	16	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets	Requires Improvement	• Working Group papers • External approval of business cases e.g. NHP	Requires Improvement	10
PL 2.3	NL	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will reduce our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people. **Risk Owner:** DOF	TBC	TBC	TBC	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population	TBC	• Regular reporting to Strategy and Transformation SLG	TBC	TBC
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients										
PL 3.1	SS	**Risk description:** Not achieving a Dorset wide integrated electronic shared care record **Risk owner:** CIO	2	3	6	Dorset Care Record project lead is the Director of Informatics at Royal Bournemouth Hospital. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director	Good	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	9
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services										
PL 4.1	NL	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use then. **Risk owner:**	3	4	12	• Your Voice group of service users • Maternity Voices Partners as part of the Local Maternity & Neonatal System • Communication and Engagement lead for estate development to support further engagement with local population • Learning Disability Advisor linked activity with independent groups of service users • Engagement roadmap with leadership from Head of patient Experience and Engagement • Networked links with external engagement partnerships such as Healthwatch Dorset, CCG/ICS team, Dorset Council • Council of Governors links into community coordinated by the Corporate Trust Secretary • Quality Improvement methodology includes service user engagement • Public Health networks into key work streams for population health and wellbeing (such as smoking cessation) • Health Inequalities group and networked activity across ICS to support engagement with diverse population • Communication teamwork across the ICS	Good	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs related to engagement • Local independent groups reports or complaints • Dis Data and Public Health reports • Health Inequalities data	Good	4
PL 4.2	NL	**Risk description:** If we fail to utilise population health data in a meaningful way to inform service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing **Risk owner:**	3	4	12	• DIS dataset • Partnership in ICS with Public health and Local authority at PLACE level • Primary care Networks • Digital data sources with shared records • Business intelligence resources across the system • ICS Health Inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance	Good	• HI group reports and actions • Benchmarking data • Patient feedback • Partners feedback • Data • National published reports or networrk reports • ICS Clinical reference group notes • National audits on outcomes	Good	4

Risk Ref:	Responsible Director	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Strength of Control	Assurance/ Evidence	Strength of Assurance	Target Risk Score
Partnership Objective 1: We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population										
PA 1.1	NJ	**Risk description:** If the Trust decision-making processes do not take due account of system elements then the Trust will not be able to engage proactively within the system so the impact of the Trust on the system will be diminished **Risk owner:** NJ	4	2	8	• SLG and Corporate Governance includes system updates and information • Membership of Provider Collaboratives and system other forums • Board feedback and monitoring of system engagement	Good	• SLG Meetings • Board and Committees • System Oversight Framework	Good	8
PA 1.2	SS	**Risk description:** If the Trust does not embed population health data within decision-making which highlights health inequalities then the Trust will not know if it is delivering services which meet the needs of its populations **Risk owner:** CIO	3	3	9	• Dorset Insight and Intelligence Service (DIIS) accessable and available to Trust • DIIS/BI dashboards on key trust metrics provided	Requires Improvement	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	6
PA 1.3	AH	Failure to provide the environment to support MDT working within DCH and the ICS leading to unsustainable services and poorer outcomes. **Risk Owner:**	3	2	6	• Divisions supported by the Strategy and Partnerships Team (Estates/place based portfolio). • Development of the clinical strategy	Good	• Reporting through SLG	Good	6
PA 1.4	AH Could be split between AH/NJ/AT	Recovery of waiting lists plus increasing workload within the hospital may impair our ability to contibute effectively to the objectives of the ICS **Risk Owner:**	3	4	12	• Development of the Clinical and People Strategies, recognising the need for integrated working • Trust Board oversight and assurance of ICS Involvement in Elective Recovery Oversight Group with clinical leads present in key workstreams - MSK, Eyes, Endoscopy, ENT - opportunities noted and acted upon to share resource, space, ideas to maximise recovery as a system	Requires Improvement/ Good	• Monitoring and oversight of Trust Stratgegy and enabling strategies, reporting to Trust Board evidenced through papers and minutes - ECOG and associated workstream documentation	Good	6
Partnership Objective 2: We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways										
PA 2.1	PG	**Risk description**: Failure to deliver sustained financial breakeven and to be self sufficient in cash terms **Risk owner:** CFO	4	5	20	• ICS Financial framework and Financial Strategy. • Current short term plans delivering close to a breakeven and do not require external financing, but are heavily reliant on non recurrent funding.	Good	• ICS Financial framework and Financial Strategy • Reporting to Board, FPC and BVBCB.	Requires Improvement	12
PA 2.2	PG	**Risk description**: Failure to deliver sufficient Cost improvements and continue to be efficient in national financial benchmarking **Risk owner:** CFO	4	3	12	• Track record, PMO facilitating ideas for savings etc. • BVBCB, FPC and Board monitoring CIP plans and delivery	Good	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	9
PA 2.3	NJ	**Risk description:** If the Trust does not engage with commercial and VCSE sector partners then cost effective solutions to complex challenges will be restricted and so the Trust will be limited in the impact it is able to have **Risk owner:** NJ	3	2	6	• Commercial and Partnerships Strategy and Plan • VCSE engagement via patient and public engagement and charity teams. • SLG reporting	Good	• Commercial strategy delivery reporting • Your Voice Engagement Group • Social Value strategy oversight	Requires Improvement	6
Partnership Objective 3: We will increase the capacity and resilience of our services by working with our provider collaboratives and networks and developing centres of excellence We will work together to reduce unwarranted clinical variation across Dorset										
PA 3.1	AT	**Risk description:** If the Trust does not collaborate with provider partners through the ICS Provider Collaboratives and other existing clinical networks then sustainable solutions via collaboration will not be explored or adopted and so v/m, sustainability and variation of services for patients will not decrease sufficiently **Risk owner:** COO	4	2	8	• Engagement in current 'provider colalboratives' e.g. Elective Care Oversight, Home First etc, UECB, DCP • Commitment to be engaged fully in ICS 'Provider Collaborative' South Walks initiative with system partners including Local Authority and community provider	Good	• Reporting to Trust Board and FPC • System documentation for Home First, Urgent and Emergency Care Board, Elective Care Oversight Group including Deep Dives and SRO roles, work-stream specific documentation	Good	8
PA 3.2	NJ	**Risk description:** If the Trust does not initially support the appropriate delegation of authority to the Provider Collaborative and then does not adequately acknowledge and accept the delegation then effective functioning of the Provider Collaborative will not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented **Risk owner:** NJ	4	2	8	• Engagement of Trust Board in ICS discussions and planning • Trust Board review and approval of any delegation. The Trust has a legal obligation to collaborate outlined in the amended provider licence	Good	• Trust Board papers	Good	8
PA 3.3	NJ	**Risk description:** If the Trust does not invest and support key services identified as 'centres of excellence' by the clinical strategy then investment into key services integral to the future sustainability of the Trust will not be forthcoming **Risk owner:** CMO	4	4	16	• The Clinical Strategy will set out the areas for investment and prioritisation. • Investment through business planning will be aligned to clincial strategy to ensure investment in key areas which are integral to the future sustainability if the Trust • Review of investment and impact via divisional performance framework and sub-committee structure.	Good	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	8
Partnership Objective 4 Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities										
PA 4.1	NJ	**Risk description:** If the Trust does not recognise the impact of it's decisions on the wider economic, social and environmental well-being of our local communities then our impact will not be as positive as it could be and so the health our our populations will be affected **Risk owner:** NJ	3	3	9	• Social Value Programme. • Social Value Impact Assessments against decisiong • Reporting of social value programme progress and impact against social value plan to SLG and Trust Board.	Good	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	6

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

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

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

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

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

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

Identifying Risks

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

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

Scoring & Grading

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

Consequence score (C)

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

DOMAIN C1: SAFETY, QUALITY & WELFARE

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

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

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

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

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

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Inadequate/poor performance rating Severely critical report

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Meeting Title:	Board of Directors
Date of Meeting:	24 November 2021
Document Title:	**Corporate Risk Register**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Mandy Ford, Head of Risk Management and Quality Assurance

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated,
Risk and Audit Committee	16/11/2021	

Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that risks corporate risks are effectively being managed and that controls are in place to monitor these. All care group risk registers are being reviewed by the Service Manager and Division. The risks detailed in this report are to reflect the operational risks, rather than the strategic risks reflected in the Board Assurance Framework.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*	✓	*Approve (✓)*	
Summary of Key Issues	The most significant risks which could prevent us from achieving our strategic objectives are detailed in the tables within the report. All current active risks continue to be reviewed with the risk leads to ensure that the risks are in line with the Risk Management Framework and the risk scoring has been realigned.							
Action recommended	The Board is recommended to: • review the current Corporate Risk Register • note the Extreme and High risk areas and actions • consider overall risks to strategic objectives and BAF							

Governance and Compliance Obligations

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

Board of Directors
Corporate Risk Register as at 31.10.2021

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

1. Introduction

1.1 This report provides an update from the report presented to the September 2021 Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 31.10.2021 unless otherwise stated and is reflective of the operational risks.

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

1.3 As agreed at the July 2021 Committee, this report details **all** risks held on the Corporate Risk Register.

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

- Heat Map (detailed in Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)
- Risk register items recommended for movement to 'managed'.

1.5 **Recommendation of Risk to be moved to 'Managed/Tolerated within Risk Appetite'.**

- PACS storage (1084)

The Board will recall that this risk related to the capacity to store images due to the increased numbers of Cardiac CT and MRI workload which was likely to completely fill the storage by Autumn 2021.

To mitigate this risk, the ICT department have procured, installed and commissioned the additional storage needed. An additional 48TB of data has been added to the PACS storage area. Whilst the service will continue to consume the disk space as the Trust increases its activity or purchases new equipment for Radiology, ICT are still producing monthly usage reports for the service so that we can plan any further replacement storage.

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

1.7 463 Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff (High – next review date 31.12.2021) ; and
468 Recruitment and retention of Medical staff across specialities (Extreme –next review date 31.12.2021)

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

1.8 896 Counter Fraud - Payroll and Agency(Very low – next review 31.03.2022)
897 Counter Fraud - HR Employment checks and sickness management (Low - next review 31.03.2022)
898 Counter Fraud – Procurement (Low - next review 31.03.2022)
899 Counter Fraud - Account Payable(Low - next review 31.03.2022)
900 Counter Fraud - IT/Telephony (Low - next review 31.03.2022)
901 Counter Fraud - Cash and Treasury (Very low – next review 31.03.2022)
902 Counter Fraud - Legal and Compliance (Low - next review 31.03.2022)

1.8.1 These risks are linked to our Financial Standing orders and we are required to hold these on the Risk Register. All of the above risks were added to the Corporate Risk Register on 18 November 2019. They are reviewed annually, or before should new guidance be issued, or should incidents be reported.

1.8.2 All of the above are subjected to scrutiny by Counterfraud Services, and Internal and External Audit as part of the rolling audit programme. Where issues have been found within Payroll or Procurement, appropriate referrals have been made to Counterfraud to review and investigate.

1.9 696 Damage or loss of building(Added to Register 04.07.2019 Low – next review 15.09.2022)
460 Terrorist and Other Malicious Attacks (Added to Register 23.10.2017 Low - next review 31.03.2022)
704 BREXIT - UK Leaving the EU without a deal (Added to Register: 04.07.2019 Low- next review 31.12.2021)

1.9.1 These form part of the Risk Register linked to Emergency Planning and Security. An annual review of the risks is undertaken, unless we receive Government notification raising the alert levels nationally or locally.

1.9.2 Risk Management also hold monthly meeting with the local Police service and other agencies, to remain informed of potential issues in the local area.

1.9.3 In terms of Risks 696 and 460, we routinely review our business continuity plans, and undertake unannounced training exercises to be assured that the processes we have in place to deal with such an event are robust, and that staff are aware of the action that needs to be taken

2. Updates

2.1 **Financial sustainability (449)**

This has been moved from managed risks back to active risks due to the change in the Trust financial status. Risk level raised form Low to Moderate. Details are contacting in Appendix 2.

3. Top Themes:

3.1 **Covid 19**

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

3.1.1 The number of cases within the South West continue to steadily increase. This has impacted on staff absence and contact isolation. However staffing has been mitigated by the use of bank and agency staff, or reallocating staff on duty to ensure both staff and patients safety.

3.1.2 In order to mitigate the risk to the staff, the Trust provides all staff with the recommended PPE types with a rational for use:

- Filtering face piece class 3 (FFP3) respirators
- Fluid resistant surgical masks
- Eye and face protection
- Disposable aprons and gowns
- Disposable gloves
- Outpatients and visitors required to wear masks on site, unless they are exempt. (Masks are provided by the Trust at all entrances, and visitors to wards are provided with the necessary PPE and visits are pre-booked.)

3.1.2 The Trust currently has sufficient quantities of all PPE as required, and training on the use of FFP3 will commence shortly to ensure that staff required to use FFP3 are competent to do so.

3.1.3 Eligible staff have been contacted to receive their Covid 19 vaccination booster to ensure resilience of the workforce. In addition, Flu jabs in have also been offered.

3.2 Constitutional standards

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

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

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

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

3.3 Mortality

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

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

- The SMR is now statistically significantly higher than expected again at 114.2, it has increased by 4.3. This may be being influenced by the high volume of uncoded activity for more recent months. Staffing vacancies have been filled but there is a level of staff sickness and movement within the team, and the focus for coding changed to try and code the elective activity due to the impact on ERF. The Executive lead is confident that by the end of the year, the backlog will have been addressed.
- Emergency admissions continue to have a statistically significantly higher than expected relative risk
- The HSMR remains within the expected range at 102.5, it has increased by 0.6 vs. the previous rolling 12 month period
- Emergency weekday HSMR remains within the expected range, it has decreased by 0.3 vs. the previous rolling 12 month period
- Emergency weekend HSMR remains within the expected range, it has increased by 2.9 vs. the previous rolling 12 month period

3.3.2 Recruitment process for a full time Coding Manger post will commence in November 2021. Assurance has been provided by the Executive lead that the backlog in coding should be completed by year end.

3.4 Staffing

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

4 Divisional Emerging Risks (Details in Appendix 3)

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

- 461- High volume of patients with no reason to reside (scored as 20 (Extreme) (Major (4) x Certain (5))
  Previously reported to Committee as 'Inpatient length of stay (Scored as 15 (High) (Moderate (3) x Certain (5))'

4.1.1 This risk has been on the register since October 2018. The risk was reviewed and reframed on 09 September 2021 to ensure that it is reflective of the situation as it stands currently. It is due to be reviewed again 30 November 2021.

4.1.2 We still have a high volume of patients residing in the hospital with no medical need or reason to remain in a hospital bed which is impacting on the patients well-being and the flow of patients. These patients have now been cohorted on to a single ward.

4.1.3 Predominantly, these cohorts of patients are waiting for some form of care package, or placement within a residential or nursing home setting. Some patients are delayed by legal processes, such as Court of Protection, where there is some dispute over placement, or the patient's capacity to make a decision on their care.

4.1.4 On 20 October 2021, the Trust held a meeting with Dorset County Council, the Trust's Safeguarding Team, Risk Management to try and move some of these cases forward and to address some discrepancies that were found with the assessment of Deprivation of Liberty Safeguards and the Mental Health Act. These were addressed and there was a renewed commitment from all involved to work more closely together. However, this does not detract from the fact that there is a shortage of care packages in the community and this is impacting on a patient's length of stay.

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

4.1.5 Mitigations and actions have been reviewed and updated and are detailed below:-

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

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

- 942 – Replacement of CRIS servers (scored as 16 (High) (Major (4) x Likely (4)

4.2.1 DCH moved to a new Radiology Information System (RIS) supplied by Wellbeing/HSS, CRIS in July 2013. New servers were installed for this service which was due to be replaced at 5 years.

4.2.2 The funding for replacement is on the various Trust spreadsheet, however due to available funding the replacement of the servers had been repeatedly pushed back. As the servers age the likelihood of catastrophic failure increases and also the Server OS is significantly out of formal supports. Catastrophic failure of the servers would likely entail the complete loss of any patient data on CRIS as there is also no resiliency to the solution. However, we have no incidents of any failures being reported to date.

4.2.3 In order to mitigate this the Trust have procured two servers to replace the existing servers, they are installed and powered on, Wellbeing (3rd party support co) have requested to build the servers so essentially internally our ICT department have done as they can do to.

4.2.4 Regarding further mitigation with the current system, there is resilience in the current solution as there are 2 servers, should one stop working the other can be manually turned over by Wellbeing. The replacement servers will be setup exactly the same, so apart from newer operating systems the mitigation will still be there.

4.2.5 This is similar or the same for a lot of the Trusts server hardware which has always been an acceptable risk for the Trust. We try and build resilience into everything we do, and we backup essential data, but the probability of losing a server room is rare but servers can have components fail. ICT design the resilience commensurate with the budget available and we have not had a major loss of any of our systems or servers for a prolonged period.

5. Conclusion

Risks continue to be regularly reviewed and updated in line with the Risk Management Framework and is linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place. The Risk team continues to work with the Divisions to review and challenge, open and active entries on the live risk register to ensure that scoring is correct and that risks are being reviewed and appropriately followed up and actions being followed through.

