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 **30th March 2022** at **8.30 am to 11.30 pm** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Dawn Harvey Emma Hallett	Note	8.30-08.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	Mark Addison Trust Chair	Note	08.55-9.00
	a) Apologies for Absence:	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 26th January 2022	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**Enabling Plans** a) Clinical Plan b) Workforce Plan c) Digital Plan	Enclosure	Alastair Hutchison Dawn Harvey Stephen Slough	Approve	9.00-9.15
4.	**Committee Reviews** a. Committee Reviews	Enclosure	Mark Addison Trevor Hughes	Approve	9.15-9.30
5.	**CEO Update**	Enclosure	Nick Johnson	Note	9.30-9.40
6.	**Recovery Report** (Standing item)	Enclosure	Nick Johnson	Note	9.40-9.50
7.	**COVID-19 Update**	Verbal	Anita Thomas	Note	9.50-10.00
Coffee Break 10.00-10.10.15					
8.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (February and March 2022) a) People and Culture Committee b) Quality Committee c) Finance and Performance	Enclosure	Committee Chairs and Executive Leads	Note	10.15-10.40

	Committee d) Risk and Audit Committee e) Charitable Funds Committee f) System Performance Update (Standing Item)				
9.	**Medical Education Report** **Item Deferred**	Enclosure	Alastair Hutchison Paul Murray	Note	9.50-10.00
10.	**Guardian of Safe Working Hours Report** (March PCC)	Enclosure	Kyle Mitchell	Note	10.40-10.50
11.	**Board Assurance Framework and Risk Register** (March RAC)	Enclosure	Nick Johnson Paul Lewis	Note	10.50-11.00
12.	**Well Led Review – Final Report**	Enclosure	Trevor Hughes	Note	11.00-11.10
13.	**Questions from the Public**	Verbal	Mark Addison	Note	11.10.11.20
	CONSENT SECTION				11.20-11.30
	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.				
14.	**DCH Charity** • Business Plan 2022/23 • Capital Appeal Plan • Charitable Funds Restructure	Enclosure	Dave Underwood	Approve	-
15.	**Maternity Safety Update**	Enclosure	Nicky Lucey	Note	-
16.	**Staff Survey Action Plan** (March PCC)	Enclosure	Dawn Harvey	Note	-
17.	**Annual Patient Survey** (March QC)	Enclosure	Nicky Lucey Ali Male	Note	-
18.	**Any Other Business** Nil notified				
19.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 25th May 2022** via MS Teams.TBC				

Minutes of a public meeting of the Board of Directors of Dorset County NHS Foundation Trust held at 10.00am on 26th January 2022 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
Dawn Harvey	DH	Chief People Officer
Alastair Hutchison	AH	Chief Medical Officer
Nick Johnson	NJ	Deputy Chief Executive
Eiri Jones	EJ	Non-Executive Director
Nicky Lucey	NL	Chief Nursing Officer
Ian Metcalfe	IM	Non-Executive Director
James Metcalfe	JM	Divisional Director
Dhammika Perera	DP	Associate Non-Executive Director
Stephen Slough	SS	Chief Information Officer
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Non-Executive Director
In Attendance:		
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Ula Brocklebank	UB	Freedom to Speak Up Guardian *(item BoD21.101)*
Natalie Violet	NV	Corporate Business Manager
Members of the Public:		
Simon Bishop	SB	DCHFT Public Governor
Judy Crabb	JC	DCHFT Public Governor
Kathryn Harrison	KH	DCHFT Public Governor
Apologies:		
Patricia Miller	PM	Chief Executive
Paul Goddard	PG	Chief Financial Officer

BoD21/089	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed members of public and governors to the meeting. MA formally welcomed the new NEDs to the meeting SP, EJ and DP. Apologies for absence were received from Patricia Miller and Paul Goddard.	
BoD21/090	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda. EJ, new Non-Executive Director to the Trust declared the following interests: Non-Executive Director Salisbury NHS Foundation Trust Director of own company Trustee and School Governor Advisory member of the Board for Allocate.	
BoD21/091	**Minutes of the Meeting held on the 24th November 2021**	

	Members of the Board considered the minutes of the meeting held on 24th November 2021 and these were approved as an accurate record**.**	
	Resolved: that the minutes of the meeting held on 24th November 2021 were approved.	
BoD21/092	**Matters Arising: Action Log**	
	The action log was considered and updates were noted with 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.	
BoD21/093	**Governance Update**	
	MA reminded the Board of their recent review of governance processes as a consequence of the COVID impact and the recently refresh of guidance on the matter for the NHS that also included revised performance indicators. The paper provided assurances that the steps taken by the Board in December 2021 were consistent with the updated guidance. The Board acknowledged that whilst the guidance recommended a focus on operational targets, the Board also remained focussed on key quality and safety metrics and staff wellbeing. The Trust's incident management included daily meetings to keep abreast of the latest guidance and service pressures and the Senior Leadership Group regularly reported to the Executive team. The NHS remained in a level 4 incident and these arrangements would remain in place until this was revised nationally.	
	Resolved that the Governance Update be received and noted	
BoD21/094	**CEO Update**	
	NJ presented key highlights from the report and drew the Board's attention to the following: • Final operational planning guidance had been published in December • Establishment of the ICS had been formally delayed until July 2022 although work continued across the system to establish the ICS in shadow form subject to recruitment to the Integrated care Board. • The Health and Social Care Levy was progressing through Parliament • A task and finish group had been established to progress the requirements for Vaccination as a Condition of Deployment (VCOD). Unvaccinated staff would need to be vaccinated by 3 February 2022 and the Trust was working with individuals where necessary to achieve this. The impact of VCOD) on the Trust was expected to be low given the high vaccination take up by staff although the position of partner organisations remained unclear. National debate on the matter continued.	

	• PM would take over as the CEO for the Integrated Care System on 1st February 2022 • The Chair of University Hospitals Dorset had announced his retirement. The new CEO was expected to take up post in June. • AT had been appointed substantively to the Chief Operating Officer post. The Board extended their congratulations. • The number of COVID cases appeared to be plateauing • Progress continued with the Elective Recovery programme. • The number of patients in hospital with no reason to reside remained very high **Recovery Report** The Trust continued to focus on people and service recovery and to ensure access to staff support measures. Good progress was being made on elective recovery despite increasing urgent and emergency care activity. Whilst waiting list performance remained challenging, the Trust was generally making improvements ahead of trajectory. The inclusion of deprivation and learning disabilities indices were noted within the report and performance in respect to learning disability diagnostics performance, currently 77%, and 104 week wait performance was questioned. AT clarified that the data related to oral maxillo-facial services and had been impacted by reduced mutual aid provision across the system. Independent sector provision was being explored. AT undertook to confirm the diagnostic figures which were thought to be small in number. Orthopaedic performance had improved ahead of trajectory although sickness absence had slightly impeded further progress. Rapid progress on the numbers of patients waiting for treatment had been made earlier in the year following a validation exercise and the Trust was participating in a number of performance improvement work streams across the region. Capacity and demand modelling would include the detail of the various factors impacting the waiting list, provide assurance about equality of access to care and outline how the Trust would work differently later in the year. The Board were informed that referral patterns had changed significantly during the pandemic making comparison of the waiting list to pre-COVID waiting lists difficult. In response to a question regarding sickness absence trajectories relating to anxiety, stress and depression, the Board heard that it was anticipated that the position would likely accelerate as staff were now very tired. The Board noted the positive link and impact between wellbeing and opportunities to innovate on anxiety and stress.	**AT**
	Resolved: that the CEO Update be received and noted.	
BoD21/095	**COVID-19 Update**	
	The number of inpatient cases had reduced during the previous week to single figures. The vaccination status of patients was noted on admission and current cases comprised mixture of vaccinated, unvaccinated or previously COVID positive patients.	