6. Recommendation

The Board is recommended to:

- review the current Corporate Risk Register ; and
- note the Extreme and High risk areas and actions
- consider overall risks to strategic objectives and BAF
- Agree to the move of the risk relating to PACS storage (1084) to be moved to ‘managed’

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 03.11.2021
Appendices
Appendix 1 – Heat map
Appendix 2 - Corporate Risk Register
Appendix 3 – Emerging Divisional Risk Details
Appendix 4 – Recommendations for movement to ‘Managed’

Heat Map **(active risks only)** **Appendix 1**

		Likelihood Score				
	score	**1**	**2**	**3**	**4**	**5**
		Rare (this will probably never happen 1x year)	**Unlikely (Do not expect it to happen but it is possible 2 x year)**	**Possible (might happen occasionally - monthly)**	**Likely (will probably happen - weekly)**	**Certain (will undoubtedly happen – daily)**
Impact/Consequence Score	**5 Catastrophic**	**5**	**10**	**15** (463, 641)	**20**	**25**
	4 Major	**4**	**8**	**12** (690)	**16** (474, 979)	**20** (468,472,709, 710, 840, 919,)
	3 Moderate	**3** (460)	**6** (898, 899,900, 902)	**9** (470, 704)	**12** (449↑ , 450, 464)	**15**
	2 Minor	**2** (896,901,973)	**4** (1084↓)	**6** (897)	**8** (449, 696)	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**
	KEY	**(↓number) (↑number)**	Risk score has decreased since previous report Risk score has increased since previous report **Please note that no arrow indicates no change to previous risk score.**			
	Managed/Tolerated risks	463 (High – next review date 31.12.2021)Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff; and 468 (Extreme –next review date 31.12.2021) Recruitment and retention of Medical staff across specialties 896 (Very low) Counter Fraud - Payroll and Agency 897 (Low - next review 31.03.2022) Counter Fraud - HR Employment checks and sickness management 898 (Low - next review 31.03.2022) Counter Fraud – Procurement 899 (Low - next review 31.03.2022) Counter Fraud - Account Payable 900 (Low - next review 31.03.2022) Counter Fraud - IT/Telephony 902 (Low - next review 31.03.2022) Counter Fraud - Legal and Compliance 696 (Low – next review 15.09.2022) Damage or loss of building 704 (Low- next review 31.12.2021) BREXIT - UK Leaving the EU without a deal 901 (Very low – next review 31.03.2022) Counter Fraud - Cash and Treasury 460 (Low - next review 31.03.2022) Terrorist and Other Malicious Attacks				
	Closed	469 Temporary Medical Workforce Planning & Capacity (this was reframed as 468) 456 (Low) Patient Transport Provision & Urgent Patient Transfers 973 (Very low) Public Disorder				

Corporate Risk Register **Appendix 2**

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

Movement on Risk Register: 	Risk Statement **DATE ADDED TO RISK REGISTER 25.03.2020**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Catastrophic Likelihood: Likely Reviewed: 02.11.2021
919	Covid- 19	Previous Rating	Extreme (20)
This will impact on all of our strategic objectives.		Lead Executive	Anita Thomas
How this risk has been scored: **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Tony James
Current position Mitigation As at 02.11.2021 (data correct as at 02.11.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible **Undetermined**
• The Trust currently has sufficient quantities of all PPE as required. Horizon scanning identifies any short comings and these can be fulfilled through mutual aid through escalation to NHS Supplies. In addition daily PPE SitReps are submitted to Dorset CCG. If any PPE item is not going to be available the Trusts Procurement Department will seek alternative supplies locally or nationally. • If supplies are provided as an alternative which are not CE marked these item go through a rigorous risk assessment process before being introduced. • Eligible staff have been contacted to receive their Covid 19 vaccination booster to ensure resilience of the workforce. • Flu jabs have also been offered. • Fit Mask testing to be re-run during November • National guidance being followed		Next review date **All actions identified to date have been completed**	02.12.2021

Movement on Risk Register: 	Risk Statement Community Paediatric Long Waits for ASD Patients **Date added to Corporate Risk Register 09.06.2021** **Opened by Service 10.09.2018 – reviewed monthly** **Escalated to Division 08.06.2021 request to escalate to Corporate**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 05.10.2021
472	There has been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 3: Collaborative** Joining up our services. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	James Male (service Manager)
Current position/Progress/Mitigation As at 05.10.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 28.02.2022
Mitigation: • Interviews for specialist grade took place 08.10.21. Post was appointed to start date 01.02.2022. Target date amended to reflect the start date. • Additional clinics continue to run and have been set up for October, November & December 2021. • Maximising capacity by reducing DNAs with significant effect • Keeping patients informed and signposting for support and information • Sending holding letters so patients and families are aware that they have not been forgotten. Safety netting advice provided • Pan Dorset pathway redesign • Waiting list remains at 320		Next review date **ACTION RE APPOINTMENT COMPLETED** **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	08.11.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 31.08.2021
709	Failure to achieve constitutional standards (elective Care)	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective 1 : **Outstanding:** Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards Strategic Objective 3 Not achieving a 96% score on our friends and family test, Not being at the centre of an accountable care system, commissioned to achieve the best outcomes for our patients and communities **Strategic Objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Anita Thomas
Current position/Progress/Mitigation As at 06.09.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Covid- 19 impacted on services – this is being reviewed as part of the start-up work. • This is coded as extreme due to the potential impact on patient safety and delay in treatment that could potentially lead to harm – this is being mitigated by reviewing patients based on clinical need and any changes in presentations. • Diagnostics – Recovery plans and trajectories are in place and being monitored by the Elective Performance Management Group to return the trust to achieving the required standard. Use of insourcing and outsourcing providers is underway. • Cancer – The Trust has recovered cancer performance to pre-COVID levels as per the 2021/22 guidance; with an improved 104 day backstop position. The required standard is still not being met and a trajectory to achieve this by the end of the year is in place. • ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national		Next review date **ACTIONS ONGOING TO RESUME ACTIVITY** **Meeting to be arranged with Anita Thomas to review now in post.**	31.12.2021

average. • Looking at alternatives to continue to provide care – wards reconfigured to assist with this.		
OTHER RISK REGISTERS LINKED TO RISK 709	**Current rating following local review**	**Target rating following completion of all actions**
450 Emergency Department Target, delays to care and Patient flow 473 Failure to meet 6 week diagnostic targets for paediatric and adult audiology 531 Same day emergency care mandated activity 554 Non-compliance with QS33 Rheumatoid arthritis in over 16s 555 Partial non-compliance with NG100 – rheumatology Numerous incidents reported in relation to cancellation of clinics and increase in complaints regarding treatment delays.	Moderate Low Risk Moderate Low Risk Low Risk Potential for litigation due to patient harm	Moderate Low Risk Low risk Very low risk Very low risk

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 31.08.2021
710	Follow up waiting list backlog	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	All services
Current position/Progress/Mitigation As at 06.09.2021(data correct as at 03.11.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2025
• Robust reporting arrangements are in place to allow the services to oversee and manage all of the patients on their waiting lists. • Follow up waiting list numbers and profile of the waiting list is routinely reported to FPC. • Patient initiated follow ups are being launched in 3 specialities in 2021/22. This will reduce the volume of non-value adding appointments, releasing capacity to address the backlog. • Where clinically appropriate, virtual appointments are now offered, either via video consultation or via telephone. Virtual appointments are more efficient and result in higher volumes of patients being seen per clinic.		Next review date **ACTIONS ONGOING TO RESUME ACTIVITY** **Meeting to be arranged with Anita Thomas to review now in post.**	31.12.2021
OTHER RISK REGISTERS LINKED TO RISK 709		**Current rating following local review**	**Target rating following completion of all actions**
462 Lack of ophthalmology service capacity to meet demand		Moderate	Low risk

472 Community paediatric long waits for ASD patients	Extreme	Moderate
505 Volume of patients on the gastroenterology follow up outpatient waiting list	Low risk	Low risk
557 Surveillance colonoscopy patients waiting greater than 6 months from their due date	Moderate	Very low risk
561 Volume of patients on the orthopaedic admitted list	Extreme	Low risk
581 Volume of patients on the dermatology outpatient waiting list	High	Low risk
777 Long waiting list for outpatient orthotic appointments	Low risk	Low risk
956 Excessive sleep diagnostic waiting times	Low risk	Very low risk
991 Increasing waiting list for paediatric dietetic outpatients	Moderate	Very low risk
1003 Ambulatory EEG waiting list	High	Low risk

Movement on Risk Register: 	Risk Statement **This risk was added to Datix on (it looks like 09.10.2019), with a review date of 09.01.2020. It was marked for quarterly review 27.11.2020 and weekly review from 30.03.2021.** **It was marked as service specific on 03.12.2020, escalated to Division at that point and to Corporate for consideration via Division on 16.03.2021.** **Risk score allocated to this by the service between 18.12.2019 and 07.10.2020 was scored as 12 (moderate), this was reviewed and rescored 19.10.2020 to 15 (high) and then 20 (Extreme) following the review on 26.11.2020** **Agreed for addition to Corporate Risk Register 01.05.2021**	CURRENT RISK RATING (Following review)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 05.10.2021
840	Paediatric Diabetes Service Staffing	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic Objective 3: Collaborative** Failing to deliver services which have been co-designed with patients and partners Failing to be an integral part of full system multi-disciplinary teams **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Certain**		Local Manager	Anna Ekerold
Current position/Progress/Mitigation As at 05.10.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING Target Date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 06.12.2021
Mitigation: • Band 5 LM previously seconded from Kingfisher covering 23hrs per week now permanent. • New Band 6 PDSN ED began employment in June 2021. • Band 7 PDSD to increase hours from 0.5 to 1 WTE with effect from 01/10/2021.		Next review date **LIKELY TARGET DATE WILL NEED TO BE EXTENDED DUE**	05.11.2021

• 1.4 WTE Band 6 PDSN posts currently out to advert. • 1 WTE Clinical Psychology awaiting advertisement. • 2 PA's Consultant time currently covered by Speciality Doctor SZ, however long term plan for Consultant PP to cover this role. • Urgent & Integrated Care Division successful for funding for transition service. Recruitment underway. • Confirmation from Division is that funding has been agreed for additional staffing from Oct 2021. **ONCE THESE STAFF ARE IN PLACE, THE RISK SEVERITY SHOULD BE REDUCED**	**TO RECRUITMENT PROCESS.** **NOT ALL VACANCIES APPOINTED TO AND NEW STARTERS NOT YET COMMENCED IN POST.**	

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 08.10.2021
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 5: **Sustainable :** Not using our estate efficiently and flexibly to deliver safe services **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Don Taylor
Current position/Progress/Mitigation As at 08.10.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING (TARGET) Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31/03/2022
We have now received all the returned tender bids for the replacement system, the final scoring pre award will be carried out on the 15 October 2021, once preferred bidder identified. This will require approval from senior management team as costs currently expected to be great than initial budget. When additional funding approved we can then awarded to contractor and commence programme. Currently expected to start Jan- March 2022. Mitigation currently is being managed through the current system and process.		Next review date **ACTIONS ON TARGET TO BE COMPLETED BY 31.03.2022**	31.12.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 15.10.2021
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Sue Eve-Jones
Current position/Progress/Mitigation As at 15.10.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING (Target) Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31/03/2022
Staffing vacancies filled but there is a level of staff sickness and movement within the team. Focus for coding changed to try and code the elective activity due to the impact on ERF. Facilities have arranged additional floor space in West Annex so that staff are able to be on site Impact of home working and lack of records on DPR also impacted on coding - unable to take paper records home. By the end of the year it is anticipated that the backlog in coding will be addressed. Recruitment process will commence for a full time Coding Manager's post in November 2021. Discussions on management of this risk continue at HMG.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	31.12.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	High (16) Consequence: Major Likelihood: Likely Reviewed: 08.09.2021
979	Removal/reduction of education funding from HEE commencing April 21.	Previous Rating	Moderate (12)
Impact on Strategic Objectives		Lead Executive	Nicky Lucey covering
Strategic objective 1 : Outstanding Not having the appropriate workforce in place to deliver our patient needs **Strategic objective 4: Enabling** Failure to deliver flexible and appropriate service models**,** Loss of training status for junior doctors **Strategic objective 5:** Sustainable **How this risk has been scored:** **Consequence: Moderate** **Patient safety** – event that impacts on a small number of patients, increase length of stay by 4-16 days **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service **Likelihood:** Certain		Local Manager	Elaine Hartley
Current position/Progress/Mitigation As at 08.09.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING (target) Target date	Low Risk (6) Consequence: Minor Likelihood: Possible 31.03.2022
We have submitted our request for funding to the Dorset ICS in July. Our request is based on the TNA scope for 21/22 and incorporates all requests for health care science, pharmacy and non clinical. We are yet to receive a confirmation of the funding we will get and we have had to go at risk for some staff to continue on programs which are longer than 12 months.		Next review date **We are hoping to receive confirmation of funding by the end of Q3 21/22**	31.12.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (Following review)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 01.11.2021
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective 1: Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **Strategic objective 5: Sustainable** Not generating 25% more commercial income with an average gross profit of 20% **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible**		Local Manager	Samantha Hartley
Current position/Progress/Mitigation As at 01.11.2021(data correct as at 03.11.2021)		POST MITIGATION RATING Target date:	Moderate (12) Consequence: Major Likelihood: Possible 31.11.2022
Mitigation: Liaison Service on site. Increase in activity is being managed with IMT ED area increased during pandemic to assist with flow and capacity. Building works commenced to enlarge ED 2021 ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average. UPDATE: Minor service has relocated to Weymouth UCC 28 June 2021 to assist with patient flow and attendances at ED		Next review date **ACTIONS ONGOING, BUILDING WORK CONTINUES TO ENLARGE FOOTPRINT. ADDRESSING FOOTPRINT VIA MASTERPLAN**	30.09.2022 (annual review)
OTHER RISK REGISTERS LINKED TO RISK 450		**Current rating following local review**	**Target rating following completion of all actions**
1060 ED Footprint not fit for purpose 1061 Workforce requirements for new ED 709 – Failure to achieve constitutional standards.		Low risk Moderate risk	Very Low risk Very Low risk

Ref: 	Risk Statement	CURRENT RISK RATING	Moderate (12) Consequence: Major Likelihood: Possible Reviewed:03.11.2021
449	**Financial Sustainability**	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 5: Sustainable Failing to be efficient as outlined in the Model Hospital, Failure to secure sufficient funding to ensure financial sustainability, Not generating 25% more commercial income with an average gross profit of 20%, Not returning to financial sustainability, with an operating surplus of 1% and self-sufficient in terms of cash, Not using our estate efficiently and flexibly to deliver safe services		Local Manager	Claire Abraham
Current position/Progress/Mitigation As at 03.11.2021(data correct as at 03.11.2021)		POST MITIGATION RATING (Target) Target date:	Low (6) Consequence: Moderate Likelihood: Unlikely 31.03.2022
We have submitted a draft 2nd half year plan showing a predicted deficit of £1.5m which is over 0.5% of annual budget		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	31.12.2021

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:20.10.2021
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective 1: Outstanding : Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit -** non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity -** National media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position/Progress/Mitigation As at 20.10.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING (target) Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2022
• The SMR is now statistically significantly higher than expected again at 114.2, it has increased by 4.3 vs. the previous rolling 12 month period, this may be being influenced by the high volume of uncoded activity for more recent months • Compared to small rural hospital peers, the Trust is one of five with an SMR that is statistically significantly higher than expected • Emergency admissions continue to have a statistically significantly higher than expected relative risk • The mortality dashboard shows four new CUSUM alerts and two new relative risk alerts compared with June 2021's report • The HSMR remains within the expected range at 102.5, it has increased by 0.6 vs. the previous rolling 12 month period • Emergency weekday HSMR remains within the expected range, it has decreased by 0.3 vs. the previous rolling 12 month period • Emergency weekend HSMR remains within the expected range, it has increased by 2.9 vs. the previous rolling 12 month period • The SHMI for May 2020 to April 2021 has increased by 1.95 vs. the previous reported period and remains statistically significantly higher than expected.		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641** **ACTIONS ONGOING AND CURRENTLY ON TARGET**	30.11.2021

Movement on Risk Register: 	Risk Statement **Added to the Risk Register 16.09.2016 reviewed in line with national policy and national risk register annually (unless incident occurs)**	CURRENT RISK RATING (Following review)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 15.09.2021
690	Malicious attack - Cyber attack on the NHS / Internal ICT failure	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards Not having effective emergency preparedness, resilience and business continuity plans **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results		Local Manager	Simon Brown
Current position/Progress/Mitigation As at 15.09.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING Target Date:	Moderate (12) Consequence: Major Likelihood: Possible 31.03.2025
PLEASE NOTE: EXTENAL RATING FROM NATIONAL RISK REGISTER OF CIVIL EMERGENCIES is Medium – low risk. This risk is linked to the ICT and Emergency Planning risk register. Linked to this risk there are others which are specific to the Trust infrastructure and Firewalls. There are full mitigations and actions in place, and these risks are reviewed monthly. To support the risk score as moderate, there have been no incidents reported in relation to any cybersecurity breaches or loss of systems due to a cyberattack which would increase the likelihood score, which in turn would then escalate the risk score.		Next review date **ACTIONS AND MITIGATION EFFECTIVE AND ONGOING**	02.09.2022

Movement on Risk Register: 	Risk Statement **Added to the Risk Register 17.10.2018**	CURRENT RISK RATING (Following review)	Low (9) Consequence: Moderate Likelihood: Possible Reviewed: 04.08.2021
470	Fire Door Maintenance	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic objective 1: outstanding failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, not achieving an outstanding rating from the care quality commission by 2020, not achieving national and constitutional performance and access standards Not having effective emergency preparedness, resilience and business continuity plans **Strategic objective 5: sustainable** failing to be efficient as outlined in the model hospital. **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results		Local Manager	Don Taylor
Current position/Progress/Mitigation As at 04.08.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING Target Date:	Very Low (4) Consequence: Minor Likelihood: Unlikely 31.03.2022
Covid has impacted on the delivery of replacement doors. Funding request could not be met until 2021/22 Further additional labour engaged to mid September. CAP funded carpenter released. REV funded carpenter position empty as waiting approval for band increase to recruit suitable candidates. Programme is focussing on high risk fire doors currently. Risk mitigated by other processes in place, regular fire inspections, fire training mandatory for all staff, health and safety audits being completed and reported to the Safety Group. No incidents of fire reported to increase the risk.		Next review date **ACTIONS AND MITIGATION EFFECTIVE AND ONGOING**	31.12.2021

Emerging Divisional Risks

Appendix 3

Movement on Risk Register: 	Risk Statement Added to Risk Register 03.08.2021	CURRENT RISK RATING (Following review)	High (16) Consequence: Major Likelihood: Likely Reviewed: 15.10.2021
942	Replacement of CRIS Servers	Previous Rating	Moderate Risk
Current position/Progress/Mitigation As at 15.10.2021 (data correct as at 03.11.2021)		POST MITIGATION RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.03.2022
Mitigation: • We have procured two servers to replace the existing servers, they are installed and powered on, Wellbeing (3rd party support co) have requested to build the servers so essentially ICT have done as much as we would need to do. • There is resilience in the current solution as there are 2 servers, should one stop working the other can be manually turned over by Wellbeing • The replacement servers will be setup exactly the same, so apart from newer operating systems the mitigation will still be there • Whilst the hardware is currently adequate to run the services we have at this time it is clear that should we wish to take any further modules or features from the company, we may not be able to due to performance of the core system being affected • New Servers are on site pending Wellbeing project management of install		Next review date **ACTIONS ONGOING**	31.12.2021

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

Recommend movement to 'Managed' Appendix 4

Movement on Risk Register: 	Risk Statement PACS Storage **Date added to Risk Register 22.04.2021**	CURRENT RISK RATING (Following review)	Very Low (4) Consequence: Minor Likelihood: Unlikely Reviewed: 14.10.2021
1084	The issue is that the new CT scanner takes a more in depth picture that is therefore larger and takes up more storage. Unfortunately the increased storage requirements weren't factored in at the time, but there has been a change in the consumption forecast.	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective 1 : Outstanding Failing to be in the top quartile of key quality and clinical outcome indices for safety and quality, Not achieving an outstanding rating from the Care Quality Commission by 2020, Not achieving national and constitutional performance and access standards **Strategic Objective 5: Sustainable** Failing to be efficient as outlined in the Model Hospital. **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	Simon Brown
Current position/Progress/Mitigation As at 06.05.2021 (data correct as at 06.05.2021)		POST MITIGATION RATING Target date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely **31.03.2022**
Mitigation: • ICT procured, installed and commissioned the additional data **(action complete)** In additional 48TB of data added to the PACS storage area, whilst the service will continue to consume the disk space as the Trust increases its activity or purchased new equipment for Radiology, we are still producing monthly usage reports so that we can plan any further replacement storage. **RISK MITIGATED - REQUEST TO MOVE TO TOLERATED**		Next review date	30.11.2021

Meeting Title:	DCHFT Board
Date of Meeting:	24th November 2021
Document Title:	**DCH Social Value Programme – Progress Report**
Responsible Director:	Nicholas Johnson, Deputy Chief Executive
Author:	Simon Pearson, Head of Charity & Social Value

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Trust Board Senior Leadership Group	26.5.21 10.11.21	Board requested 6 month progress report on DCH Social Value programme.

Purpose of the Paper	To report progress on the DCH Social Value programme and commitments.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The enclosed report presents an update on key activities relating to development of the DCH Social Value programme. • Social Value Action Plan • Embedding Social Value across DCH • Social Value Evaluation • DCH Social Value communications • Dorset Anchors Networks • Health Anchors Learning Network bid							
Action recommended	The Trust Board is recommended to: 1. **NOTE** progress to date and plans for further development of the DCH Social Value programme.							

Governance and Compliance Obligations

Legal / Regulatory	Y	The Public Services (Social Value) Act 2012
Financial	N	
Impacts Strategic Objectives?	Y	DCH Social Value commitments to be embedded through DCHFT strategic objectives and activities.
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	Purpose of the Social Value programme is to deliver DCH social value commitments as per DCHFT Social Value Pledge.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DCH Social Value Programme: Progress Report (Nov 2021)

Our Social Value Pledge
Dorset County Hospital Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental well-being of the local population. Through our approach to delivering social value as an Acute Trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community.

This report presents a six month progress update in implementing our Social Value programme.

- **Social Value Programme Group:** the group's role is to develop, manage, evaluate and report on DCHFT's social value commitments and the impact we have as an anchor institution. Meetings are held monthly to progress the Trust's social value programme development and implementation. The Programme Group will provide six-monthly progress reports to SLG and the DCHFT Board.

- **DCHFT Social Value Action Plan:** our current operational plan comprises key workstreams which reflect our social value commitments and objectives – the plan is available on sharepoint here: http://sharepoint/departments/DCH-Social-Value/SitePages/Home.aspx . Development of the plan will also align with the new Trust Strategy and enabling strategies, integrating social value into the Trust's business planning and operational activities as we move forward.

- **Embedding Social Value Across DCH:** SV Programme Group is considering our approach to embedding social value in the Trust's strategic planning process, integrating social value into business planning and operational activities as we move forward. We are aligning this work with DCH's Health Inequalities programme and the related interdependencies.

- **Social Value Impact Assessment:** we have developed a Social Value Impact Assessment template to integrate social value across the Trust's operational activities and align with DCH Health Inequalities work. An assessment of social value impact will be embedded in Trust policies, business planning and key corporate documents. The process for implementing this in Trust procedures is currently under consideration.

- **Social Value Evaluation:** we are working with DCH Business Intelligence team to develop our management information dashboard, aligned to our Social Value Action Plan. This will present our key social value metrics, comprising both quantitative and qualitative information. We are also considering the evaluation services of external providers, including online platforms, which would integrate with our systems. Once implemented, we will present a social value dashboard summary with our six-monthly reports to SLG and the Board.

- **Communications:**

  DCH Social Value communications: as we develop our programme we are communicating our social value ambition and delivery (internally and externally)**.** Current DCH activities delivering social value have been publicised including the Kickstart scheme which is providing work placements for young people age 16-24 who are not currently in employment or education.

  Regional Services Network Spotlight (Oct 2021): This is the e-newsletter for members of the Rural Services Network. DCH published an online article entitled 'Addressing rural health inequalities as an anchor institution'.

  DCHFT Annual Report 2021/22: the Trust's Annual Report will reflect our social value commitments across our operational activities. From 21/22 we will plan to report key metrics and qualitative information to convey the Trust's positive social value impact on the community we serve.

- **Dorset System – Anchors Network:** DCH recently contributed to a Health Foundation led workshop with our Dorset system partners looking at the role of anchor institutions in the post-pandemic recovery. Work is now taking place to establish a Dorset Anchors Network and Anchor Charter . DCH has signed the charter (Oct 2021). This will lead to a system-level approach to take forward our ambition to improve the social, economic and environmental well-being of our communities.

- **Funding: Health Anchors Learning Network Test & Learn grants** - these are aimed at Anchor Institutions working in partnership at system level. DCH working with Public Health Dorset and CCG representatives submitted an EoI and have now been invited to submit a full application for £25K grant. The proposal is focussed on development of a Dorset Sustainable Procurement Network.

Simon Pearson MCIOF
Head of Charity & Social Value

Meeting Title:	Trust Board
Date of Meeting:	24 November 2021
Document Title:	Handover Delays – Review of NHSE/I Letter Requirements
Responsible Director:	Anita Thomas, Interim Chief Operating Officer
Author:	Anita Thomas Tony James, Head of EPRR

Confidentiality:	None
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
None		

Purpose of the Paper								
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	A letter from NHSE/I received in late October described the need to eliminate handover delays in ED, the letter also described that the use of corridor care was not to be considered acceptable. • During the ED15 works 'majors' capacity is maximised throughout the phasing of the works. • A designated Priority Admissions Lounge will not be completed until Quarter 1 of 2022/23. • ED uses the FAB process to maximum effect until the department is too full to facilitate onward movement from the FAB bays to either a Majors bay or 'Fit to Sit area' at which point a queue out of the department comprising of patients assessed to be stable to move is created in the Major Incident Corridor next to Majors A/Radiology. The DCH Head of EPRR completed an assessment of the processes in ED to manage ambulance handovers and has concluded the approach reduces the risks to patients and staff and is the best use of estate at this time. The assessment has been shared with SWAST and Dorset CCG and it is seen as good practice and other Trusts are encouraged to adopt a similar approach.							
Action recommended	The Trust Board is recommended to: 1. **NOTE** the contents of the paper 2. **APPROVE** the approach taken to ambulance handovers in ED							

Governance and Compliance Obligations

Legal / Regulatory	Y	Ambulance Handovers form part of the H2 performance standards and are

		a feature of the NHS Standard Operating Procedure performance metrics
Financial	N	
Impacts Strategic Objectives?	Y	Negative Impact on ED standards
Risk?	Y	Referenced in numerous risks associated with ED and hospital flow
Decision to be made?	Y	Approved continued approach to ambulance handovers in DCH ED
Impacts CQC Standards?	Y	Safety
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Trust Board
24 November 2021

Handover Delays – Review of NHSE/I Letter Requirements

Executive Summary

NHSE/I wrote to Trusts at the end of October (see Appendix 1) to reaffirm the content of the Urgent and Emergency Recovery 10 Point Plan and to request that all Trusts work collectively with system partners to eliminate Ambulance Handover Delays with immediate effect.

'Handover delays' are any ambulances reported as held for over 15 minutes within a hospital which is the expected standard time for arrival and clinical handover. There are some exceptions to this expectation which include patients taken immediately into Resus in ED but the majority of ambulance arrivals should expect to conclude within 15 minutes.

The 10 Point Recovery Plan includes actions from system partners to ensure there are sufficient resources throughout the system to promote best use of services and appropriate levels of access and capacity under the following headings:

- Supporting 999 and 111 Services
- Supporting Primary Care and Community Health Services to help manage the demand for UEC Services
- Supporting greater use of Urgent Treatment Centres
- Increasing support for Children and Young People
- Using communications to support the public to choose wisely
- Improving in-hospital flow and discharge (system wide)
- Supporting adult and children's mental health needs
- Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
- Reviewing staff COVID isolation rules
- Ensuring a sustainable workforce

The Dorset UEC Board will oversee the Dorset System response.

In order to provide internal assurance on DCH responsibilities, the Head of Emergency Planning and Response (EPRR) for DCH has undertaken a risk assessment of the DCH ED 'front door' response to ambulance handovers including policy, procedure, and observation of implementation and the summary of his findings is contained within Appendix 2 of this paper.

1. Introduction

DCH has consistently performed well in handover delays with the lowest proportion of handovers over 15 minutes in the region throughout 2021/22. 9% of handovers in Quarter 1 and 21% of handovers in Quarter 2. Sadly this does indicate an increasing number of handover delays despite maintaining our position as best performing Trust in the Region with regular praise from SWAST expressed at local and Regional meetings.

This deterioration must be viewed within the context of consistently also having one of the highest levels of bed occupancy in the region at >95% and between 18 - 20% of beds occupied with patients with no reason to reside. It is therefore necessary for the System to provide a coordinated approach to tackling demand and capacity across the whole urgent and emergency care pathway including onward conveyance to a non-acute venue once the acute care period is medically indicated as complete.

This paper does not detail the System response to the requirements of the 10 point plan as this is still in development.

Internal assurance is presented in Appendix 2.

2. Narrative

Ideally flow is maintained throughout ED at all times but the reality of the current pressures is such that the ambulance service lowers the criteria for conveyance when the service is stretched in order to free up crews more quickly, the hospital is constantly at high bed occupancy which means flow from an ED will slow while discharges are affected and these two key factors can lead to queues forming during pressured parts of the day, predominantly early evenings.

The FAB process at the front door has proven very effective in the management of ambulance handovers and has been regularly praised by SWAST, with other EDs in the region encouraged to adopt a similar approach. By having two bays reserved at the front door to facilitate an immediate handover of ‘majors’ arrivals queuing to handover is minimised as long as flow out of the bays to either a Majors bay or the ‘Fit to Sit area’ for further investigation can be maintained.

The letter requests that corridor care does not take place in EDs.

‘*It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.*’

DCH ED protocols prioritise the maintenance of the FAB processes with ‘queuing out’ if the department begins to become crowded. Until the Priority Admission Lounge is completed in 2022 as part of ED15 the only suitable estate for cohorting patients safely is the Major Incident Corridor outside of Majors A/Radiology in North Wing.

As described in Appendix 2 the Head of EPRR has assessed the policies and procedures for managing ED flow and observed the use of them live in ED. He has deemed 'queuing out', the act of moving patients assessed as stable out of ED into a designated area, the method by which the least risk is experienced within the department when ambulance queues start to form.

The outcome of the assessment and recommended have been shared with SWAST and the CCG who have agreed that the DCH approach should be recommended to other Trusts as it supports flow, through the safest approach and has demonstrably shown positive results for ambulance handover times.

3. Conclusion

- All efforts to reduce handover delays are in place and efficacy can be seen in continuing to be the trust with the lowest proportion of delays in the Region
- Policies and procedures have been assessed and shown to provide the least risks when queues form
- SWAST and CCG accept that the DCH FAB and 'queuing out' approach in the current available estate is good practice and have recommended it to other Trusts.

4. Recommendation

The Committee is recommended to:

1. **NOTE** the contents of the paper
2. **APPROVE** the approach taken to ambulance handovers in ED

Name and Title of Author: Anita Thomas, Interim Chief Operation Officer
Date: 05 November 2021

Appendices
Appendix 1 – NHSE/I Letter – Addressing Ambulance Handover Delays
Appendix 2 – Review of using a designated corridor to queue out of ED against the national directive of no corridor care in ED

Appendix 1
Classification: Official
Publication approval reference: BW1101

To: ICS Leads
Acute Trust Chief Executives
Ambulance Service Chief Executives
Acute Trust Chairs

CC: CCG Accountable Officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

26 October 2021

Dear colleague

For action – Addressing ambulance handover delays

We are writing to all Trusts and ICSs regarding delays in handing over responsibility for the care of patients from ambulances to Emergency Departments, recognising that these delays can only be addressed through good system working and cross-organisational cooperation.

In the UEC Recovery 10 Point Action Plan we asked that ICSs "make sure there are robust steps in place to avoid handover delays". We know, and are grateful, that staff within your system are already working incredibly hard to resolve this problem. Given the impact on patients, we must however press to identify further solutions to eliminate all handover delays.

Handover delays

National policy has set out that handovers should take no more than 15 minutes, ensuring patients receive necessary emergency care and allowing ambulances to get back on the road responding to patients in the community.

You will be keenly aware of the risks associated with hospital handover delays.

Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services.

Taking action to eliminate delays

All systems must take action to ensure that ambulances are not used as additional ED cubicles, and that crews are able to safely offload their patient to the care of the ED. It is important that patient safety is prioritised and as a result we emphasise that corridor care is unacceptable as a solution.

We are now asking you to work together as a system and agree what actions you would need to take to immediately stop all delays. We appreciate that this may involve some difficult choices, and that we will need to discuss and involve colleagues, including the CQC, where helpful. For ease of reference we are attaching a list of measures which we know that some of you have implemented which have demonstrated clear benefits.

Today we also are asking Trusts, and their Systems, to report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue. You may find it helpful to invite clinical staff from the relevant areas to join these discussions.

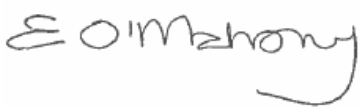
Initiatives being used in systems

The following is not exhaustive, and a combination of initiatives is likely to be most effective:

- Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward
- Wherever practical implement “fit-to-sit” for patients that do not require a trolley
- Ensure early access to clinical decision-makers to enable prompt admission / discharge
- Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
- Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
- Maximise discharge through following principles within the hospital discharge and community support: policy and operating model
- Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
- Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
- Work with two hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
- Local agreement of staffing models e.g. using acute trust, ambulance service and community service staff in partnership to support surge capacity
- Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
- Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site

We thank you for taking this necessary rapid action to address the risks associated with handover delays.