	Patient flow issues continued as two wards remained closed and the number of personnel required to isolate had impacted overall capacity. There were no COVID positive patients in ITU. The Level 4 incident remained in situ nationally and surge planning had been completed.	
	Resolved: that the COVID-19 Update be noted.	
BoD21/096	**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 and in December 2021, noting the Escalation Reports and highlighting key points: **People and Culture Committee:** There was nil to add to the Escalation Reports as presented. **Quality Committee:** JG highlighted the committee maintained continued focus on key quality and maternity safety indicators. Positive feedback had been received from patients despite the amount of pressure services and staff were under at this time. The January meeting heard that further review of blood services was in train and that an action plan was to be reviewed at the next meeting. Regarding a recent Never Event, the Quality Committee would monitor outcomes of the root cause analysis and subsequent action plans and the Trust maintained regular communication on the matter with the CCG. **Finance and Performance Committee:** The Board noted the escalations regarding waiting lists, focus on patient flow and the number of patients with No Reason to Reside. The matter of Clinical Coding and the ongoing work to address this were also noted and an action plan had been presented to the committee. There was an increased confidence that the year-end break-even position would be achieved as a result of additional non-recurrent funds received and recognition that the cost efficiency requirement for the coming financial year would be challenging. The Health Education England funding allocation for the new financial year had not yet been received which impeded the ability to fully plan education and training activity. **Risk and Audit Committee:** There were no issues to escalate from the committee. Internal auditors had commended the timely closing of actions arising from Audit and action had been requested of the People and Culture	

	Committee in respect of recruitment delays. The Internal Audit Plan 2022/23 would be returned to the committee for approval in March 2022. **Charitable Funds Committee** The meeting had been unable to proceed and would be rearranged. The later Board agenda item on funding was noted.	
	Resolved: that the Performance Scorecard, Board Sub-Committee Escalation Reports and System Performance Update be noted.	
BoD21/097	**ICS Development Update** (Standing Item)	
	The formal establishment of the ICS had been delayed nationally until July 2022 although work to establish the Integrated Care Board (ICB) continued. Plans to develop the Integrated Care Partnership (ICP) were also progressing alongside development of the Integrated Care Strategy. The definition of Provider Collaborative functions and roles was yet to be determined although the ambition was to complete this by the end of February 2022. The ICS performance was report taken as read and noted that demand across the system was similar to that at DCH with continuing issues across the care sector. There was an expectation that the system would achieve a year-end break-even position and the non-recurrent funding contribution to this position and the challenging efficiency savings for the forthcoming year were noted.	
	Resolved: that the ICS Development Update be received and noted.	
BoD21/098	**NED Board Champion Roles**	
	MA summarised the paper which outlined the NHSE review of Non-Executive Director (NED) oversight roles, which had become extensive and required an holistic review, undertaken in 2021. The review recommended that the number of NED Champion roles be reduced significantly to five and the associated responsibilities attached to those roles removed be remitted to committees. The paper recommended that these remitted responsibilities be included within cycles of committee business going forward and this was approved. Health and safety responsibilities were noted to span more than one committee and responsibilities in this area would be clarified as cycles of committee business were reviewed during quarter 4.	
	Resolved: that the recommendations within the NED Board Champion Roles paper be approved.	
	The meeting was paused to enable members to take lunch.	

BoD21/099	**Charitable Funds Finance Update**	
	DU noted the challenges to attracting charitable income due to the pandemic and advised of the commitments against income and included operating costs and provision of funds to services. The position had strengthened a little in the current year with an increased outturn position of £75k on that of the previous year. The Board noted the imminent launch of the extensive campaign in support of the Emergency Department.	
	Resolved: that Charitable Funds Finance Update be received and noted.	
BoD21/100	**Board Assurance Framework (BAF) and Risk Register**	
	The Board noted that the Risk Register would be discussed in Part 2 of the meeting. NJ noted prior discussion of the BAF by the Risk and Audit Committee and the further developments of the document that included strength of assurance, committee ownership and deep dives. The Board noted the following: • the strategic estates risk score could be reduced due to seed funding received • the risk score relating to patients with No Reason to Reside needed to be increased and • addition of the health inequalities risk to be noted. Strategic risks were underpinned by demand, workforce and sustainability challenges. The Board commended improvements in the presentation and format of the report and requested that there was greater sight of the timescales and trajectory for achieving risk score targets, particularly in relation to the planned workforce risk score reduction. In response to a question regarding the inclusion of net zero and social value sustainability risks, the Board noted the inclusion of aspects within other areas. It was agreed that these areas would be made clearer and identified more specifically.	**NJ** **NJ**
	Resolved: that the Board Assurance Framework be received and noted.	
BoD21/101	**Freedom to Speak Up Report**	
	UB attended to present this item. UB had been in post since August 2021 and the report reflected initial finding as of November 2021. Themes were unclear at that time and subsequent reports would include a revised thematic. The level of speaking up was generally good and staff were making approaches and raising concerns. UB was progressing Listening Up work with support from HR colleagues on issues raised and triangulating with other sources of data. Further	

	training to ensure that managers listened actively to the concerns raised, however, was required. A programme to strengthen manager competence, including speaking up and listening up, was planned within the People Strategy. There were 18 Freedom to Speak Up Champions across the Trust and further training and recruitment was planned. UB confirmed that many more concerns raised had been closed since the report had been written and that action was being taken to resolve concerns. The issue of 'fear of detriment' was raised within the report and the Board sought clarity on how psychological safety to enable staff to speak up was promoted. UB highlighted the work in train to better understand the barriers to speaking up, stating that the ambition was to support staff in making direct approaches to line managers to address concerns. DH supported the ambition and advised that the 'you said, we did' approach going forward would underpin progress. The Board noted UB's visibility across trust, that the report had started to set out areas for development and that the Speak Up agenda was central to supporting the People Strategy. The Trust induction programme encouraged staff to speak up although it needed to be further demonstrated that there was no detriment for staff by doing so. In response to a question about the diversity of those staff speaking up being representative of the staff population, the Board noted that this was the case. UB had worked in the Trust for many years and was well known and understood what staff felt was important. Future reports would include actions taken and be linked with the risk management data to identify any connected themes or operational issues. The People Dashboard included and triangulated speak up data providing a cultural barometer which linked to risk. MA thanked UB for her report.	
	Resolved: that the Freedom to Speak Up Report be received and noted.	
BoD21/102	**Mortality Report**	
	The Quarter 3 Mortality Report would be presented to the Board in March 2202.	
	Resolved: that the Quarter 3 Mortality Report be reported in March 2022.	
BoD21/103	**Maternity Reports**	
	NL advised that the three reports had been reviewed by Quality Committee and advised that the Ockenden Review required the Board to note the reports and approve these for inclusion in the Board	**NL**

	Minutes. A summary of the committee discussion would be included in future front sheets noting any escalations. **Maternity Safety Report** Key messages from the report included the implementation of the digital maternity system, Badgernet, which had been a key change for staff. Maintaining staffing due to COVID related issues continued to present challenges although the situation was improving and the provision of mutual aid or divert continued across the system. No patient complaints had been received over the preceding three-month period. **Continuity of Carer Report** This was the first Continuity of Carer Report to Board. Further reports would be provided on a quarterly basis following prior discussion by the Quality Committee. The Board noted that the Trust operated an integrated community and acute team and that continuity of carer transformational change was being supported by the Local Maternity and Neonatal System (LMNS). **Education and Training Report** As part of requirement. This report had been developed in order to satisfy CNST premium and Ockenden Review requirements and would be reviewed by the People and Culture Committee going forward prior to Board consideration. The Board accepted the report and noted future reporting arrangements.	
	Resolved: that the Maternity Reports be received and future reporting arrangements be noted.	
BoD21/104	**Questions from the Public**	
	KH advised that Governors had been welcomed at Part 2 meetings of the Board in the trust where she had been a governor previously. She asked that the Board give the matter further consideration and advised that one third of trusts nationally allowed this. JC enquired whether it would be possible to break the Freedom to Speak Up Report down by staff group. The numbers contained within the report at the current time were small although it was felt that over time it would be possible to undertake a further breakdown.	**MA**
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD21/105	**Charitable Funds Committee Terms of Reference**	
	Resolved: that the Charitable Funds Committee Terms of Reference be approved.	
BoD21/106	**Any Other Business**	
	No other business was raised or notified.	

BoD21/107	Date and Time of Next Meeting
	The next Part One (public) Board of Directors' meeting of Dorset County Hospital NHS Foundation Trust will take place at **8.30am** on **Wednesday 30th March 2022.**

Action Log – Board of Directors Part 1

Presented on: 30th March 2022

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 26th January 2022						
BoD21/094	**Recovery Report**	To confirm Learning Disability diagnostic waiting list numbers	**AT**	February 2022	No update received	
BoD21/100	**Board Assurance Framework (BAF) and Risk Register**	Trajectories for achieving risk reduction targets and trajectory milestones to be included in future reports	**NJ**	March 2022	In progress. To be reviewed by Risk and Audit Committee	No
		Net zero carbon and social value sustainability risks to be more clearly identifiable within the BAF	**NJ**	March 2022	In progress. To be reviewed by Risk and Audit Committee	No
BoD21/103	**Maternity Reports**	A summary of committee discussion and escalations to be included in future report from sheets. This to be fed back to JH	**NL**	February 2022	Completed	Yes
BoD21/104	**Questions from the Public**	Consideration to be given to Governor attendance at Part 2 (private) meetings of the Board	**MA**	March 2022	No update received	
Meeting Dated: 24th November 2021						
BoD21/077	**WDES Report**	Members of the Board to update disability status declarations	**All**	December 2021	Board members were reminded to complete – TH to check in one week	No
Meeting Dated: 29th September 2021						
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**~~ **NJ**	~~November 2021~~ January 2022	Raised with Kyle Mitchell, GoSW	No
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~~ January 2022	Ongoing	no
Actions from Committees…(Include Date)						

Meeting Title:	Trust Board
Date of Meeting:	30th March 2022
Document Title:	**Trust Clinical Plan, People Plan and Digital Plan**
Responsible Director:	Alastair Hutchison – Chief Medical Officer Dawn Harvey – Chief People Officer Stephen Slough – Chief Information Officer
Author:	Ciara Darley – Senior Programme Manager

Confidentiality:	Yes – draft
Publishable under FOI?	No

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Enabling plans have been reviewed at the Executive Management Meeting, Trust Committees and at the March Board Development session.	Feb – Mar 2022	Recommended for all three documents to presented together with one cover document to highlight the interdependencies and common themes which will be presented across all three.