Yours sincerely



Pauline Philip DBE
National Director for Emergency and Elective Care

Professor Steve Powis
National Medical Director

Elizabeth O'Mahony
Regional Director
South West

Dorset County Hospital
NHS Foundation Trust

Review of using a designated corridor to queue out of ED against the national directive of no corridor care in ED.

Situation

National guidance has been in place since the onset of the Covid-19 pandemic to ensure the reduction of nosocomial infections in emergency departments, with zero tolerance of corridor care.

DCHFT expanded the emergency department footprint to maximise capacity and reduce risk to patients of airborne transmission of Covid-19. The trust has since been awarded the £15 million ED15 building money to keep the expanded footprint and develop the clinical space, this will includes a Priority Admissions Unit due for completion June 2022.

Until the completion of the building works the ED is operating using the maximum amount of majors capacity but demand has increased nationally with high acuity patients. The Priority Admissions Unit, which will provide a safe zone for patients who are clinically stable and awaiting an inpatient bed to reside until the bed becomes available, will not be completed until Quarter 1 of 2022/23. As a consequence, estate for patients to 'queue out' of the dept has to be located in different areas around ED when required in line with what is available and not subject to building works.

NHSE/I letter on ambulance handover delays includes guidance to get ambulances back on the road swiftly and reduce delays. DCHFT ED already meets the majority of the guidance within the letter but to further reduce risk the department endeavours to 'queue out' rather than in (i.e. queue arriving patients prior to clinical review) this approach is supported by the CCG and SWASFT and has now become advice to other Trusts within the region to adopt the same approach.

The hospital flow is reduced with averaging 50 patients (18-20% beds) with no reason to reside, elective restart, Covid-19 and socially distanced guidance has changed the criteria of some of the bed base which limits the usability if patients do not meet criteria and elective pathways remain protected.

Appendix 2

Background

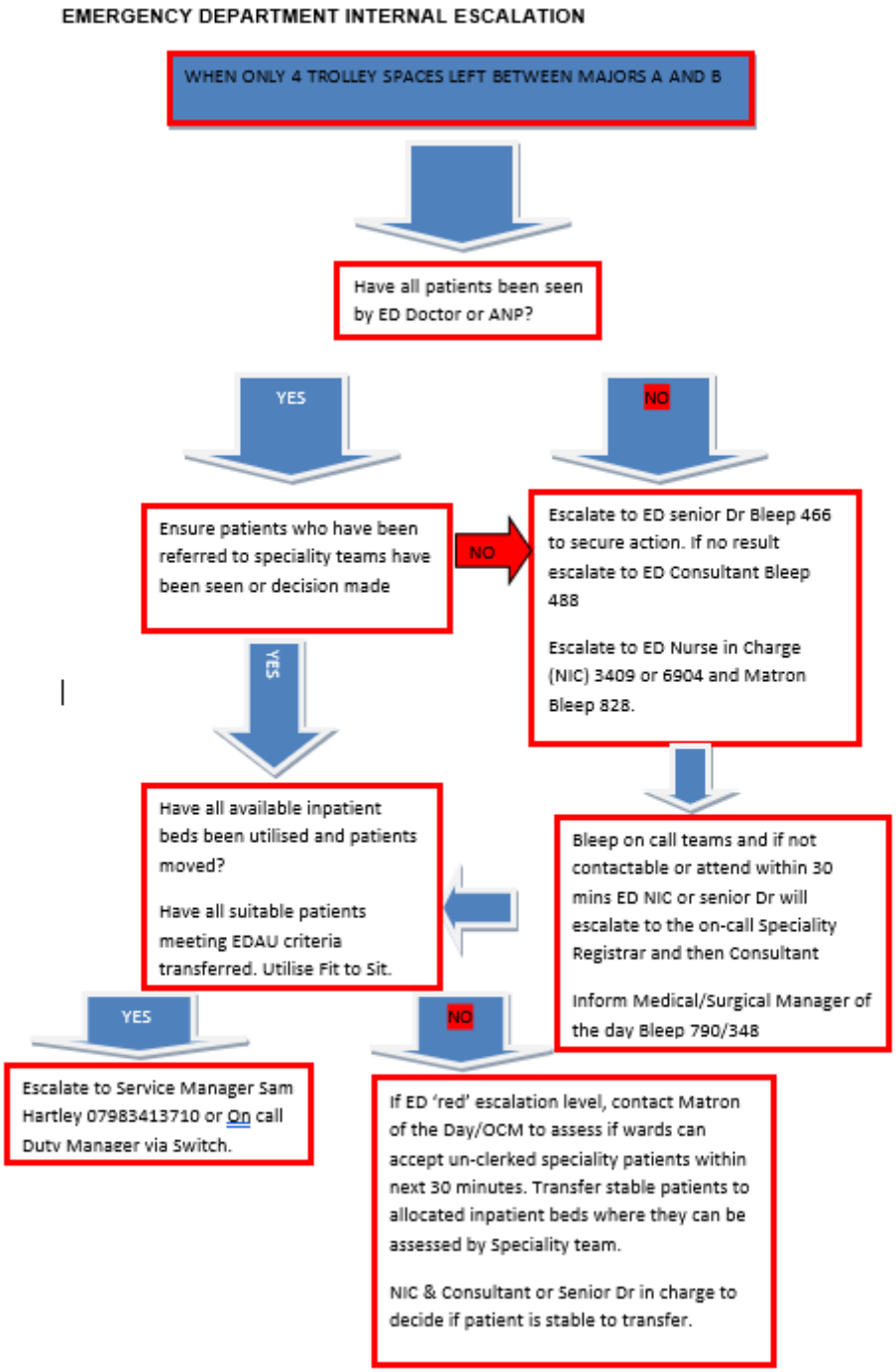
ED have an embedded escalation process which considers capacity and forms part of normal day to day operation.

Emergency Department Escalation Plan

GREEN - Business as Usual	AMBER - Early Escalation	RED - Safety Concerns	BLACK - Sustained Safety Concern
Majors A– Less than 7 trolleys in use Majors B– Less than 6 trolleys in use	Majors A– 8 trolleys in use Majors B– 7 trolleys in use	Majors A– 9 or more trolleys in use Majors B – 8 or more trolleys in use	Social Distancing Compromised
Majors W/R – Less than 5 chairs in use	Majors W/R – 6-7 chairs in use	Majors W/R – 7-8 chairs in use	
Minors W/R – Less than 5 chairs in use	Minors W/R – 7 chairs in use	Minors W/R – 7-8 chairs in use	
No ambulances waiting	If more Ambulances than capacity expected to department	Delay in Ambulances off loading	
Triage less than 15 minute wait	Triage more than 15 minute wait		
Who Do I Escalate To?	**Who Do I Escalate To?**	**Who Do I Escalate To?**	**Who Do I Escalate To?**
Regular communication with ED Matron Bleep 828/CSM Bleep 500	Ensure Internal Escalation Protocol has been followed	See ED Internal Escalation Plan	CSM ICC – 3219 Hospital Commander ICC - 4191 Medical Commander ICC - 5177 Nurse Commander ICC - 5199 Operations Commander ICC - 5151 Support Services Commander ICC – 5133
Consider Following Actions:	**Consider Following Actions:**	**Consider Following Actions:**	**Consider Following Actions:**
No further actions	Open Triage 2 & Send staff to Minors Ensure all available transfers have been completed Patients to be spaced in waiting room Patients are transferred to SDEC and EDAU where possible	Queue patients ensuring 2 metre apart to ensure social distancing Advise ambulance service of potential delays Advise primary care and 111	Trauma and ambulance divert if appropriate

The Sister in Charge (in ED) follows a flow chart to enable early escalation to managers and matrons.

Appendix 2



The escalation process then triggers the response of managers to assess the ability to ask bronze for a HALO (Hospital Ambulance Liaison Officer) and to consider 'queuing out' of the department.

ED have risk assessed the department and has identified the major incident corridor outside majors A as the best place to queue stable patients out of ED who are waiting for admission.

Assessment

The Head of EPRR for DCH reviewed the documentation underpinning ED decision making and observed the department during the week of 25 October. Conscious that the NHSE/I letter stops short of advocating 'queuing in' or cohorting patients at the front door to release one or more ambulance crews, it does however imply this may happen as a consequence of queuing ambulances,

"*Acute trusts should take responsibility for patients from when the ambulance arrives and ED staff are informed of arrival, regardless of the patient's exact location. In practice, there is a need for close cooperation and risk sharing between services*."

the following assessment considered the patient safety, departmental and staff safety and nosocomial concerns of both queuing in and queuing out of ED when the department is under pressure. The options considered therefore are:

Option 1 – Remain within current capacity and continue ambulance delays where flow is compromised.

Risk score: Likelihood: 5 x Consequence: x5 =25

Advantages

- Maintains COVID-19 compliance and reduces risk of transmission of infection
- Maintains some dignity and respect for patients located in corridors
- Maintains staffing levels to RCEM standards

Disadvantages

- Increased risk of transmission of covid in ED due to overcrowding in clinical spaces
- Increased risk of clinical incidents in ED due to overcrowding
- Increased system risk as potential to hold SWASFT ambulance and impact on clinical outcomes due to delays in response to higher risk calls (category 1 & 2).
- Increased negative staff experience in ED and SWASFT
- Corporate reputational risk due to consistently being one of the lowest ambulance delay trusts in the region.

Option 2 – Cohort patients arriving by ambulance, keeping one crew or HALO to monitor 3 – 4 patients (Queuing in).

Risk Score: Likelihood 5 x Consequence x 4 = 20

Advantages

- Releases ambulance crews to attend further incidents

Disadvantages

- Patients in the queue not assessed by secondary care staff for risk factors associated with deterioration during witing time

- Increased risk of transmission of covid in ED due to overcrowding in clinical spaces
- During 2021/22 refurbishment works there is limited space to undertake this effort near to ED (Radiology OPD being the previous space utilised and currently subject to Estates work)
- Increased risk of clinical incidents in ED due to overcrowding
- Increased system risk as potential to hold SWASFT ambulance and impact on clinical outcomes due to delays in response to higher risk calls (category 1 & 2).
- Increased negative staff experience in ED and SWASFT

Option 3 – Flexible use of the major incident corridor outside of ED. The corridor is situated outside of Majors A with designated marked bays separated by screens, access to telephone and easy access to resus.

Risk score: Likelihood 5 x Consequence x 3 = 15

Advantages

- Supports hospital flow
- Supports ED flow and release of ambulances
- Reduces risk of overcrowding in ED including infection transmission and clinical incidents)
- Decreases risk of patients queuing in ambulances with many trusts reporting incidents in ambulance queues with poor patient outcomes and even deaths.
- Reduces pressure on staff within ED as reduces the number of patients within the footprint.

Disadvantages

- Potentially increases the risk of nosocomial transmission
- Potentially compromises staffing levels in ED
- Potentially compromises patient dignity and privacy
- Potentially delay in getting oxygen and suction as none pipped in the area although bottled available.

Recommendation

On the basis of this assessment the Head of EPRR advises that in the event of ambulance queues forming the use of the corridor to queue out patients assessed as stable is the first order approach, second order is to also queue in if there is a space available. All efforts to avoid queuing in ambulances is to be avoided. This recommendation will be reviewed in 2022 when the Priority Admissions Lounge is completed as part of the ED15 refurbishment and provides a purpose built unit with staffing for pre-admission management of patients.

Meeting Title:	Board of Directors
Date of Meeting:	24 November 2021
Document Title:	**National Patient Surveys - Presentation**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Nicky Lucey, Chief Nursing Officer Emma Hoyle, Acting Deputy Chief Nursing Officer

Confidentiality:	*No*
Publishable under FOI?	Yes

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

Purpose of the Paper								
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	As part of the assurance required for Trust Board an update of national patient surveys in the Trust is required The Board of Directors is asked to accept the presentation, and to use the information to highlight concerns and areas for quality improvement to the Trust Board. For noting: Surveys carried out during 2020-2021 as follows: ➢ Inpatient 2020 ➢ Urgent & Emergency Care 2020 ➢ Children & Young People 2020 ➢ Maternity 2021 Surveys supported and carried out by Picker annually to measure quality of care and measure service provided at DCHFT. Annual feedback received to inform Trust and provide benchmark for actions going forward. Notable DCHFT performance in the most recently release survey - CQC NHS Adult Inpatient Survey 2020 Performance better than other Trusts in: • Communication to patients when transfers happened out of hours • Being given opportunity to communicate with family and friends during restricted visiting • Patients felt that there were enough nurses on duty • Patients felt staff helped them with their meals • Patients felt that they had enough support on discharge Trust did not fall lower than any other Trust in any other area but felt from the feedback the following areas could be improved on: • Patient Information • Noise at night – staff and other patients							

	• Operational delays • Recommendations Survey summaries and detail to be presented to Patient Experience Group and recommended divisional actions reported to Quality Committee
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **RECEIVE** assurance on actions to address any performance issues 3. **AGREE** the key points, risks & concerns to be reported to the Board

Governance and Compliance Obligations

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

National Patient Surveys

Nicky Lucey
Chief Nursing Officer

What our patients are telling us…..

This presentation summarises the findings from the all of the National Patient Survey results received in 2021 at Dorset County Hospital NHS Foundation Trust. All of the following surveys were carried out by Picker on behalf of the Trust:

- Inpatient 2020
- Urgent & Emergency Care 2020
- Children & Young People 2020
- Maternity 2021

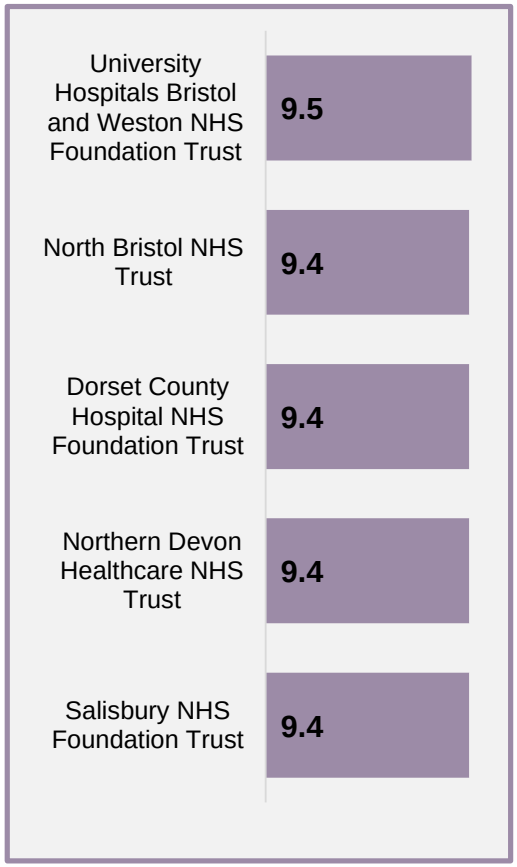
Overall the results for all of the National Patient Surveys have been positive and a celebration that during the pandemic our staff have ensured that our patients have a positive experience.

Celebrations…!

- **100%** of parents said that staff explained how the operation or procedure had gone
- **99%** of patients treated with respect and dignity
- **96%** of patients were able to keep in touch with family and friends during the Covid-19 restrictions
- **96%** of patients waited under an hour in A&E to speak to a doctor/nurse
- **98%** of patients had enough privacy in A&E when discussing their condition
- **90%** of patients said that staff completely explained reasons for changing wards at night
- **97%** of parents were told what to do or who to contact if worried at home
- **91%** of children liked the hospital food
- **94%** of parents given enough support for mental health during pregnancy
- **99%** of parents had telephone number for midwives (postnatal)

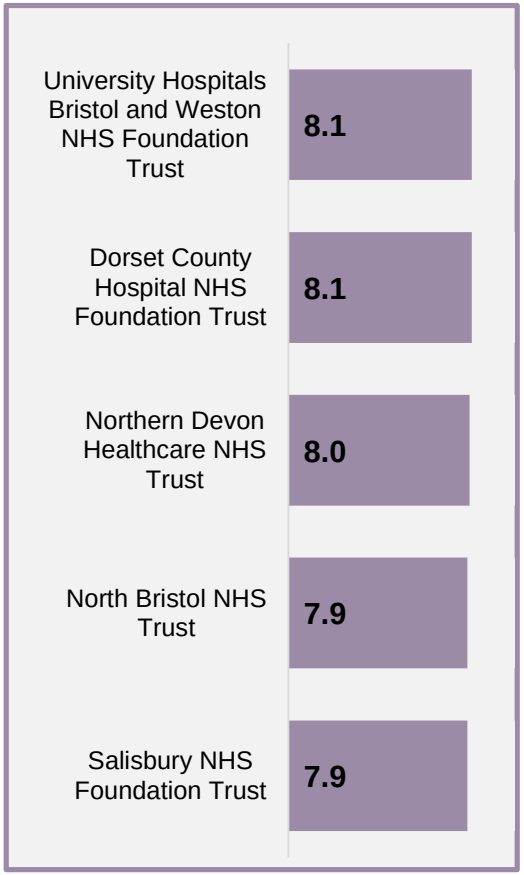
Benchmark – top five Trusts in the Region

Overall, did you feel you were treated with **respect** and **dignity** while you were in the hospital?



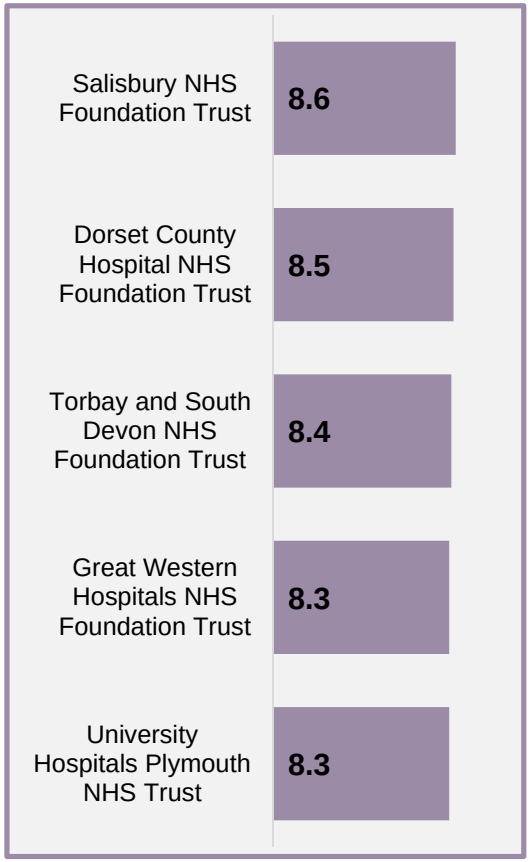
Benchmark – top five Trusts in the Region

Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?



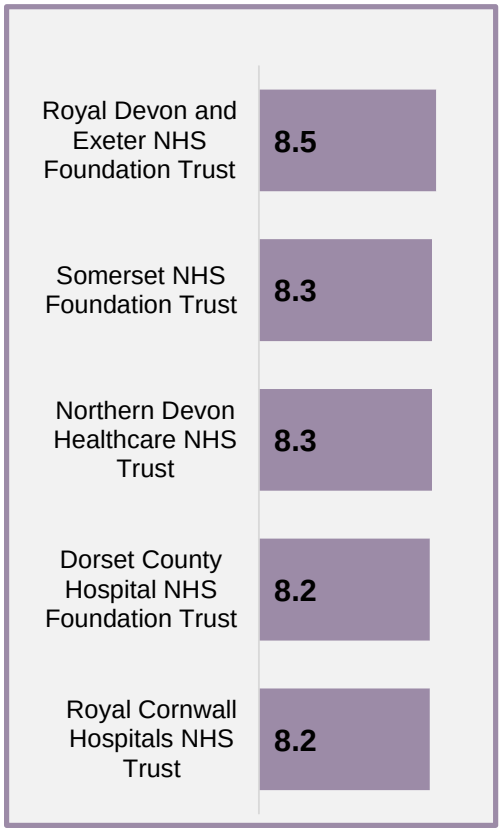
Benchmark – top five Trusts in the Region

There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?



Benchmark – top five Trusts in the Region

Did you get enough help from staff to eat your meals?



Key areas for Improvement

- **Patient Information:** Expectations after the operation or procedure: patients being given an explanation from staff, before their operation or procedure, of how they might feel afterwards
- **Noise at Night:** patients not being bothered by noise at night from staff
- **Noise at Night:** patients not being bothered by noise at night from other patients
- **Operation delays (Access):** this is part of the Recovery Plan and will be monitored through FPC rather than PEG

Actions plans for each survey are being developed with the Divisions and will be monitored through the Patient Experience Group.

Further details of the National Patient Surveys are available from Alison Male, Head of Patient Experience via email alison.male@dchft.nhs.uk.

Dorset County Hospital
NHS Foundation Trust

Maternity Quality and Safety report

November 2021

Submitted by Jo Hartley, Associate Director of Midwifery & Neonatal Services

Executive sponsor: Nicky Lucey, CNO

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Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of October and where relevant, quarter two. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Unable to populate the dashboard due to BadgerNet reporting problems. There is an action plan in place to improve data entry.
- Maternity staffing remains challenging with increased sickness linked to poor mental health, short term illness and further absence due to relatives with covid
- SCBU staffing remains extremely challenging with 15 datix submitted in October
- Increasing numbers of women booked for induction of labour is putting pressure on capacity and workforce. These are now being captured more accurately in Datix reporting
- Regular escalation to divert with women being diverted to other maternity units. However, increasingly, there is no capacity in the system within the LMNS. Therefore women attend DCH even if divert has been actioned
- Midwifery recruitment commenced
- Picker survey results – DCH 2nd out of 66 Trusts surveyed.
- First stage of review of evidence submitted for Ockenden – 70% compliance reported but multiple areas challenged in resubmission – supported by the LMNS

Section 1: Activity and incidents reported.

1.1 Activity as of the end of the second quarter July-Sept 2021

Currently unable to report on his data from BadgerNet – DCH Information Team and CleverMed working to resolve these difficulties

1.2 DCH reported incidences

Dorset County Hospital reported Maternity Patient Safety incidents from October to Sept 2021 using data collated from Datix Web Electronic Reporting Systems. Some reports refer to more than 1 incident (for example, 3 inductions of labour delayed) and this has been counted as 3 incidents. Likewise, 2 reports referring to the same incident will be reported as one incident

Total Number of Incidents for November to October 2021:

Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct
54	49	54	72	50	52	50	60	60	65	98	91

Red Flag incidents: A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. DCH Maternity initially (and for some months) utilized an Acuity App to collect red flag data, but this platform was not suitable for our service, so the data is now collected via Datix.

Red flag	Descriptor	Incidence
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	30 of which 15 are SCBU
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0

RF4	Delay of more than 30 minutes between arrival and admission in ANDAU -	Not currently captured effectively but happens regularly. New system in place from mid-nov
RF5	Full clinical examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	18
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	1
RF10	Delay of time critical activity	0

RF1 staffing challenges are a combination of sickness, primarily poor mental health and covid alongside staff unable to work due to shielding, and AL. Several as-and-when staff have resigned/retired and substantive staff choosing not to work extra shifts (siting burn-out and exhaustion). This has led to periods of escalation with women diverted to neighbouring trusts. SCBU has escalated vacant shifts repeatedly this month due to LTS and STS. Despite authorisation for high cost agency, many have remained unfilled

RF6 & 7 The delayed activity relates to Induction of labour (IOL). This has been discussed at regional and national level and continues to be a significant concern. Noted at the recent LMNS Safety Meeting

RF4 some women have booked appointments for ANDAU and others are walk-in. Women are assessed due to risk factors but many wait longer than 30 minutes. Plans to expand the service have been discussed at length but currently are on hold.

1.3 Incidents in the last 6 months requiring RCAs

Severity	May	June	July	Aug	Sept	Oct
Risk still open		16	8	12	24	19
Incidents requiring RCAs				5	0	0

1.5 Health and Safety incidents in month:

reference	detail	Ongoing action
	Midwife fell off her chair whilst bending down to retrieve an object from the phone	Work station assessed. Member of staff does not work clinically due to limited mobility. Has a bariatric chair. Did not require time off work but was distressed.

1.6 Medication incidents

Medication Incidents:

Category	May	June	July	Aug	Sep	Oct
Administration: Duplication	-	-	-			
Administration: Missed or delayed medication	1	1	1		1	2
Administration: Wrong dose	-	-	1			1
Prescribing: drug choice inappropriate	2	-				
Prescribing: Missed or Delayed	-	-	1	3		
Storage/Security: Medicine left unattended	-	1	1			
	3	**3**	**2**	**4**	**3**	**3**

ID	Title	Open	Review	Risk	Risk Level
858	Staffing on SCBU is often critical with vacant shifts unfilled with QIS nurses.	18/12/2019	15/11/2021	extreme	Division
664	Gynaecology middle grade rota	22/03/2016	02/12//2021	moderate	Division
871	Levels of Entonox Exposure on the maternity unit	24/12/2019	15/11/2021	High	Care Group
1127	Maternity Staffing	20/07/2021	15/10/2021	High	division
1126	Introduction of the new Maternity Digital System	20/07/2021	15/11/2021	High	Division

3.1 Complaints

Month	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct
Formal	1	3	1	3	0	1	0	3	2	4	1	0
Informal	4	3	1	3	0	0	0	0	1	3	4	1
Total	5	6	2	6	0	1	0	3	3	7	5	**1**

Learning/actions from complaints and PALS

The purchase of pulse oximeters from charitable funds following a complaint about a missed diagnosis for a baby

Reminding staff that anyone phoning with concerns about their newborn baby must be carefully triaged with a very low threshold for inviting the parents to bring the baby back for review

Make every effort to ensure that personal care is carried out, including emptying catheters, changing linen etc

Ensure partners understand how to administer the Clexane injection

Mortality, Morbidity, Serious Investigations, External Reporting & Learning

4.1 Mortality MBRACE (Mothers and Babies Reducing Risk through Audit & Confidential Enquiries) reportable cases

Clarification of all Intra-uterine deaths & stillbirths for 2021 thus far. A total of 6. 3 in January and 3 in August

January 2021 until August 2021	
No care issues identified at PMRT	Raised BMI
No care issues identified at PMRT.	Raised BMI
Discussion at PMRT whether increased surveillance in this high risk pregnancy would have altered the outcome, unknown if it would have aided management of pregnancy.	Raised BMI
No care issues identified at PMRT (covid +ve at time of iud)	Social concerns
No care issues identified at PMRT. However following this case we have altered our Papp-A leaflet and sounds like we are moving towards offering women with dating scan Papp-A screening	Social concerns
Did not deliver at DCH and for discussion at PMRT with tertiary unit	Social concerns

Neonatal Deaths for quarter two July-Sept 2021

Ref	Description
	No neonatal deaths reported

4.2 Perinatal mortality reviews

Cases pending review at Perinatal Mortality Review panel as of date of report

Number of cases pending initial review at PMR panel	**0**
No of cases awaiting pending PM/final review/review closure	
TOTAL cases requiring review completion	

4.3 Morbidity including M&M meetings

No incidents reported in October 2021 of term live babies requiring cooling, meeting RCOG EBC criteria and reporting to NHS Resolution.

Mortality and Morbidity – multi professional with maternity, obstetrics and neonatal

Learning & Actions: Case one.

- Possible late onset of GDM. Next pregnancy will possibly need early GTT. At scan reviews for 'large babies' do we test for glucose on urine. -to be d/w diabetic lead cons
- Late onset maternal GDM would be in keeping with the neonatal presentation
- In line with regional practice all babies to be give 60/90/120 ml/kg/d to replace 40/60/80 ml/kg/d for term babies (IV fluid guideline being updated)
- Babies with hyponatraemia need strict fluid in/out measurement

Case two.

- Increase in adverse outcomes in women with Diabetes cannot be underestimated. Careful planning for booking ELCS prior to 39/40
- Any abnormal gas must have action documented by identifiable clinician.
- Discussion about use of Less Invasive Surfactant Administration (LISA) – may have prevented need for transfer. To discuss at regional network/outreach session

4.4 further maternity learning

Report to benchmark the Maternity Service at DCH against the service at The Jessop Wing at Sheffield Teaching Hospitals following their CQC assessment in March 2021. Exceptions reported below – all amber as partially complete

Report for STH	DCH current position	Actions required	Anticipated completion date
Baby abduction policy in place but not had a drill to test it.	We have an abduction guideline and have had 2 drills to test it, but not in the last year.	Another abduction drill organised	Nov 2021
Adult resuscitation trolley only checked 16 out of a possible 190 occasions	Adult resuscitation trolley is part of the co-ordinators nightly checks. Months Jan 21- June 21 (6 months) out of 181 occasions checked 152 times **Update:** trolley checked every day in October Audit continues	Now allocated to a new team as well as being on the coordinators' daily activity sheet	Audit continues
Daily checking of neonatal resuscitation trolley	We have two neonatal emergency trolleys on the maternity unit. Both checked by SCBU staff but not clear to us that they have been checked.	Record of checks kept by SCBU staff	closed
Women were not risk assessed to prioritise who should be seen first on the labour ward	Wwhen women admitted the co-ordinator is informed and they are responsible for arranging a doctor review based on severity of admission symptoms.	Women are risk assessed as required on arrival onto labour ward.	closed
The Trust had not followed staffing recommendations	Recently shortlisted 28 midwives for interview at the end of November	Interviews and job offers to suitable candidates	ongoing

2.4 HSIB quarterly review meeting

- No new cases

Section 3:Reports and national guidance

3.1 Progress against relevant reports and guidance

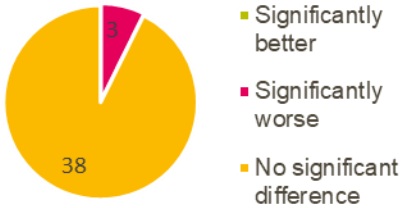
Picker Maternity Survey

This report summarises the findings from the Maternity Survey 2021 carried out by Picker, on our behalf. Picker was commissioned by 66 organisations to run their survey – this report presents our results in comparison to those organisations. Overall a very positive set of results with specific areas requiring some attention. These will be drawn together into a comprehensive action plan

Providing relevant information about infant feeding. This will be addressed by the work to achieve the UNICEF Baby Friendly accreditation
Ensuring informed consent in a decision to bring a pregnancy to an end (either with IOL or elective caesarean)
Improve on efficiency around discharge
Improve on information sharing around place of birth (this may reflect the fact that our midwife-led unit was not fully open at the time of the survey)
Explore ways to improve staff's awareness of a woman's medical history

241 Invited to complete the survey	238 Eligible at the end of survey	**58%** Completed the survey (137)	54% Average response rate for similar organisations	46% Your previous response rate

96% C23. Treated with respect and dignity (during labour and birth)	Historical comparison*	Comparison with average*
95% C24. Had confidence and trust in staff (during labour and birth)		
99% C22. Involved enough in decisions about their care (during labour and birth)		



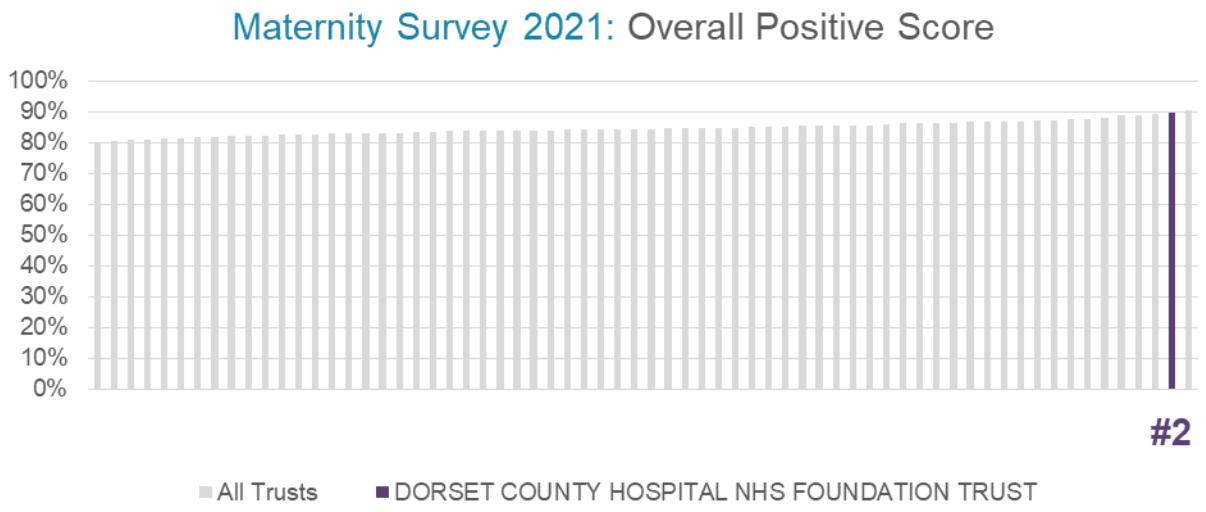
Top 5 scores vs Picker Average	Trust	Picker Avg
D7. Found partner was able to stay with them as long as they wanted (in hospital after birth)	93%	33%
F20. Felt GP talked enough about physical health during postnatal check-up	81%	65%
C18. Not left alone when worried (during labour and birth)	88%	75%
B12. Given enough support for mental health during pregnancy	94%	82%
F17. Received suppport or advice about feeding their baby during evenings, nights or weekends	81%	70%

Bottom 5 scores vs Picker Average	Trust	Picker Avg
B16. Provided with relevant information about feeding their baby	78%	81%
C10. Involved enough in decision to be induced	81%	83%
B7. Felt midwives or doctor aware of medical history (antenatal)	81%	83%
C24. Had confidence and trust in staff (during labour and birth)	95%	96%
D2. Discharged without delay	63%	64%

Most improved scores	Trust 2021	Trust 2019
F7. Felt midwives aware of medical history (postnatal)	82%	75%
D2. Discharged without delay	63%	57%
D5. Given enough information (in hospital after birth)	96%	92%
F13. Given information about changes to mental health after having baby	89%	87%
F2. Had a telephone number for midwives (postnatal)	99%	97%

Most declined scores	Trust 2021	Trust 2019
B16. Provided with relevant information about feeding their baby	78%	91%
B7. Felt midwives or doctor aware of medical history (antenatal)	81%	93%
F16. Received help and advice about feeding their baby (first six weeks after birth)	85%	94%
B5. Given enough information about where to have baby	83%	92%
C24. Had confidence and trust in staff (during labour and birth)	95%	99%

The league table shows your overall positive score's ranking in comparison to the overall positive score of every other organisation that ran the Maternity Survey 2021 with Picker.