Purpose of the Paper	To gain approval of the high-level content, principles and direction included within the Trust Clinical, People and Digital Plans as enablers to the Trust Strategy.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓

Summary of Key Issues	The Clinical, People and Digital Plans have been developed following the publication of the Trust Strategy, setting out their contributions to the three strategic themes of People, Place and Partnership.
	
	The approach to creating the enabling plans was to develop a clear line of sight from Trust strategy to Clinical plan followed by the people and digital plans as crucial supporting arms. This flows to division, care group, department and downstream team action. The approach to development of enabling plans was as important as the output. This was a bottom-up exercise designed to increase a sense of purpose, belonging and control – a 'show' not tell' approach to the culture we want to perpetuate at DCH.
	
	A cover paper has been prepared as an introduction to the three plans. It highlights the key challenges being faced by the organisation, strategic alignment and the common themes which sit across all three plans, including:
	• Sustainability, broken down into
	  ○ Financial
	  ○ Social
	  ○ Environment
	• Population Health Management
	
	The enclosed plans then provide the strategic context for the specific and details of the inputs, outputs and metrics to deliver the goals.
	
	The Board is asked to approve the high-level content and principles with final amends being delegated back to the Executive Leads.
	
	Next steps following approval would be to complete any final amendments before							

	the plans are designed fully to provide the same look at feel, highlighting that they form part of a joint strategic effort. More detailed planning can then take place with colleagues from across the organisation and progress will be reported through Trust governance mechanism. The high-level risks to delivering the ambitions set out within the three enabling plans include operational pressures and the strain this will put on resource and ability to deliver change. The ongoing Covid-19 pandemic and possible implications on the NHS through the lifespan of these plans and not securing the funds or resources to support delivery.
Action recommended	The Board is recommended to • Approve the Clinical, People and Digital Plans

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	Y	Delivery of Trust Strategy
Impacts Strategic Objectives?	Y	Mechanisms to achieve Strategic Objectives
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	Yes - safe; effective; caring; responsive, and well-led
Impacts Social Value ambitions?	Y	Positive impact as Strategy aligned to achieving Social Value ambitions
Equality Impact Assessment?	Y	
Quality Impact Assessment?	N	

Introduction to the Enabling Plans

At Dorset County Hospital we have a mission – to **provide outstanding care for people in ways which matter to them** and a vision to **work with our health and social care partners, being at the heart of improving the wellbeing of our communities**.

Like many other Trusts, the challenges we face are reflective of the national picture: demand exceeds capacity, we are facing workforce supply issues and there is a financial deficit to be rebalanced. In addition, staff are recovering from the effort of responding to the Covid-19 pandemic, waiting lists must be addressed and the issue of displaced services continues. Similar pressures are being felt across the ICS system, impacting the availability of care in alternative settings meaning that there are higher numbers of patients in hospital who should be at home or in more appropriate settings.

In the face of these challenges, our approach to strategy must be ambitious, but realistic. The Trust Strategy provided the framework for strategic change in alignment with the ambitions of our Dorset ICS, and summarised this into three themes:

People – Putting our staff first to make DCH a great place to work and receive care
Place – Building a better and healthier place for our patients and population
Partnership – Working together to ensure outstanding services, accessible to our patients and population.

The enclosed Clinical, People and Digital Plans provide the next level of detail; they have been developed together, support each other, and should be read in conjunction with one another.

The approach to creating the enabling plans was to develop a clear line of sight from Trust strategy to Clinical plan followed by the people and digital plans as crucial supporting arms. This flows to division, care group, department and downstream team action. The approach to development of enabling plans was as important as the output. This was a bottom-up exercise designed to increase a sense of purpose, belonging and control – a 'show' not tell' approach to the culture we want to perpetuate at DCH.

Each sets its individual priorities for the next three years, with some common themes which sit across all three, including:

- Sustainability
    - Financial - The financial envelope in which we are operating must be considered when developing plans and solutions for the future, ensuring that our ambition is consistent with the available budget.
    - Social - As an organisation our commitment to fulfilling our role as an anchor institution has been set out within our Social Value Pledge. The People Plan aligns in supporting DCH in being a model employer, contributing to the local economy through employment opportunities and principles of good work. The Clinical and Digital plans ensuring staff have positive and fulfilling experiences, championing equality, diversity and inclusion and considering our impact on the environment.
    - Environmental - factors are brought together within our Green Plan. Opportunities to provide more environmentally friendly care should be considered in all plans moving forwards.
- Population Health Management - Across our ICS and internally, we recognise the value of using real time data to embed a more proactive approach to healthcare. Demand and capacity planning will support our understanding of patient pathways and subsequent workforce models that improve quality and productivity. The wider determinants of health are significant, with only 20% of a person's health outcomes attributed to accessing good healthcare. We will look to our system

partners to engage with population health approaches. The Digital Strategy highlights the criticality of Business Intelligence and informed decision making, which will overlap with the way we look to deliver clinical care in future.

The Clinical Plan

The Clinical Plan is built on the most pressing considerations we have in regard to clinical care, which have been solidified through engagement with Clinical Teams. It aims to provide a clear understanding of the priorities to ensure that we are aligning our efforts into achieving the right goals for our staff, patients and population.

The plan includes a number of outcomes and measures which we hope to make progress in achieving over the next three years, with a key focus on interventions that will reduce the waiting lists for elective care. These include options for dedicated elective beds and off-site rapid access clinics. At the front door and through the Trust we will look for opportunities to increase flow, starting with plans to provide more care in the community, the use of digital interventions and optimising SDEC. The plan will also look to the recommendations of the Dorset Clinical Services Review to understand the requirements for DCH to be an effective Major Planned and Emergency Hospital, considering the services that need to be on-site and where care could be provided at alternative locations.

If the Clinical Plan is to be successful it must be supported by the right workforce and ability to provide the right digital solutions.

The People Plan

The People Plan continues the DCH journey of creating a fantastic, inclusive place to work for all our people. This is the basis for attracting and retaining the right people, with the right values, to deliver outstanding care.

The plan centres on building our understanding of demand and capacity and innovative workforce plans that we can recruit to and sustain financially. A clear understanding of new ways of working and new roles will fall out of the commitment to implement 5-year workforce plans for all services over the next two years.

To sustain clinical services, we need to be able to attract and retain workforce to deliver services over the long term. This means providing opportunities for fulfilling roles and professional growth and development. Workforce models must be achievable and sustainable. We need to be realistic about workforce supply and utilise workforce planning principles to understand how we can deliver care differently with Workforce Business Partners working as part of divisional Senior Leadership Teams to translate this plan to local action.

The Digital Plan

The Digital Plan sets out the ambition to create a landscape by design that supports optimal care, patient experience and staff usability. It highlights the need to ensure that the landscape is maintained to the highest sustainable standard, applying best practice to our processes with robust cyber resilience and embedding clinical safety as standard.

Digital skills and awareness will be promoted to support staff in their roles, and our patients as we improve and expand our digital patient services. Innovative and new solutions throughout the Trust will be supported by digital via regular engagement with divisions and departments. Appropriate funding opportunities will be leveraged to support this ambition with end-to-end change management prioritisation processes

established.

The investment into Business Intelligence will be strengthened and a network of digital skills champions to support staff and patients will be embedded.

Next Steps

More detailed planning will take place to ensure adequate resource is available to support the delivery of these plans, with relevant key performance indicators identified and monitored. The high-level risks to delivering the ambitions set out within the three enabling plans include operational pressures and the strain this will put on resource and ability to deliver change. The ongoing Covid-19 pandemic and possible implications on the NHS through the lifespan of these plans and not securing the funds or resources to support delivery.