Section 4: Safety Champions action plan

4.1 Action Plan

Awaiting next action plan. Issues raised are referred to in other sections of this report

Section 5: Service User Feedback

5.1 debrief feedback and F&F

There were 29 positive comments on the F&F for September with many comments naming particular staff. This is shared with them as individual emails. There were negative comments about lack of staff both on the ward and in community, a desire to see their midwives more often postnatally, difficulties accessing BadgerNet, lack of information about appointments, staff talking loudly during night shifts and inadequate explanation about blood glucose monitoring for a baby.

> Every appointment I have had within antenatal service has been brilliant. A really lovely and caring team who obviously enjoy their jobs. Amber the student midwife today was lovely, really welcoming and made me feel at ease. Richard the Dr was

also great, knowledgeable and made sure I knew I had a choice of options. Thank you both.
The staff were all incredible despite being so short staffed, Julie (community midwife covering) who was our midwife on the day of delivery was fantastic and looked after us so well, Emma who took care of us in theatre, including my husband, and took so many great photos for us, and Janet johns who has been such a great support since our 20 week scan when we found out we had some complications, she has been so brilliant at following up on appointments and coordinating everything for us, she's just been fantastic!
All staff were excellent offering fantastic care and support. It wouldn't be fair to nominate just one person as we had so many different people help us.
The cygnet team are fantastic, they came out to me and made me feel well looked after. Emma Barrett was fantastic the first day I was home from hospital
Our whole experience from start to finish was incredible. Huge thanks to the Doctor who performed our Emergency surgery and our anaesthetist, plus midwives Shelley, Nicki, Nat Clemi, Kerry and everyone else I haven't listed
All the staff were so caring, friendly and efficient. They made me feel comfortable and secure during my labour. I loved the cove, the birthing room was fantastic and again made me feel so secure. My main midwife, Gemma, was absolutely incredible and made my labour so positive.
I can't thank the whole ward enough they made me feel completely at home and made the whole experience amazing. All the facilities were outstanding myself and my husband were so impressed with the care and attention from the staff. I'd like to personally thank Helen our midwife during the birth and also Jo the anaesthetist. Everyone from the cleaners to the midwifes to the doctors was amazing and we can't thank them enough!
All the staff were so lovely, I was meant to have a home birth but going to hospital was still a very positive birth experience
All the staff were so friendly and helpful. Made us feel so comfortable and helped with any questions
Attentive midwives and student midwife who listened to me and prioritised my well-being following difficult labour with first child

5.2 Maternity Voice Partnership

Section 6: Training

MDT obstetric emergency training	
staff	**Percentage/number**
Consultant obstetricians	**100%**
Anesthetists	**85%**
Obstetric trainees &specialty doctors	**new cohort started this month**
midwives	**77%**

NLS (4 yearly accredited course)	Senior Midwives/Homebirth Midwives	96%
NLS (yearly update)	Midwives	72%
K2 Fetal Monitoring	Doctors (All grades) Midwives	85% 83%

Section 7: Maternity and medical staffing

Maternity Staffing

Staffing continues to be extremely challenging with very few shifts fully staffed. This is a combination of absence due to covid and self-isolation, poor mental health amongst staff and sometimes their family members, post-operative recovery and sadly compasionate leave.

Sickness absence	October 2021
midwives	9.80%

Sickness absence	October 2021
MSW	10.75%

This doesn't include those members of staff self-isolating due to a family member being positive

Section 8: Maternity incentive scheme Year 3

Year four evidence requirements just published

Section 9: Ockenden Actions

Evidence portal

Email received from Chief Midwife for the South West on 25th October.

We have now received from the CSU your Ockenden Evidence Reports following your submission of evidence to the portal.

We have also sent a copy of your report to your LMNS and have asked them to support you through the next stages of the process in terms of assurance as outlined below. Please note that that report will not be finalised until there is agreement from between the Provider, LMNS and the Regional Chief Midwife that the report is a true reflection of the evidence submitted.

Stage One:

- We would ask LMNS to work with providers to go through their CSU reports and to either agree that they correlate with the CSU assessment or not, identifying on the reassessment spreadsheet where the Provider considers that to be Yes or No against each submission
- Once this initial conversation has taken place we would like to book a meeting with each LMNS and provider to review the provider reassessments.
- Once we have assurance that providers and LMNS agree with the CSU assessment the regional team will sign it off and submit to the CSU as confirmation that the reports reflect an accurate position against Ockenden recommendations.

- If there are discrepancies, the CSU team will re-review with the national and regional teams and a final decision will be made by the Deputy CMO and the regional chief midwife.
- The deadline for this stage has been set by the national team at 26 November 2021
- All final reports that have been agreed with providers, LMNS and regional teams will be sent to providers and regional teams soon after the 26th November.

Stage Two:

- LMNS are asked to provide ongoing assurance of compliance and sustainability of improvement with support from the regional team.
- These processes may include quality assurance visits but this process will be agreed and managed locally. The Deputy CMO may periodically choose to join regional visits/engage with the assurance processes
- LMNS are asked to work with providers to pull together Ockenden action plans. For systems that have these in place it will be building on the ones you currently have in operation.
- These action plans will outline how providers intend to move from amber/ red to green status and the timescales anticipated to do so
- The ongoing assurance of these action plans will take place through the PQSSG meeting.

Stage Three:

- Reports to the national team of compliance and assurance will be agreed, this will however include reports from regional teams that will be shared at national JSOG and other associated quality committees
- Ockenden 2 – once this report is published, we will ensure as far as possible that there is synergy with work underway for Ockenden one, but there are no guarantees in the absence of knowing the content of the report.

Stage one completed as an LMNS Initial assessment of DCH was 70% compliance. Multiple areas of challenge identified where evidence already submitted and duplicate requests made. Actions ongoing to comply with other expectations. Evidence spreadsheet too big to copy into this document.

Meeting Title:	Board of Directors
Date of Meeting:	24th November 2021
Document Title:	**Dorset County Hospital SubCo Ltd Annual Report and Accounts**
Responsible Director:	Paul Goddard, Chief Financial Officer
Author:	Mark Lovett, Financial Controller

Confidentiality:	Yes
Publishable under FOI?	No

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee	16/11/2021	Noted

Purpose	To note the 2020/21 Dorset County Hospital SubCo Limited Annual Report and Accounts.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The Annual Accounts and Annual Reports for the year ending 31 March 2021 have been prepared in accordance with UK accounting standards and applicable law (UK Generally Accepted Accounting Practice), including Section 1A of FRS 102, The Financial Reporting Standard applicable in the UK and Republic of Ireland. The Annual Reports and Accounts were audited by KPMG during May and June 2021 and are presented for review.							
Action recommended	The Board is recommended to: 1. **To note the DCH SubCo Limited Annual Report and Accounts**							

Governance and Compliance Obligations

Legal / Regulatory	Y	The Annual Report and Accounts of DCH SubCo Ltd for the year ended 31 March 2021 have been prepared by the Directors in accordance with the accounting policies set out in Note 1 to the accounts and comply with UK accounting standards and applicable law (UK Generally Accepted Accounting Practice), including Section 1A of FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.
Financial		
Impacts Strategic Objectives?	Y	The Annual Report and Accounts summarises the activity of the company for 2020/21 and demonstrates compliance with preparing the Annual Report, the Director's Report and the financial statements in accordance with applicable law and regulations.
Risk?	Y	The Annual Report and Accounts were independently audited using a risk

		based approach.
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Meeting Title:	Board of Directors meeting Part 1
Date of Meeting:	24th November 2021
Document Title:	**Annual Complaints Report 2020/21**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Alison Male, Head of Patient Experience Emma Hoyle, Interim Deputy Chief Nursing Officer

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

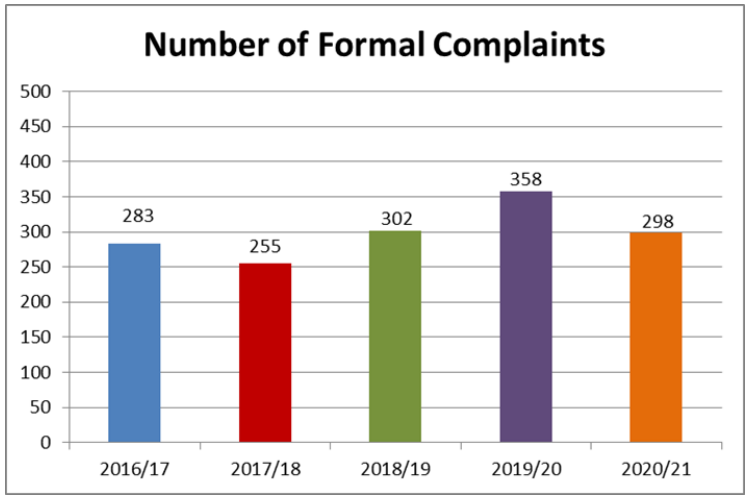
Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Patient Experience Group	29th July 2021	Include information about patient stories relating to complaint themes – section 5.3.
Quality Committee	21/09/2021	
Board of Directors part 2	29/9/2021	

Purpose of the Paper	The annual complaints report complies with the Local Authority Social Services and National Health Service Complaints Regulations 2009, which requires each NHS trust to produce an annual report regarding complaints received.						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	

Summary of Key Issues

The paper covers the reporting period 1st April 2020 to 31st March 2021.

- The total number of formal complaints received by the Trust for this year was 298 which have decreased (16%) from the previous year. There were also 447 recorded contacts for PALS informal issues resolved, also a decrease (49%) on the previous year.



- During this year 24 complaints (8%) have been reopened. Complaints are normally reopened for the following reasons:

  - Complainants contact us to seek further clarification about the complaint

	raised indicating that the complaint has not been fully addressed or they disagree with aspects of the response from their perspective. ➢ Additional questions have been asked following receipt of the response. ➢ Complainants take up the offer of a meeting with staff to discuss their complaint in more detail. • At the end of March 2020 there was a national pause of NHS Complaints as we entered a lockdown situation due to the COVID-19 (Coronavirus) pandemic. The Trust wrote to all existing complainants to explain that due to the pandemic the clinical staff would not be able to continue to investigate their complaint. We explained that the investigation would continue once the clinical staff were in a position to continue with complaint investigations but we were unable to give a timescale for their response letter. The national pause on NHS Complaints ended on the 1st July so new complaints received from the 1st July 2020 were given a 40 working day response timeframe which was agreed by both Divisions. This enables the Trust to respond to those complaints in a realistic timeframe due to the demands on the clinical staff during the past year. • Complaints are an integral element of improving the patient's overall experience of health care and help to ensure that safe, high quality care is provided within the hospital. Learning from complaints is included in response letters to provide assurance that complaints are taken seriously and the learning as a consequence of the complaint.
Action recommended	The Board is recommended to: 1. **Approve** the Annual Complaints Report 2020/21.

Governance and Compliance Obligations

Legal / Regulatory	Y	Complies with the Local Authority Social Services and National Health Service Complaints Regulations 2009
Financial	N	None currently identified
Impacts Strategic Objectives?	Y	NHS Foundation Trusts are required to produce an Annual Complaints Report. Using this feedback will help deliver further improvements to patient care. This relates to our strategic themes of **People** - Putting our people first to make DCH a great place to work and receive care; **Place** - Building a better and healthier place for our patients and population.
Risk?	Y	Failure to act on the feedback from complaints will have a negative impact on both staff wellbeing and patient care and strategic objectives
Decision to be made?	N	
Impacts CQC Standards?	Y	As feedback is designed to enhance and improve both patient safety and experience, non-delivery may result in a detrimental consequence to the quality and experience of our patients.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Title of Meeting	**Board of Directors – Part 1**
Date of Meeting	**24th November 2021**
Report Title	**Annual Complaints Report 2020/221**
Author	Alison Male, Head of Patient Experience Emma Hoyle, Interim Deputy Chief Nursing Officer

1.0 INTRODUCTION

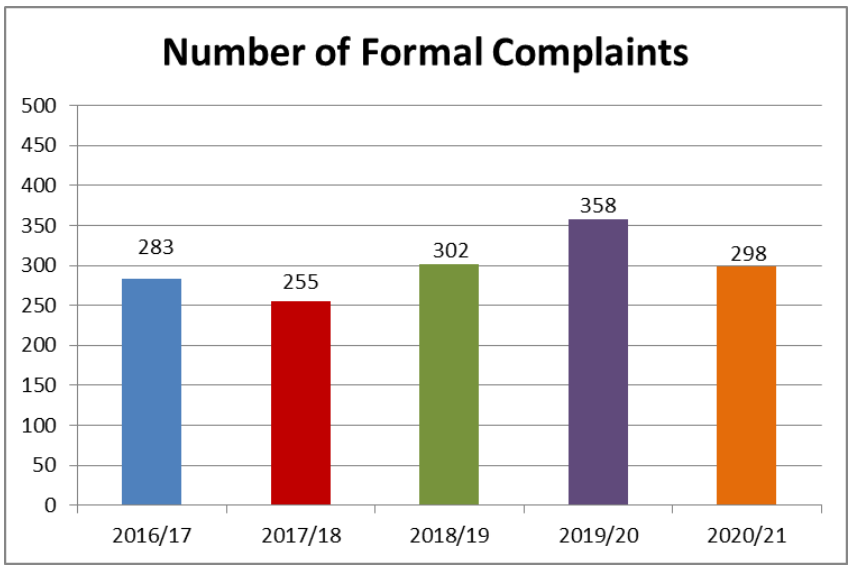
1.1 The annual complaints report complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which requires each NHS Trust to produce regular reports about complaints received, including an annual report.

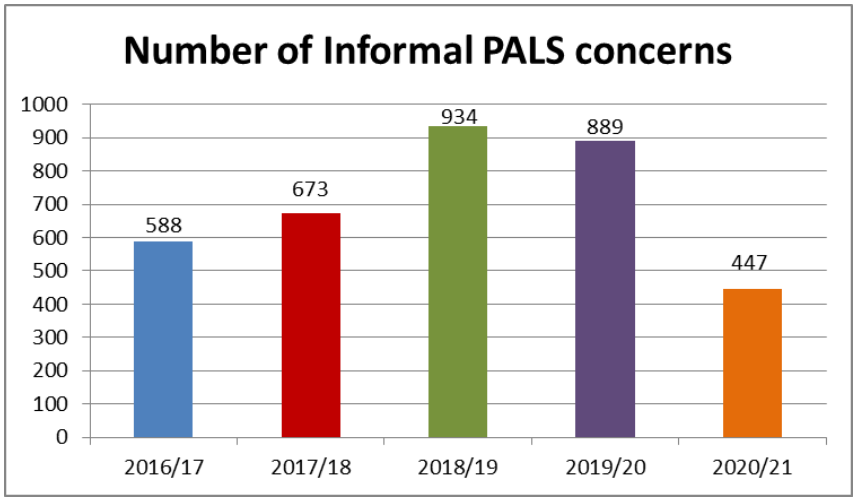
1.2 This annual report includes an overview of the number and nature of complaints received and how complaints are handled.

2.0 NUMBER OF COMPLAINTS RECEIVED

2.1 The total number of formal complaints received by the Trust for this year was 298 which have decreased (16%) from the previous year. There were also 447 recorded contacts for PALS informal issues resolved, also a decrease (49%) on the previous year.

2.2 The charts below shows a visual comparison of the number of formal complaints and informal PALS concerns over the last five years:





2.3 Each formal complaint is treated as well-founded in order to investigate and a response is provided to the complainant outlining the findings of the investigation.

2.4 During this year 24 complaints (8%) have been reopened. Complaints are normally reopened for the following reasons:

- Complainants contact us to seek further clarification about the complaint raised indicating that the complaint has not been fully addressed or they disagree with aspects of the response from their perspective.
- Additional questions have been asked following receipt of the response.
- Complainants take up the offer of a meeting with staff to discuss their complaint in more detail.

Of the 24 reopened complaints 9 of those reopened were due to additional questions being asked or requesting a meeting.

3.0 PROCESS FOR COMPLAINTS HANDLING

3.1 The Trust informs patients and carers how to raise concerns in the bedside folders, on the Trust website and in the “How was your experience at Dorset County Hospital” leaflet which is found around the hospital. This leaflet has been updated this year to promote ways to give positive feedback as well as information about raising a complaint.

3.2 All feedback, concerns and complaints are co-ordinated centrally and upon receipt are screened and triaged according to the seriousness of the issues raised. The focus is to consider each complaint from the complainant’s perspective and complainants is offered the opportunity to discuss the way in which their complaint is handled.

3.3 Details of complaints are recorded on the Datix web-based system, this enables complaints and concerns to be managed in an open, central and accountable manner.

3.4 The responsibility for investigating complaints is devolved to the Divisions and their respective teams, who are required to provide a comprehensive response within an agreed timeframe. This outlines the response to the investigation and recommendations or actions taken for improvement where appropriate. The final response to every formal complaint is agreed and signed by the Chief Executive or a nominated deputy.

3.5 The complaints process allows the Trust flexibility in arranging local resolution meetings with complainants. These meetings usually include the relevant healthcare professionals including the Consultant or Matron in order that questions can be answered by the clinicians delivering care and a personal apology given where appropriate. This has proved to be a very positive and helpful process with the openness of the meetings being well received by all participants. Prior to the COVID-19 (Coronavirus) pandemic, the majority of these discussions were face-to-face. During the COVID-19 (Coronavirus) pandemic, and due to the challenges around staff availability and social distancing, alternative methods to facilitate this option were explored via virtual meetings or telephone.

4.0 RESPONSE TO COMPLAINTS DURING COVID-19 (CORONAVIRUS)

4.1 This year again our task was to improve the timeliness of responses to complaints so that complainants are responded to within mutually agreed timescales and to improve the quality and compassion in the response so that it responds to the emotions of the complainant.

At the end of March 2020 there was a national pause of NHS Complaints as we entered a lockdown situation due to the COVID-19 (Coronavirus) pandemic. The Trust wrote to all existing complainants to explain that due to the pandemic the clinical staff would not be able to continue to investigate their complaint. We explained that the investigation would continue once the clinical staff were in a position to continue with complaint investigations but we were unable to give a timescale for their response letter. The national pause on NHS Complaints ended on the 1st July so new complaints received from the 1st July 2020 were given a 40 working day response timeframe which was agreed by both Divisions. This enables the Trust to respond to those complaints in a realistic timeframe due to the demands on the clinical staff during the past year.

During the lockdown period the Patient Experience Team were and continue to work remotely with 2 staff on site in order to comply with social distancing guidance. We stopped face to face meetings with patients and visitors and all enquiries were dealt with via email or telephone.

We entered further lockdowns in November 2020 and January 2021 with the second and more demanding wave of Covid-19 (Coronavirus) during December/January 2021. During this second wave we explained to complainants that there may be a delay in responding to their complaints due to clinical staff being unavailable to complete complaint investigations. Where possible, we continued with complaint investigations and provided responses during the lockdowns.

During this period of recovery we will continue with the 40 working day response timeframe and review this with the Divisions in 6 months. This will be monitored via the Patient Experience Group quarterly reports.

It is pleasing to report that we are meeting this timescale since returning to business as usual and have maintained 100% of responses within the agreed timescales. Where any complaints are not likely to meet the 40 working day timeframe, the complainant is contacted with an update and a revised response date.

4.2 In order to support the Divisions during this difficult time we continued to:

4.2.1 Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, and complaints in need of urgent response.

4.2.2 Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions and senior management team and Deputy Director of Nursing & Quality.

4.2.3 Review the complaints training offered to staff and promote the complaints management toolkit available on Sharepoint.

4.2.4 Provide adhoc training and support to clinicians and managers around complaint process and responses.

4.2.5 All complaints responses are reviewed by the Chief Nursing Officer or in her absence the Deputy Chief Nursing Officer for quality assurance before sent to the Chief Executive or nominated deputy to sign.

4.3 Divisions report that complainants receive a personal telephone call or email from the relevant Manager wherever possible.

4.3.1 The purpose of the call is to reassure the patient and try to deal with the matter there and then if possible and to find out whether a written response or meeting is required in the first instance. A timescale for response will also be agreed at this time.

4.3.2 If the patient wants a full and formal response this is provided and is read and signed by the Chief Executive Officer or nominated deputy.

4.3.3 If this response does not meet the needs of the patient, then the patient is offered a meeting with an appropriate person (usually the Divisional Manager). At this meeting every attempt will be made within reason to meet the patient's needs.

5 LEARNING FROM COMPLAINTS

5.1 The opportunity to learn from complaints should not be missed by the Trust and most

complainants make complaints in order for the organisation to learn from what has happened to them. In order for them to be assured that the Trust has taken their complaint seriously and taken the opportunity to learn from their complaint, the learning points are included in the complaint response. These learning points are owned by the Division and form part of the Divisional quality improvement plan.

5.2 Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings, in grand rounds, during junior doctors training, sisters and matrons meetings and porters & housekeeping briefings. Support is provided by the Patient Experience Team which enables them to understand the emotional experience from the complainant and staff perspective and reflect upon improvements in relational aspects of care.

5.3 Patients have assisted in making videos narrating their experience of the care that they received, and also their feelings about the complaints process. These patient stories are arranged based on the themes around the complaints that are being received. For example we have had a patient story about a patient surviving Covid-19 and their experience as well as their loved ones who were unable to visit at the time. Another patient story talked about their experience of a consultation where communication and the attitude of the clinician were poor. These videos are shown to the relevant divisional leads and are available for presentation at Board when required. The creation of patient video stories has been paused during the Covid-19 (Coronavirus) pandemic and will resume in the coming months.

5.4 Complaints are an integral element of improving the patient's overall experience of health care and help to ensure that safe, high quality care is provided within the hospital. Learning from complaints is included in response letters to provide assurance that complaints are taken seriously and the learning as a consequence of the complaint. Below are some examples of learning identified and included in response letters:

Concern raised:	**Learning/Actions taken:**
Discharge planning failure	• To ensure that families are contacted and advised of their loved ones arrival on the ward. • Staff have been reminded of the importance of working together with families regarding discharge arrangements for their loved ones to ensure this is safe and well planned. • The importance of keeping families informed as the discharge process occurs, so that families wherever possible, can be prepared in assisting with the transition between hospital and home.

	• To ensure that all actions undertaken by the MDT are in line with the Trust values of Excellence, Integrity, Teamwork and Respect.
Inappropriate discharge planning for patient going to a residential care home.	• Staff will be reminded of the requirements of COVID screening and the management of transferring patients back to care homes. This will include embedding in to practice the use of their newly formulated discharge checklist. • Ilchester ward will ensure that their local induction for bank / agency staff includes checking and ensuring the staff are aware of the COVID screening requirements and the nurse in charge will ensure it is included each shift as a reminder at patient safety brief. • Staff will be reminded that they should check that all patients have the relevant medication/equipment provided prior to discharge and that this is sent home with them. • Staff will be reminded of the importance of referring patients to the district nursing team for ongoing treatment requirements.
Delay in accessing advice and treatment	• The Dermatology secretaries have been reminded as to where to find information relating to the 2-week waiting times. • The team have been reminded of the importance of communication with their patients.
Breakdown in communication following death of patient	• For the team to respond to visitors at the door as soon as possible in order to maximise visiting times. • For the ward team to be reminded to leave a general message to contact the ward if there is no answer when calling family members and to ensure they have the correct contact details. • Your complaint has been discussed anonymously with the whole team to ensure they can reflect and understand the impact their actions can have on already worried and anxious families.

5.5 From 1st April 2021 the divisions provide a named individual responsible for the action/learning identified in the complaint response letter. This enables actions/learning to be monitored and best practice shared across the divisions. This makes it easier for investigators to ensure that the staff responsible for the learning required, complete the action identified in order to provide assurance that lessons have been learnt, and to close the loop. The divisions also identify if they deem the complaint to be upheld, partially upheld or not upheld at the end of the complaint investigation. This information will be recorded by the patient experience team at the time of closing the complaint. We were hoping that this would be captured earlier in the year but due to demand during the pandemic this has not been possible.

5.6 The quality improvement or learning outcome following investigation of a complaint is identified and action taken by the respective Division. This is monitored through the Patient Experience Group which meets quarterly. This framework enables the information gained from patient and public feedback to be owned locally whilst providing a strategic overview with a clear focus on improving service quality, ensuring that lessons are learnt and processes are changed to prevent situations recurring.

5.7 To enhance the learning there is triangulation of Risk Management information on incidents alongside complaints and PALS enquiries. Where a complaint raises a clinical concern or falls within the realm of an incident the Risk Management and Patient Experience Team will link and ensure thorough investigation and engagement with the complainant. This is made easier with Complaints being on the same system as incidents and enables proactive analysis of any trends in certain services.

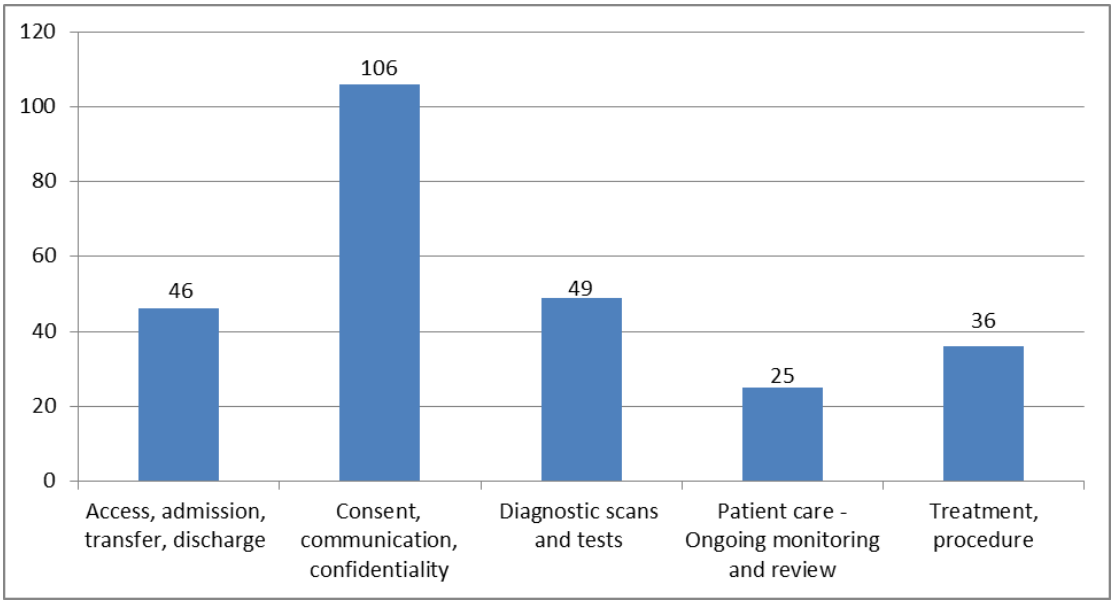
6.0 REPORTING & MONITORING

6.1 The Trust Board receives a monthly summary of the number of complaints received and the issues raised as part of the Integrated Operational Report. A further report which contains a more in depth analysis of the issues raised in complaints is provided quarterly to the Patient Experience Group and Quality Committee.

6.2 Complaints are coded on the Datix system under a variety of categories. Although the subject matter may vary, the root causes which result in a complaint being raised can be associated to three main themes: communication, staff attitude and delays.

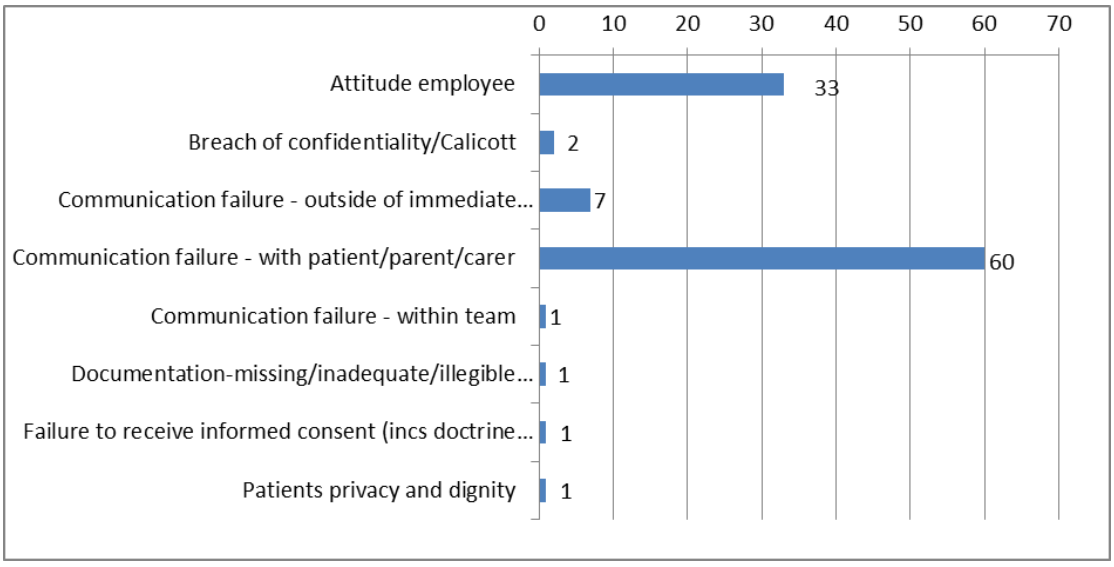
6.3 Complaints related to Consultants are shared with the Medical Director for professional conversations as required.

6.4 The five main themes are shown in the chart below.



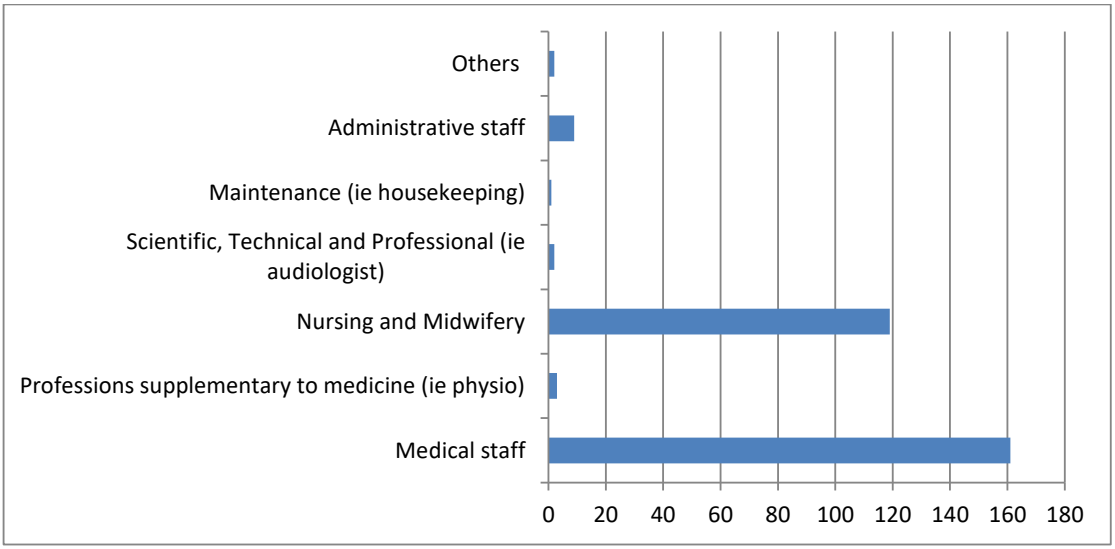
NOTE: SOME COMPLAINTS ARE LOGGED TO MORE THAN ONE SUBJECT

6.5 The chart below shows a breakdown of the largest theme of **consent, communication and confidentiality** in more detail.



NOTE: SOME COMPLAINTS ARE LOGGED TO MORE THAN ONE SUBJECT

7.0 COMPLAINTS BY STAFF GROUPS



8.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

8.1 Contact information for the Parliamentary and Health Service Ombudsman (PHSO) is provided to all complainants should they remain unhappy with the outcome of the Trust's investigation and response. During the last year we have been contacted by the PHSO once. This complaint related to an initial contact from the family in 2018 and involved the Coroner's. On reviewing the complaint and relevant documentation, the PHSO did not uphold the complaint and there were no further actions for the Trust.

9.0 NEW NHS COMPLAINTS STANDARDS

9.1 Led by the Parliamentary Health Service Ombudsman (PHSO) these standards are being tested in pilot sites in 2021 and will be refined and introduced across the NHS in 2022.

The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.

The Complaint Standards set out a single vision for staff and patients/complainants of what is expected when a complaint is raised. This will help make sure everyone experiences a culture that seeks out learning from complaints, and meets the outcomes set out in co-designed PHSO published document My Expectations.

The Standards are the first step towards recognising complaint handling as a professional skill. They will set a clear path for all services to harness the rich learning that comes from feedback and complaints to help improve services for the benefit of all.