Dorset County Hospital
Clinical Plan
2022-2025

Contents

1. Strategic Context

At Dorset County Hospital we aspire to deliver outstanding care for people in ways which matter to them. In developing a Clinical Plan to underpin the People, Place and Partnership aims of the Trust Strategy, we hope that this will bring us one step closer to achieving our mission, through providing a clear set of priorities and actions for the delivery of clinical care over the next three years.

The Clinical Plan has been developed with our clinical teams to understand the key challenges that they face and gain an idea of the possible solutions. The pages that follow lay out our intention for tackling these challenges so that we can continue to deliver safe, sustainable, and high-quality services for our population. Many of these challenges are not unique to DCH, however some of the solutions may be. Like many Trusts, we are operating within an incredibly tight financial envelope which must be considered throughout this plan to ensure that it is ambitious, yet achievable. Now more than ever innovative and creative thinking will be required to use our resources differently to combat issues such as workforce, the elective backlog, flow through our hospital and space limitations.

The intent is for the Clinical Plan to be a living document; it will be reviewed annually to evaluate progress and ensure that clinical teams continue to engage, inputting their plans and ideas. Ideally, teams will meet at least twice a year to discuss strategy for their service, which will then feed into the process. Additionally, this allows us to be more prepared for potential funding options should they arise.

What the Clinical Plan will provide:

- For our staff – an understanding of the key priorities from which more detailed plans and solutions can be developed to meet the needs of the population. In turn this will help to translate the aims of the Trust Strategy into tangible actions so that our clinical teams can understand their contribution to achieving our strategic objectives
- For our system partners – understanding what is important to DCH and thus also supporting staff from other organisations to work more closely with us. It will also provide information on our vision for more integrated care and how this aligns to the ambitions of Our Dorset ICS
- For our patients and population – We hope it will help to outline our plans to provide the best possible care, to convey our desire to listen and work more closely with patients and the population to improve our services and ensure that we deliver the right care, in the right place at the right time.

Developing the Clinical Plan

To develop a meaningful Clinical Plan, the first step was to listen to those colleagues who work directly with our patients and population, who understand the current ways of working and are therefore well placed to provide ideas for the future. A series of ten externally facilitated away days were organised, seeking the experience and expertise from each clinical team to understand what was important to them when providing safe and clinically effective patient care. These thoughts were then shared and discussed more broadly across clinical teams and non-clinical Support Services in recognition of the fact that we need to work better together. The priorities and aims that were captured throughout the engagement period have formed the basis of this document, the

People Plan and the Digital Plan and as such, the three should be read in conjunction with one another. They are intrinsically linked to one another and the delivery of the Trust ambition and will be used to drive the future development of DCH services.

Covid 19 Recovery

As stated within our Trust Strategy, our staff are our best asset. At a time of great uncertainty for the NHS we are thankful to every member of staff for going above and beyond to support one another whilst demonstrating such hard work, dedication and commitment to providing outstanding care.

Throughout the pandemic the Trust and wider NHS has learned to work differently and adapt quickly to an unpredictable and unprecedented set of changing clinical events. Whilst dealing with the continued challenges of the pandemic, we have seen a significant backlog in appointments for elective care, meaning longer waits for patients.

Nationally we know that this is likely to have a disproportionate effect on the vulnerable and those in socially deprived areas. Our percentage of elderly and very elderly residents is higher than the national average and there are 11 areas in Dorset within the top 20%[1] most deprived nationally for multiple deprivation.

The NHS Delivery Plan for Tackling the COVID-19 Backlog of Elective Care sets out the key ambitions for recovery of elective waiting lists and focuses on four areas of delivery:

- **Increasing health service capacity**, through the expansion and separation of elective and diagnostic service capacity. The physical separation of elective from urgent and emergency services ensures the resilience of elective delivery, as well as providing service efficiency. This will include a strengthened relationship with independent sector providers to accelerate recovery.
- **Prioritising diagnosis and treatment**, including a return towards delivery of the six-week diagnostic standard and reducing the maximum length of time that patients wait for elective care and treatment.
- **Transforming the way we provide elective care;** for example, by reforming the way we deliver outpatient appointments, making it more flexible for patients and driven by a focus on clinical risk and need, and increasing activity through dedicated and protected surgical and diagnostic hubs.
- **Providing better information and support to patients**, combining better data and information to help inform patient decisions, and in time, making greater use of the NHS App to optimise appointments, bookings and the sharing of information. We will ensure patients have choice at the point of referral, and additionally for long-wait patients through a national hub model.

Our response to adhering to the national guidance has been woven throughout the Clinical Plan.

[1] Dorset Council https://mapping.dorsetcouncil.gov.uk/statistics-and-insights/topics/Topic/Deprivation

2. Background

Our Hospital

Dorset County Hospital Foundation Trust (DCHFT) is located in the County Town of Dorchester in the southwest of England. We provide a range of clinical services for approximately 260,000 people who reside towards the west of Dorset, in both rural and urban communities.

We employ around 3,500 members of staff from over 80 different countries, working within DCH but also across GP surgeries, schools, residential homes, people's own homes and in the five community hospitals in Weymouth, Portland, Bridport, Blandford Forum and Sherbourne.

We have approximately 380 beds, including 32 for maternity, 14 for paediatrics and 8 critical care beds. There are seven main operating theatres and two day-surgery theatres.

Our Emergency Department has been under increasing pressure, treating twice as many people as it was designed for each year. In July 2020 the Trust was earmarked £77.3m of funding from the Governments New Hospitals Programme to expand services on the DCH site, including extending the ED and Intensive Care Unit, plus creating an Integrated Care Hub.

The Dorset Clinical Services Review (CSR) confirmed DCHFT as the Major Emergency and Planned Hospital for the west of Dorset, meaning we provide both elective and accident and emergency services, including a trauma unit. This ensures that DCH continues to fulfil the CSR recommendation and will be a factor in future decision making, for example when considering where services should be located.

To offer an understanding of activity, in 2021 the Trust provided approximately:

- 47,822 A&E attendances
- 21,350 non-elective (emergency) admissions
- 260,638 outpatient appointments
- 23,147 elective day case procedures
- 2,372 elective admissions
- 1564 maternity deliveries

Celebrating Success

The Trust achieved a CQC rating of Good in 2018 with both Diagnostic Imaging and Emergency Services found to have examples of outstanding practice. We are very proud of our rating and further examples of excellent care include:

2021

- Our Maternity Service being recognised as one of the best in the country in the latest national survey
- The Trust was shortlisted for a National Health Finance Award for delivering value within digital technology
- The Trust was ranked as one of the top 10 in the country for emergency care
- Staff were awarded for outstanding contributions to Covid19 research

2020

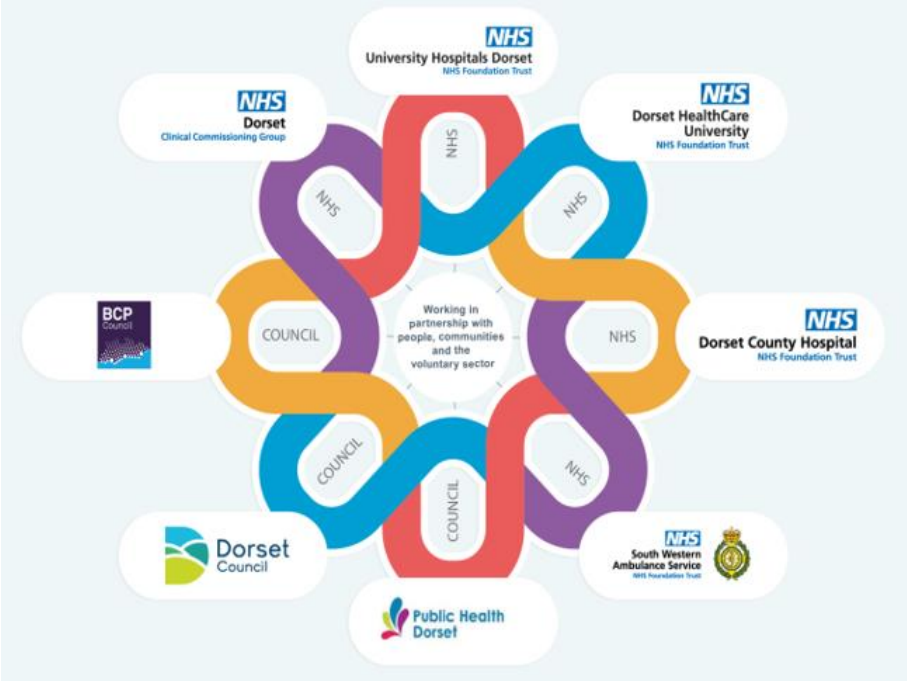
- DCH ambulance hand-over times were the quickest in the Southwest Region thanks to a new innovative approach
- Hip fracture mortality rate scored amongst the lowest in the country

Our Dorset

We form one part of the broader collective effort to ensure the best possible care for our population. Within the county, our key health and care providers have come together to form an Integrated Care System (ICS) called 'Our Dorset'. Our Dorset ICS aims to remove the traditional barriers

between organisations to instead work together to ensure that people and communities get the support and care that they need. As one of the first wave ICS areas in the country, a strong foundation for partnership working has already been built.

The ICS consists of a number of organisations, including the NHS, councils, public services, voluntary and community partners, as demonstrated below.

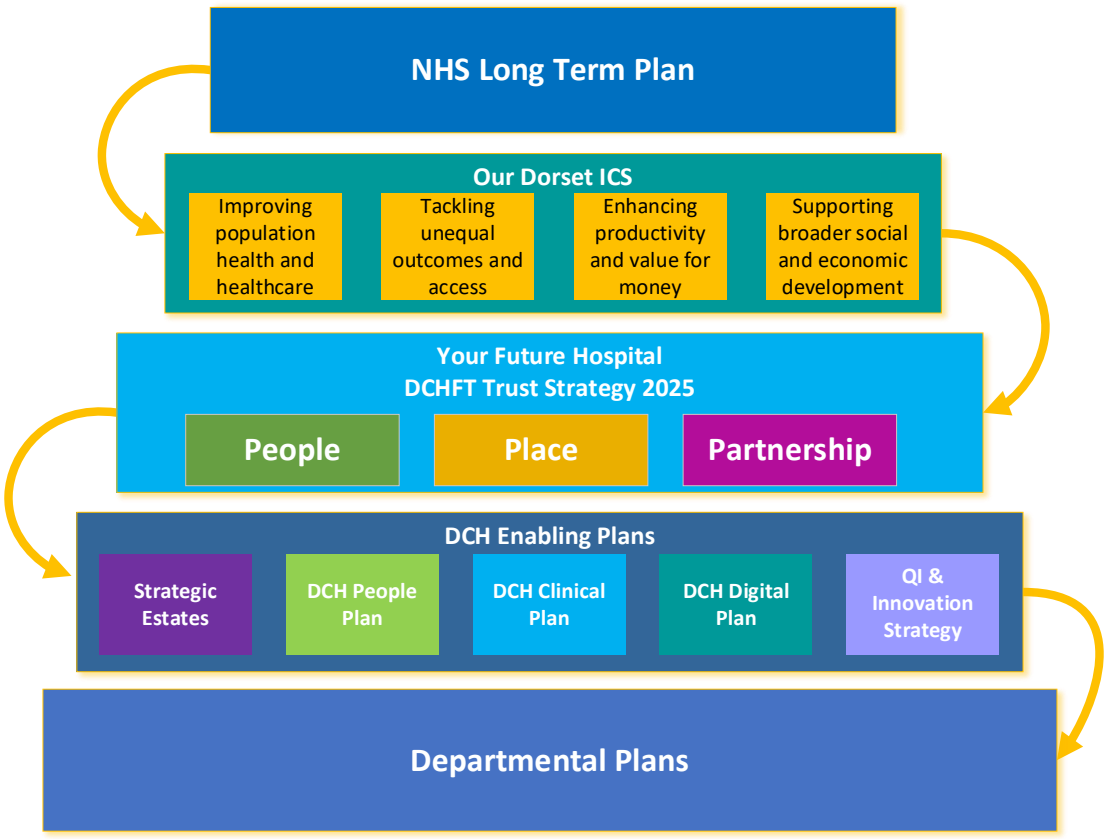


This Clinical Plan has been developed with the ICS in mind and demonstrates our commitment to supporting its ongoing development right through from the Trust Strategy to caring for our patients.

Following the direction set within the publication of the NHS Long Term Plan, systems were invited to determine what this means locally, and in Dorset the ICS presented four key aims:

- 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

The above aims have been highlighted within the Trust Strategy as key areas of focus. This focus is maintained within the enabling plans which underpin the Trust Strategy, such as this Clinical Plan, carrying through a ‘golden thread’ to individual departmental plans, as below.


NHS Long Term Plan
Our Dorset ICS
Improving population health and healthcare
Tackling unequal outcomes and access
Enhancing productivity and value for money
Supporting broader social and economic development
Your Future Hospital
DCHFT Trust Strategy 2025
People
Place
Partnership
DCH Enabling Plans
Strategic Estates
DCH People Plan
DCH Clinical Plan
DCH Digital Plan
QI & Innovation Strategy
Departmental Plans

3. Our Clinical Services

DCH operates through two Divisions, each with four Care Groups providing a range of clinical services, supported by a number of corporate functions.

The Divisions are at the heart of the Clinical Plan as those who provide frontline care to our patients and regularly interact with our population.

Urgent and Integrated Care Division			
Vascular and Metabolic Care	**Integrated and Holistic Care**	**Unscheduled Care**	**Clinical Support Services and Research**
Cardiology Endocrinology Coronary Care Unit Renal Vascular	2A Acute Oncology Haematology Neurology Palliative Care & End of Life Respiratory 2B Adult OT and Physiotherapy Dietetics Older People Parkinson's Disease Pulmonary Rehab Stroke Orthotics Speech and Language Therapies Acute Hospital at Home Discharge Team	Acute Medicine Ambulatory Care Clinical Site Management ED Medical Day Unit Urgent Care - GP	Bereavement Blood Sciences Clinical Engineering Histopathology Medical Physics Microbiology & Infection Control Mortuary Pathology Pharmacy Phlebotomy Research and Innovation

Family Services and Surgical Division			
Surgery and Gastroenterology	**Head & Neck and Specialist Medicine**	**Theatres, Radiology and Outpatients**	**Family Services**
Trauma & Orthopaedics Urology Junior Doctors Endoscopy General Surgery Colorectal Gastroenterology Breast Lymphoedema	Audiology Dermatology ENT Maxillofacial Ophthalmology Orthodontics Rheumatology	Anaesthetics Critical Care Decontamination Operating Department Outpatients Outreach and Hospital at Night Pain Services Pre-Assessment SAL Radiology	Children's Therapy Gynaecology Maternity Special Care Baby Unit Obstetrics Paediatrics

The Divisions provide structure for the organisation, yet consultation highlighted the importance of focussing on patient pathways, rather than the disease to be treated. This strategy will look to support teams to wrap care around individuals, ensuring those with multiple conditions are supported to navigate the healthcare system. The timing, location and manner of interactions between patients and healthcare providers are often dictated by the priorities of the provider, including convenience, location and economies of scale, rather than patient wishes. Control of the pathway resides almost exclusively with the providers, not those being provided for.

Patients may prefer to have elements of their care provided at a time or location that suits them. They may want to have more control in how decisions are made and communicated and they may wish to take advantage of technology to facilitate some of their healthcare needs, including use of internet consultations rather than rely exclusively on face-to-face interactions. Innovations to support such interactions are already spreading rapidly within some areas of medicine.

The notion of silos within healthcare is reinforced by care providers' tendency to think and act in relation to their immediate physical and organisational surroundings, particularly when considering elective/scheduled care pathways. Health financing mechanisms may reinforce this 'silo behaviour'. The Clinical Plan will look to support teams to think about the patient in a more holistic, patient centred way.

4. Strategic Principles

The common themes across the Trust Strategy, Clinical, People and Digital Plans have been outlined as key principles which should be considered and applied within the delivery of clinical care and more broadly across the organisation. These principles have been included below to offer more detail about what this means for the Clinical Plan.

Patient Safety

"Patient Safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience"

-The NHS Patient Safety Strategy

The Patient Safety Strategy has set out nine priorities and our response to these are regularly reviewed at the Patient Safety Strategy Steering Group and reported through the Quality Committee. We are working with our system colleagues to embed the priorities in a consistent way that is right for our staff and patients and will impact the way we learn from and deliver care to our patients. Recent updates include:

- Embedding a Just Culture, working with Our Dorset Workforce to agree a set of principles to underpin policy and develop a set of metrics to monitor and evaluate just culture
- Using a system approach to support the transition to the Learn from Patient Safety Events (LFPSE) system. This will see us change the way we investigate incidents moving forwards so ensure a more systematic analysis with more meaningful learning
- Preparing for the new Patient Safety Incident Response Framework
- Developing a Dorset Framework for the Strategic involvement of Patients and Service Users to ensure equity to support patient representative roles in respective organisations
- Delivering patient safety education and training

Population Health Management

Population Health Management is an important consideration in looking to the future of clinical care. It spans the entire Trust, ICS and includes the wider determinants of health such as social and environmental factors. These wider determinants of health have a significant impact as only 20% of a person's health outcomes are attributed to the ability to access good quality health care. No one organisation can tackle population health alone, however we know that we must do our bit to contribute and make plans which will further embed the approach into clinical delivery to help us understand demand and plan better for the future.