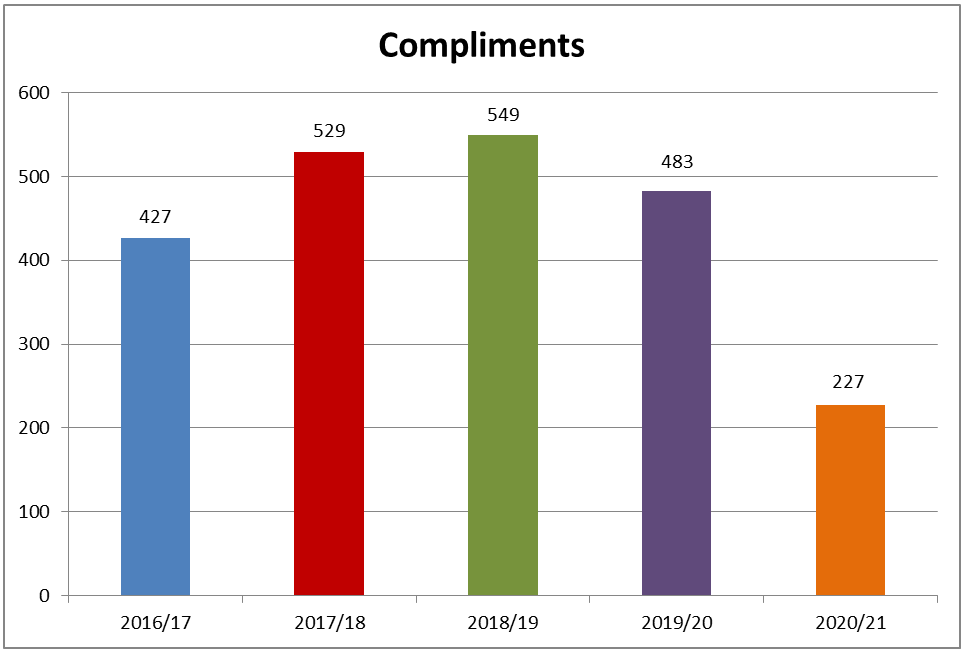
By adopting the Standards, NHS staff will be able to address and resolve more complaints at the earliest opportunity, which will benefit everyone involved. The Standards will help make sure that staff take learning forward to improve services for future users.

Earlier resolution of complaints will also reduce the possibility of complaints becoming legal claims or being referred to the Ombudsman. This can save financial and emotional costs for everyone.

The Standards and the guidance modules describe how staff can meet those expectations. Guidance modules to implement the standards can be downloaded from the PHSO website.

10.0 COMPLIMENTS

10.1 The graph below shows the number of compliments collected by the Patient Experience team in recent years, with the number of compliments received this year being 227. The usual monthly ceremony which celebrates those staff who have been nominated for a Hospital Hero award was suspended to the Covid-19 (Coronavirus) pandemic however those staff who were nominated received their certificate in the post and a voucher for tea/coffee & cake from Damers Restaurant. The 'Celebrating Success' weekly email is circulated to the organisation which highlights those staff who have been complimented about their work during the past week.



11.0 CONCLUSION

The Trust has maintained the improvements in managing complaints and continues to meet the regulatory requirements on managing complaints, identifying learning from complaints. The Trust has met the recommendations of the CQC report on complaints taken seriously, identifying learning and responding using clear language with compassion. The focus for next year as part of our continuous improvement in managing complaints will be:

- To continue to respond to complaints in a timely manner with compassionate responses to include learning from complaints to enhance quality improvement.
- The Patient Experience Team with the Divisions will continue to work closely to monitor complaint responses provided within the agreed timescales and improve the process where necessary.
- To develop complaints training for staff in relation to the new NHS Complaints standards.
- The action plan implemented last year has been updated below:

	ACTION:	**Timescale/Update**
1	Monitor the number of extensions granted and the reasons for needing the extension.	Process in place - completed
2	Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, and complaints in need or urgent response.	Process in place - completed
3	Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions and senior management team and Deputy Director of Nursing & Quality	Process in place - completed
4	On-going monthly monitoring of response timeliness. A monthly report is provided to reflect progress and numbers received. To be continually monitored to maintain target of 95%.	Process in place - completed
5	Review the complaint journey from receipt of complaints for further development of the Complaints web-based module on Datix	Monthly with Risk Management Team - ongoing
6	Review the complaints training offered to staff and promote the complaints management toolkit available on Sharepoint.	September 2020 - ongoing
7	Provide adhoc training and support to clinicians and managers around complaint responses.	Process in place

8	Plan quarterly meetings with Patient Experience & Engagement Lead and Divisional Managers to review progress and track improvement made.	Process in place - completed
9	Send out the complaint process survey regularly throughout the next year to gain feedback on the complaint process and monitor the impact of improvements made.	Process in place – ongoing
10	Theme the learning from complaints identified in complaint response letters - to be included in the Patient Experience Quarterly report.	Process in place - completed
11	Identify and record if complaints are upheld, partially upheld or not upheld. Information to be recorded on Datix	Process in place – completed.
12	Review the process of collating and recording compliments	September 2020 - ongoing

12.0 RECOMMENDATIONS

12.1 The Board is requested:

- to receive and note the contents of this report
- receive assurance of improvements in complaints management and learning

Meeting Title:	Board of Directors
Date of Meeting:	24 November 2021
Document Title:	**Mortuary Security Statement of Compliance**
Responsible Director:	Anita Thomas – Interim Chief Operating Officer
Author:	Sonia Gamblen

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	16/11/2021	Approve

Purpose of the Paper								
	Note (		*Discuss*		*Recommend*		*Approve*	✓
Summary of Key Issues	***On 12 October 2021 NHSE/I asked Trusts with either a body store or mortuary to undertake a review of local operational procedures against the requirements set out in the Human Tissue Authority's (HTA) standards and guidance with the addition to these standards that****; " there must be effective CCTV coverage in mortuary areas and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and mental health support may be required to support staff to undertake this task."* ***Following feedback from Trusts the above was further clarified as*** *"Ensure there is effective CCTV coverage, monitoring access to and from mortuary areas. CCTV data should be reviewed, alongside swipe card data, by an appropriately trained and authorised individual to audit access."* *The Pathology Operations Manager has confirmed that the mortuary is compliant with the general HTA standards and has an action plan to address the CCTV requirement. The action plan is attached and was required to be submitted to NHSE/I on 16/11/21 therefore approval for submission was provided at the Quality Committee held on the same date.* *The main issue for DCHFT is that CCTV exists but does not record any data. During office hours staff can monitor access and exits from the mortuary and body store. Out of business hours the area is protected by cotag only. Options to extend our current CCTV which is already at capacity or to have a stand-alone CCTV unit are being explored.*							
Action recommended	The Board is recommended to: 1. **APROVE** the report							

Governance and Compliance Obligations

Legal / Regulatory	Y	
Financial	Y	
Impacts Strategic Objectives?	Y	

Risk?	Y	
Decision to be made?	Y	
Impacts CQC Standards?	Y	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Appendix A

Dorset County Hospital NHS
NHS Foundation Trust

RISK ASSESSMENT OF:	**Mortuary security**
DATE OF ASSESSMENT;	**26/10/2021**
DIRECTORATE AND DEPARTMENT:	**Urgent and integrated care/ Mortuary**
ASSESSORS:	**Andrew Ellis/Jude Whitehead**
WARD/SERVICE MANAGER NAME:	**Jude Whitehead/Andrew Ellis**

Process Map

(For Risk Evaluation Graph and Risk Profiling please refer to Appendix 3 and 4 of this document)

Appendix 1

What are the hazards and what is the likely harm?	Who might be harmed?	Current control measures i.e. What are you already doing?	LIKELIHOOD	CONSEQUENCE	TOTAL	VLR, LR, MR, HR, VHR	What further action is necessary? i.e What are the additional control measures to reduce the risk to an acceptable level?	LIKELIHOOD	CONSEQUENCE	TOTAL	VLR, LR, MR, HR, WHR	Action by who	Action by when?	outcome
Potential risk of unauthorised access to mortuary.	Staff. Deceased and/or families. Data breach. Theft from.	• All access points into department currently have CCTV (not monitored continuously or recorded and only used to view door entry during business hours) • The hospital cotag system restricts access • DBS checks for staff.	3	5	15	HR	As a minimum, recorded CCTV should record all persons entering and leaving the department. Extra cameras would be necessary for recording inside the department. Recording CCTV does not remove any risk but enhances the security. **Action: Explore additional CCTV either stand alone or add to existing hospital's CCTV. Current system is at capacity so to add 4 additional cameras would require 4 others to be decommissioned.**	2	3	6	LR	Pathology Operations Manager Emergency Planning officer	11/11/21	
There are 4 access doors to the mortuary controlled by cotag.	As above	Cotag system records entry into department for the person who opens the door using their cotag card. During normal hours, staff are present in the department to monitor entry and exit during business hours. It is possible to review who has accessed a door via cotag but this is only investigated if a problem is being investigated.	2	3	6	LR	Action: • Recorded CCTV required. The current system does not have the functionality to record. • A review of who can access via cotag requires a	2	2	4	VLR	As above Facilities Manager	31/12/21	

What are the hazards and what is the likely harm?	Who might be harmed?	Current control measures i.e. What are you already doing?	LIKELIHOOD	CONSEQUENCE	TOTAL	VLR, LR, MR, HR, VHR	What further action is necessary? i.e What are the additional control measures to reduce the risk to an acceptable level?	LIKELIHOOD	CONSEQUENCE	TOTAL	VLR, LR, MR, HR, WHR	Action by who	Action by when?	outcome
		OOHs access is determined by cotag, CCTV does not record access and no staff present to monitor entry exit.					review.							
Only the person who opens the door by using their cotag will be recorded. Any other persons entering at the same time are not recorded.	As above		3	5	15	HR	Recorded CCTV required All Cotag access to be reviewed.	2	3	6	LR	Pathology Operations Manager & Emergency planning Officer & head of Estates	31/12/21	
Masterkey allows access to mortuary which circumvents the Cotag door entry system so no option to record details of cotag access.	As above	Cotag system records entry into department for the person who opens the door using their cotag card.	3	5	15	HR	Under normal circumstances, there should be no need to have a key which circumvents the Cotag system. However, in the event of an emergency, eg power failure, access will be necessary. Change to sign in / out system – switchboard to hold the key Ownership and use of the keys must be monitored and recorded. All Cotag access to be reviewed.	2	3	6	LR	Facilities manager	31/12/21	

What are the hazards and what is the likely harm?	Who might be harmed?	Current control measures i.e. What are you already doing?	LIKELIHOOD	CONSEQUENCE	TOTAL	VLR, LR, MR, HR, VHR	What further action is necessary? i.e What are the additional control measures to reduce the risk to an acceptable level?	LIKELIHOOD	CONSEQUENCE	TOTAL	VLR, LR, MR, HR, WHR	Action by who	Action by when?	outcome
Body storage area accessible once inside the department. Door between PM room and body storage area does not have suitable security.	As above	Door from mortuary corridor into body store area is cotag secure.	3	5	15	HR	Cotag access required between PM room and body store areas.	2	3	6	LR	Head of Estates	22/11/21	
Patient details stored as paper copies in huge numbers of files on shelves in offices. Potential data breach risk.	Potential data breach.	During normal hours, the department is staffed and minimal concerns about unauthorised access. Outside normal hours, doors to offices are locked All staff complete IG trainining	3	4	12	MR	Secure data storage is critical. Encrypted and firewalled electronic system required. Review security provision on office doors. Recorded CCTV for monitoring will provide additional assurance.	2	3	6	LR	Pathology Operations Manager	June 2022	
Patient belongings and valuables are kept in the department	Possible risk of theft. Belongings or valuables	Patient belongings are kept in locked room within department. Valuables are kept in locked safe inside the same locked room. During normal hours, the door to this area may be open but the department is staffed and only minimal concerns about unauthorised access.	2	4	8	LR	Recorded CCTV for monitoring would provide extra assurance. Review the process of patient property being sent to the mortuary with deceased	2	3	6	LR	As above	31/12/21	
Doorway from body store to outside space doesn't seal or give appearance of being secure.	Staff. Deceased and/or families. Data breach. Theft from.	Door is fully glazed (toughened, obscured glass to BS6206AT) double door with drop bolt top and bottom on one side and has internal twist lock and key operation externally on the other side.	2	4	8	LR	Recorded CCTV for monitoring would provide extra assurance.	2	3	6	LR	As above	31/12/21	

Appendix 2

DETAILED PROPOSED RISK ACTION PLAN FOR ADDITIONAL CONTROL MEASURES

		Risk Category								
Risk No.	**Description of Risk**	**Very High**	**High**	**Moderate**	**Low**	**Very Low**	**ACTION PLAN**	**Cost**	**Person (s) Responsible**	**Due Date**
1	Potential risk of unauthorised access to mortuary. All access points into department currently have CCTV (not monitored continuously or recorded and only used to view door entry during business hours) During normal hours, staff are present in the department to monitor entry and exit. Outside normal business hours when the department is not routinely staffed the risk is considerably higher. Recording CCTV does not remove any risk but enhances the security. Specialist training required for individuals tasked with reviewing CCTV footage.		15				• All Cotag access to be reviewed. • Extra CCTV cameras to be installed with recording facility.	TBC	JW to obtain quotes with assistance from AE, estates and procurement. TJ	
2	Only the person who opens the door by using their cotag will be recorded. Any other persons entering at the same time are not recorded. Recorded CCTV will ultimately provide a record of all persons accessing the mortuary.		15				• Cotag access to be reviewed. • Sign in / out system to be implemented	Nil	Facilities Manager	31/12/21

3	Possible that cotags could be shared or borrowed but still only the person swiping in is recorded as entering the department.		15				All Cotag access to be reviewed.	Nil	Estates/facilities to review cotag access	31/12/21
4	Exit from the department is not recorded at all. Risk someone could remain inside the facility		15				Recording CCTV required to monitor access and exit	TBC	Mortuary Manager to obtain quotes with assistance from AE, estates and procurement	30/11/21
5	Body storage area accessible once inside the department. Door from mortuary corridor into PM room does not require cotag access and can then enter body store area.		15				Enhanced security/Cotag access to be implemented for access into PM room and body store areas. Current cotag system unable to expand. Awaiting new cotag system	TBC	Head of Estates	April 2022
6	Masterkey allows access to mortuary which circumvents the Cotag		15				Review use and ownership of masterkey.	Low	Head of Facilities	31/12/21
7	Patient details stored as paper copies in huge numbers of files on shelves in offices. Potential data breach risk.			12			Secure data storage is critical. Ideal option would be encrypted and firewalled electronic storage of patient records. Review security provision on office doors.	TBC	IT for data storage Estates for security review	TBC

N.B. If the additional control measure has budgetary implications then the only person who can sanction the action is the manager of your department. If the action requires someone from outside of your ward or department then you must in the first instance have their approval to add their name as the person responsible and you must also give them a copy of the risk assessment.

RISK EVALUATION TABLES QUALITATIVE MEASURES OF CONSEQUENCE

LEVEL	**DESCRIPTOR**	**DESCRIPTION**
1	Insignificant	No injury or damage caused
2	Minor	Minor injury/damage: (ie no lasting effects, will probably be resolved in a short time period: Resource implications < £50,000)
3	Moderate	Moderate injury/damage: (ie Semi-permanent injury but will recover: Moderate resource implications > £50,000 < 500,000)
4	Major	Major injury/damage: (ie Life-long injury: Life-long adverse effect on lifestyle: Major loss of service: Major resource implications >£500,000)
5	Fatality/Multiple Fatalities	Avoidable fatality/multiple fatalities/catastrophic damage

QUALITATIVE MEASURES OF LIKELIHOOD

LEVEL	**DESCRIPTOR**	**DESCRIPTION**
5	Certain	The event is expected to occur on many occasions (e.g. daily?)
4	Likely	The event probably will occur but not an everyday occurrence (e.g. weekly?)
3	Possible	The event may occur occasionally (e.g. monthly?)
2	Unlikely	Do not expect event will happen but it is a possibility (e.g. twice a year?)
1	Rare	Can't believe event will ever happen (e.g. once a year?)

Appendix 4

Result from “Consequence Table” and “Likelihood Table” plot on the “Risk Evaluation Graph” to obtain the “Risk Category”. Once complete you insert the initial findings from your hazards and insert your existing control measures. If after applying the initial control measures your risk remains in the Moderate, High risk or Very High then you will need to apply additional control measures to reduce the risk to a level that is as low as in reasonability practicable

RISK EVALUATION GRAPH (5X5 Matrix)

	CONSEQUENCE				
LIKELIHOOD	**1 Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Fatality Multiple/ Fatalities**
5 – Certain	**5 Yellow**	**10 Orange**	**15 Red**	**20 Red +**	**25 Red +**
4 – Likely	**4 Green**	**8 Yellow**	**12 Orange**	**16 Red**	**20 Red +**
3 – Possible	**3 Green**	**6 Yellow**	**9 Yellow**	**12 Orange**	**15 Red**
2 – Unlikely	**2 Green**	**4 Green**	**6 Yellow**	**8 Yellow**	**10 Orange**
1 – Rare	**1 Green**	**2 Green**	**3 Green**	**4 Green**	**5 Yellow**

Very Low Risk 1 to 4	Low Risk **5 to 9**	**Moderate Risk 10 to 14**	High Risk **15 to 19**	**Very High Risk 20 to 25**