Already within DCH the Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Cardiovascular Medicine teams are using the real time data provided through the Dorset Intelligence Insights Service (DIIS) to review and alter care based on public health trends in our local area. Throughout the lifespan of this Clinical Plan and as the Population Health Management approach evolves, we will look both internally and towards our system colleagues to further utilise the approach and help support patients to take more responsibility for their own health and wellbeing.

<u>Health Inequalities</u>

Health inequalities are a part of the broader Population Health Management ethos. They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. Factors associated with poorer health outcomes are complex and, like population health management, acute care is just one part of the approach to resolving health inequalities. Working with our system partners, we are exploring how to do things differently to understand and reduce health inequalities.

COVID-19 is widely recognised as having exacerbated existing health inequalities, with both the direct and indirect impact of the pandemic disproportionately affecting many already disadvantaged populations. For example, in January 2021 the mortality rate for deaths due to COVID-19 in the most deprived areas was 1.8 times that in the least deprived areas.

Patient Engagement and Consultation

Listening to our patients to understand how we can improve services to meet their needs is important, this is something we do already and encourage teams to continue. Through engagement, clinical teams told us that patients with complex and long-term conditions often know their condition better than the clinician. By involving people in decisions about their health and care we can improve health and wellbeing, improve quality of care and ensure people make informed use of healthcare resources.

Sustainability

From an organisational perspective, we are aware that financial, social and environmental sustainability are all important to ensuring that DCH is a hospital fit for the future. There is more that can be done to embed this thinking into clinical care – we want to look for opportunities to use money more efficiently and make services more financially sustainable by providing staff with the tools to turn their own innovative ideas into changes that make a difference. We will continue to engage with the Getting it Right First Time (GIRFT) initiative to use data to achieve more cost effective and safe services and will consider more where environmental factors, in line with the Green Plan, can be considered in delivering clinical care. The Trust has outlined its commitment to Social Value and through delivery of this Clinical Plan we will work to deliver on our responsibilities to be a model employer in doing more to advocate for equality, diversity and inclusion.

5. The Vision

'Outstanding care for people in ways that matter to them'

The Clinical Plan has been designed to offer an element of flexibility to accommodate changes over the next three years to ensure that priorities remain in line with what is best for the organisation. It provides an understanding of the strategic clinical direction to support staff to see where they can help to achieve the Trusts Strategic Objectives, with the opportunity for detailed planning to take place with further engagement.

- Work together with those who use, commission and provide services to improve outcomes for our patients. Focus more on finding ways to help people be as healthy as they can be, take responsibility for their own wellbeing and prevent as much illness as possible.
- Where illness cannot be prevented, strive to ensure that patients are diagnosed as rapidly as possible and cared for in the community and closer to home where appropriate, Provide diagnostic hubs, increase the use of hospital at home and our community hospitals and implement digital technologies to help reduce the need to attend hospital appointments.
- When hospital care is required, make better use of services including SDEC to reduce waiting times to see a clinician, obtain a diagnosis and prevent or reduce inpatient stay.
- Where inpatient stay is required, work with the community and our social care partners at the outset to develop a plan to support the patient to return to their home at the right time.

All these will be reinforced by the right workforce, digital technologies and solutions. All the time ensuring that we are listening to our patients, caring for the young, frail and vulnerable and providing safe, high quality care in a way that ensures the sustainability of the service.

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Outpatient Assessment Centre @ Dorset Health Village

An opportunity arose within a prime central location to develop a high flow operational model to reduce waiting times within Orthopaedic Outpatients.

The project was developed in close partnership with Dorset CCG and went from concept to delivery in 5 weeks - a showcase of what can be achieved in a short space of time.

Patients are able to attend orthopaedic, musculoskeletal and physiotherapy appointments at the centre, and are able to access a wealth of health and wellbeing advice whilst they are there.

1245 patients have been seen on site since opening its doors (to 31st January 2022), and there has been a reduction in the non-admitted waiting list in this time by 34.76%* and a 63.64%* decrease in those patients waiting 78-104 weeks.

The project will be used to inform the development of community diagnostic centres and is part of wider work using innovation to help see, assess and triage patients more quickly. It will also help use time more effectively so they can see more patients. Clinicians have been involved with every step of the design process.

'*I loved today!' I'm loving the challenge of something new, the excitement of being involved in a project that really has the potential to make a difference to patients and just working with a big team again."*
***Rachel Marsden** -Extended Scope Orthopaedic Practitioner –Dorset MSK*

**figures taken from RAIDR National Elective Waiting List Dashboard 09/02/22*

6. How we will achieve this

The following sections highlight the specific areas where the Clinical Plan will contribute to achieving the Strategic Objectives of the organisation, also considering overlaps with the People and Digital Plans. Each objective has been broken down into a number of goals that will be achieved over the next three years.

People

We will look after and invest in staff, developing our workforce, creating collaborative and Multidisciplinary Teams to support outstanding care and equity of outcomes

To sustain clinical services, we need to be able to attract and retain the right workforce to deliver services over the long term. The People Plan highlights the link between high levels of staff satisfaction, an inclusive culture, and improving patient experiences, outcomes and reducing health inequalities. It indicates that workforce supply challenges are likely to continue for several years and therefore we need to consider new and innovative ways to solve workforce issues. The interdependencies between the People Plan and Clinical Plan are significant – **the key deliverables for this section can be found in the People Plan**, with examples of how the two plans will come together provided below:

- We will work with workforce Business Partners to explore new and innovative ways to solve workforce issues, including
    - understanding of demand and capacity and innovative workforce plans that we can recruit to and sustain financially. A clear understanding of new ways of working and new roles e.g. Anaesthetic associates, Physicians Associates and Advanced Nurse Practioners will emerge from the commitment to implement 5-year workforce plans for all services over the next two years.
    - Clear career progression and opportunities to 'grow our own' and enhance our ability to attract staff e.g. offering support with Certificate of Eligibility for Specialist Registration (CESR) Academy
- We will work with the People Plan to support the wellbeing of our staff, ensuring that the wellbeing offers are embedded within Clinical Teams, to ensure that training and opportunities are supported and to make sure wellbeing is factored into any changes to the delivery of care
- We will work with the People Plan to build on expanding clinical leadership and continuing to develop an inclusive culture
- We will support Workforce colleagues in seeking opportunities to solve key workforce issues in partnership across the ICS

We will improve safety and quality of care by creating a culture of openness, innovation, and learning

The People pillar also captures the Quality Improvement and Innovation Strategy, again whilst the deliverables are captured within the People Plan, the interdependencies with innovation and the Clinical Plan have been included below:

- We will encourage staff within clinical teams to voice opportunities for innovation within their departments and support them to undertake training to deliver change
- We will use the Trust Strategy and Clinical Plan to prioritise change, to support teams to understand the strategic focus of the organisation whilst encouraging better two-way discussion between Senior Leaders and Clinical Teams

Place

We will delivery safe, effective, and high-quality personalised care for every patient, focussing on what matters to every individual

Delivering safe, effective, and high-quality personalised care sits at the heart of the Clinical Plan. The backlog for elective treatment must be addressed as a key priority for the Trust, including options for dedicated elective beds. At the front door, patient flow through the hospital must be improved through optimising the use of SDEC and the Paediatric Assessment Unit. We will look for opportunities for more care to be provided in the community and embrace digital technologies such as Patient Initiated Follow Up (PIFU) to help reduce routine and unnecessary follow up appointments. Within these changes, staff wellbeing and support will be at the forefront of our thinking as supported by the People Plan.

- We will recover waiting lists for elective care to pre-pandemic levels
  - Explore options for dedicated elective care beds, space, and necessary staffing
  - Develop further One stop clinics, Rapid Access Clinics and MDTs

- We will reduce unnecessary admissions and keep patients in their homes for treatment wherever possible, through
  - Optimising the use of SDEC, ambulatory and outpatient models
  - Collaborating with the Southwest Ambulance Service (SWAST) to create a process for direct paramedic referrals into SDEC as per the national directive
  - A Paediatrics Assessment Unit to be brought back into ED

- We will use digital technology in line with the Digital Plan to transform DCH Outpatient services to provide more care at home and increase productivity
  - Continued use of digital options, where appropriate for the patient, including PIFU, Attend Anywhere and Consultant Connect
  - Greater use of the electronic prescribing system

- We will develop a Diabetic Transition Service to support patients who are moving from child to adult services
  - Resourcing a project to pilot the transition service for Trust wide adoption

- We will provide consistent high-quality emergency and elective care to ensure that every patient is admitted under the care of the most clinically appropriate speciality to support flow, reduce length of stay and improve the patient experience.
    - Review and revise the medical inpatient model
    - Include a frailty service in ED as per the national directive
    - Set up remote access for Speciality Consultants to liaise with ED and other services to offer advice for patients within the hospital

- We will deliver more care closer to, or within, patients' homes. In doing so we will reduce travel times and help contribute to the Green Plan
    - Develop a haematology treatment service on the DCH Trust site
    - Develop a new haemodialysis capacity for the Weymouth and Portland area and increase provision of home-based dialysis therapies

- We will ensure that all measures have been taken to continue to provide a safe Maternity Service
    - Implement the Ockenden Maternity Report
    - Implement the NHS England 'Better Births' Ambition, a fundamental aim of the NHS National Maternity Transformation Programme
    - Review the Early Pregnancy Advisory service. EPAC

- We will maintain and improve patient safety, building on the foundations of a safer culture and safer systems.
    - Work with Governance teams and others to build the infrastructure and work force to move to PSIRF as the new system for investigating safety incidents

- Involve patients more not only in their care but in the organisation and functioning of the services that they use
    - Increase forums and find new ways of listening to our patients

We will build sustainable infrastructure to meet the changing needs of the population

Delivery of the Clinical Plan will link closely to the Your Future Hospital Strategic Estates Programme, which is working to expand services on the DCH site, including extending our Emergency Department and Intensive Care Unit, plus creating an Integrated Care Hub.

Space was a key theme throughout engagement and a number of actions will take place with clinicians to help ensure that we are making the best use of the available space, both within DCH and in the community. Options will be considered against achieving the Trusts Strategic Objectives and our commitment to becoming the Major Planned and Emergency Hospital as identified within the Dorset Clinical Services Review. As part of this work, we will address those services which were displaced as a result of the response to Covid-19.

- We will complete a review of the internal and external spaces available for clinical care to provide options for how the estate can best meet the needs of the Trust, our patients and population.
    - Formation of a Group, including Clinicians, to consider viable options for the estate which would make a difference to staff and patient outcomes.
- We will expand day surgery and maximise theatre capacity to optimise efficiency
    - Develop a plan for Day Surgery to work towards three sessions per day, considering staffing models in conjunction with the People Plan
- We will develop our radiology services to support the wider clinical processes and our surrounding communities
    - Consider options for diagnostics in the community
    - Work with the People Plan to understand requirements for staffing e.g., for the increase in image-based procedures, the new ED and ICU
    - In line with the Digital Plan, explore options for increased digital solutions, such as Artificial Intelligence
- We will work with Digital Colleagues to provide the infrastructure for remote access for speciality consultants, making the best use of IT to enable advice to be transferred within DCH to provide the best care for patients

We will utilise digital technology to better integrate with our partners and meet the needs of the population

The Covid-19 pandemic accelerated the use of digital options when delivering care. The option to deliver care virtually remains an ambition nationally and locally and this will be completed in conjunction with the Digital Plan. The **key deliverables for this section will be found within the Digital Plan**, with key interdependencies highlighted below.

- We will use digital technologies to support new ways of working
    - Embrace more virtual options
    - Consider more options to bring ‘one stop shop’ approaches
    - Promote patient self-care through the use of digital modalities
- We will embrace innovation
    - When available and appropriate we will consider options for innovative decision making , for example ,using Artificial Intelligence
- We will embed digital options within pharmacy
    - Rolling out electronic prescribing in outpatients across DCH to facilitate virtual clinics
    - EPS to allow secondary care doctors to send prescriptions straight to community pharmacies.

Partnership

We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of our population

The idea of working better together through the ICS is not a new one, but work is still ongoing to establish how all the system partners will work together as we move towards the next steps in the ICS Development Plan. This will involve the evolution of Place Based Partnerships, Provider Collaboratives with the right clinical and professional leadership to oversee the process. The aim for the Clinical Plan is to be supportive of further system discussions as new governance arrangements are established, bringing the right partners together to solve key system issues.

We will ensure best value for the population in all that we do, and will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways

- We will explore all resources that can support the organisation to achieve its missions, including the Voluntary, Community and Social Enterprise (VCSE) sector to help solve key issues such as patient flow
    - Clinical Teams to explore opportunities to relieve operational pressure within the Trust
- We will use data from GIRFT and Model Hospital to understand DCH's position against national comparators regarding value for money and cost-effective services
    - To continue to implement GIRFT adoption within the trust and monitor outcomes within Model Hospital
- We will support the Trust priority of progressively reducing the underlying financial deficit
    - Consideration of finances in plans moving forwards
    - Supporting Clinical Teams to work more closely with CIP/Finance/QI Teams to gain a better understanding of finances within their service and sharing ideas more broadly across the organisation

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

- We will work to explore opportunities to develop Centres of Excellence as part of our Research development to bring the right people together to develop innovative ideas for specialist care
    - Utilising input from departmental strategies to identify DCH Centres of Excellence and supporting the development of Business Cases
- We will look for opportunities for better system working to find ways to increase capacity and resilience for our services
    - Link with the People Plan to explore areas where system working would improve capacity and resilience
    - Develop plans to appoint a pan Dorset Clinical Lead for the High-Volume Low Complexity Services as identified by GIRFT
    - Look at development of Pan Dorset waiting lists
- We will Work more closely with the local authority to support delayed transfers of care
    - Working with outputs from regular ICS Board Meetings which will enable communications with Local Authority Partners and a greater understanding of the challenges

- We will enable clinical teams to work more easily with system partners across provider collaboratives and networks
    - Develop a sustainable Hyper Acute Stroke Unit and associated services – with CCG and ICS
    - Work closely with the Dorset Cancer Partnership and Wessex Cancer Alliance to improve performance against cancer wait times and local access for patients to receive relevant treatments and participate in clinical trials in DCH

7. Outputs and Measures

Please see Part B.

Trust Priority	Goal	Input	Measures	22/23	23/24	24/25
We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual	To provide consistent high-quality emergency and elective care to ensure that every patient is admitted under the care of the most clinically appropriate specialty to support flow, reduce length of stay and ensure greater patient satisfaction.	Review and revise the medical inpatient model	Reduction in Length of Stay to align with recommendations by GIRFT. The reduction will be dependant on speciality and procedure. Elective Length of stay reduced from 3.08 to 2.9 Non elective for 6.05 to 6 Reduce 12 hour wait in ED to less than 2% Fewer long stay patients aged over 85. (25,000 reduction Nationally)	X		
			Reduce SHMI to less than 1.05%		X	X
			There will be a reduction in incidents causing harm	X		
		In conjunction with the DCH People Plan, review staffing for each department to consider alternative models e.g., role of Advanced Nurse Practitioners, specialist nurses, Physicians associates etc.	The measures will reflect staffing requirements within the department	X		

		Create a frailty service in ED as per the NHS long term plan	Provide an acute frailty service for at least 70 hours a week Achieve clinical frailty assessment within 30 minutes of arrival		X X	
		Set up remote access for Speciality Consultants to liaise with ED and other services for advice for patients within hospital	Reduction of time spent in ED and inpatient wards		X	
	To reduce unnecessary admissions and to keep patients in their homes for treatment, where possible	Explore options to optimise the use of SDEC, ambulatory and outpatient models Collaborate with SWASFT to create a process for direct paramedic referrals into SDEC . Hyperlink to 'Standard guidance: Ambulance clinician (on scene) referral to same day emergency care Increasing direct referral from ambulance clinicians to same day emergency care Version 1, 15 October 2021'	Increase percentage of Hospital at Home patients from approx. 4 % to 8% Increase the proportion of acute admissions discharged on the day of attendance from 1/5 to 1/3. SDEC available for a minimum of 12 hours a day, seven days a week. Eliminate handover delays of over 60 minutes between ambulance service and hospital	X X X	 X X	

		Review the staffing model for the new ED Link to people plan	Paediatrics Assessment Unit to be brought back into new ED Staff satisfaction and retention .	X	X	X
	To provide a haemodialysis in the community, closer to people's homes	Develop a new haemodialysis capacity for the Weymouth & Portland area, and increase provision of home-based dialysis therapies	Increase in number of patients receiving haemodialysis in the Weymouth and Portland area Reduce carbon footprint for patient traveling to hospital for treatment Better patient satisfaction Improve patient Quality of life		X	
	Recover the elective waiting lists to pre-pandemic levels. **Priority**	Increase the use of One stop and Rapid Access Clinics. Increased use of MDTs Explore more services working 7 days a week with appropriate staffing Redesign clinical pathways	Reduction in elective care waiting lists No patient waiting more than 24 months by 2022, 18 months by 2023, more than 65 weeks by 2024, 12 months by 2025 Diabetic Paediatric Transition pathway for young people	X X	X	X
		Explore options for recovery, including dedicated elective care beds/ space and staff	Reduced waiting lists to meet national targets outlined above Improvement in patient experience seen through Friends and family feedback Increased Staff Satisfaction	X	X	X

	Ensure that all measures have been taken to continue to provide a safe Maternity Service **Priority**	Implement the 7 immediate and essential actions of the Ockenden maternity report and those of the follow-on report when published. HYPERLINK TO OCKENDEN REPORT	7 recommendations implemented Improved outcomes for mothers and babies Halve the rates of stillbirths and neonatal deaths in England Reduce stillbirth rate to 2.6 stillbirths per 1,000 births, neonatal mortality rate to 1.5 deaths per 1,000 live births by 2025	X		X
		Implement the NHS England 'Better Births' Ambition, a fundamental aim of the NHS National Maternity Transformation Programme focusing especially on the recommendations for continuity of care for pregnant women	All pregnant women will be supported through their antenatal, delivery and postnatal period by their own continuity of care team	X		
		Review Early Pregnancy Advisory service. EPAC	Provide 7 days a week access to this service for patients who use this service		X	

	To continue to transform DCH Outpatient services to provide more care at home and increase productivity	Continued use and expansion of digital options where appropriate for the patient and the organisation, including PIFU Attend Anywhere Consultant Connect Explore greater use of Electronic Prescribing system	Maintaining Remote outpatient appointments level of 20% Meet PIFU targets 1.5% of all outpatient attendance on a PIFU pathway 5% of outpatient attendances moved or discharged to PIFU pathways Improvement in 18 week RTT , due to reduction in number of appointment slots issued Increasing number of specialties using Consultant Connect Electronic prescribing in Outpatients across DCH to facilitate virtual clinics	X X X X X		
	Involve patients more not only in their care but in the organisation and functioning of the services that they use Maintain and improve patient safety, building on the foundations of a safer culture and safer systems.	Increase forums and ways of listening to our patients Work with Governance teams to build the infrastructure and work force to move to PSIRF as the new system for investigating safety incidents	Instigation of Youth Board Set up Patient safety incident report framework(PSIRF)replacing the current Serious Incident reporting model	X X		

Trust Priority	Goal	Input	Measures	22/23	23/24	24/25
We will build sustainable infrastructure to meet the changing needs of the population	To complete a review on the internal and external spaces available for clinical care to provide options for how the estate can best meet the needs of the Trust, our patients and population	Development of a forum including Clinicians to review available space against the requirement and options for offsite working	Organisation of Clinical Estate Review Group with appropriate representation form all areas Delivery of options for use of internal and external estate	X		
	To ensure that the services which remain on the DCH site are consistent with those required for DCH to fulfil its CSR ambition in becoming the Major Planned and Emergency Hospital. Patients will only be treated on the DCH site if they cannot be managed elsewhere, and measures will be put in place to ensure that staff are provided the same benefits whether working on or off site.	Review and identify the services which must remain on the DCH and review how best to use the space and relocate those that can be moved off site Review the staffing and other uses of the discharge lounge to maximize efficiency	Confirmed list of services to be delivered on the DCH site Confirmation of external locations for services to be delivered off site Identification of space for Clinical Services to deliver care in DCH Reduction in displaced services as a result of Covid-19	X	X	
		To develop diagnostic hubs within the community	95% of patients needing diagnostic tests will receive them within 6 weeks	X		
	Expanding Day Surgery and maximising theatre Capacity to optimise efficiency Priority	Develop a plan for Day Surgery to work towards a minimum of 4 days of 3 sessions, considering staffing models in conjunction with the People Plan.	Improve operating theatre utilisation and throughput Meet GIRFT/BADS – day surgery target recommendations Reduction in waiting lists	X		

		Develop workforce plan to align with People Plan	Planning and assurance of workforce required presented as part of Business Case	X	X	
	Develop our radiology services to support the wider clinical processes and our surrounding communities. We will be at the forefront of digital solutions such as Artificial Intelligence, and Image Sharing. We will expand our workforce in anticipation of radiology requirements in the new build A&E/ICU development	Explore options for increased digital solutions, such as AI, with digital leads in line with outputs of the Digital Plan Consider options for diagnostic hubs in the community including a CT Scanner in Weymouth Understand requirements for Radiology Staffing in new A&E/ICU Working with People Plan…	Reduced waiting times for diagnostics. 10 % improvement in productivity Increase diagnostic activity to a minimum of 120% of pre-pandemic levels Increased patient flow as evidenced by a reduction in ED waiting times Increased patient satisfaction as a result of better care closer to home Increase staff satisfaction as a result of adequate staffing numbers	X		X

Priority	Goal		Input	Measures	22/23	23/24	24/25
We will increase the capacity and resilience of our services by working with our provider collaboratives & networks, and developing Centres of Excellence. We will work together to reduce unwarranted clinical variation across Dorset	To work with the Research team to explore opportunities to develop Centres of Excellence to bring the right people together to develop innovative ideas for specialist care.		Utilising input from departmental strategies to identify DCH Centres of Excellence and supporting the development of Business Cases	Delivery of Research Strategy		X	
	Better system working to find ways to increase capacity and resilience for our services		Link with the People Plan to explore areas where system working would improve capacity and resilience	Improved staffing capacity to meet demand for services Improved flow/reduced waits Improved staff satisfaction Increase in solutions for workforce challenges	X	X	
			Looking for opportunities to solve issues through collaborating with the ICS Review and expand EPS Combined waiting lists across Dorset for patients	Single medication record for Wessex. Create within Dorset Care Record a Single Medication Record. EPS to allow secondary care doctors to send prescriptions straight to community pharmacies. Reduction in waiting times for outpatient appointments and surgery	X	X X	

			Appointing a pan Dorset Clinical Lead for an entire service (e.g. Urology, Cardiology – GIRFT HVLC services) possibly on a rotational basis *links to People Plan	Appoint pan-Dorset clinical leads	X		
	Enable clinical teams to work more easily with system partners across provider collaboratives and networks		Develop a sustainable Hyper Acute Stroke Unit and associated services – working with CCG and ICS	Improvements against ISDN Performance indicators 7-day consultant on-call in place	X	X	
			Work closely with the Dorset Cancer Partnership and Wessex Cancer Alliance to improve performance against cancer wait times and local access for patients to receive relevant treatments and clinical trials in DCH	Increased number of Haematology patients receiving specialised treatment in DCH Increased number of patients involved in clinical trials. Reduction in unwarranted clinical variation across Dorset for patients 75% of urgent referrals for suspected cancer diagnosed or cancer excluded in 28 days. Personalised stratified follow up pathways created for breast, prostate, colorectal and 1 other pathway by 2022/3 and 2 further pathways by 2023	 X	X	
	Working more closely with local authority to support DTOC		Regular ICS Board Meetings will enable communication with LA partners and a greater understanding of the problems and difficulties	Collaborative working to reduce the number of DTOCs		X	

Priority	Goal	Input	Measures	22/23	23/24	24/25
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	To use data from GIRFT visits and MODEL hospital to understand DCH position against national comparators in regard to value for money and cost-effective services	To continue to implement GIRFT adoption within the trust and monitor outcomes within Model Hospital	Number of GIRFT actions completed Reductions in costs as identified as outliers in Model Hospital	X		
	To progressively reduce the underlying Dorset financial deficit	Consideration of finances in plans moving forwards Supporting Clinical Teams to work more closely with CIP/Finance/QI Teams to gain a better understanding of finances within their service and show to share ideas more broadly across the organisation	Reduction of deficit by 30%	X		

	Looking at other resources that can support the organisation to achieve its missions, e.g., gaining support from Voluntary, Community and Social Enterprise (VCSE) sector to help with patient flow	Clinical Teams to explore voluntary service opportunities and how this can help to relieve operational pressure within the Trust	Greater numbers and projects involving voluntary staff	X		

The X inserted into the year columns represents the chronology of when the measures will be achieved or completed. For some areas this will take several years to achieve and so the X spans several years. As this will be a living document, the progress of these goals will be reviewed and amended over time.

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Teamwork
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NHS
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NHS Foundation Trust

People Plan 2022-2025

Outstanding care for people in ways which matter to them

Contents

'All the staff photographs used in this document were taken before the COVID-19 pandemic PPE requirements.

Introduction

At Dorset County Hospital (DCH) we aspire to providing outstanding care for people in ways which matter to them. The Trust Strategy was developed by seeking the views of the people who are central to delivery, our staff. The views of patients, service users and community groups were also integral to strategy development.

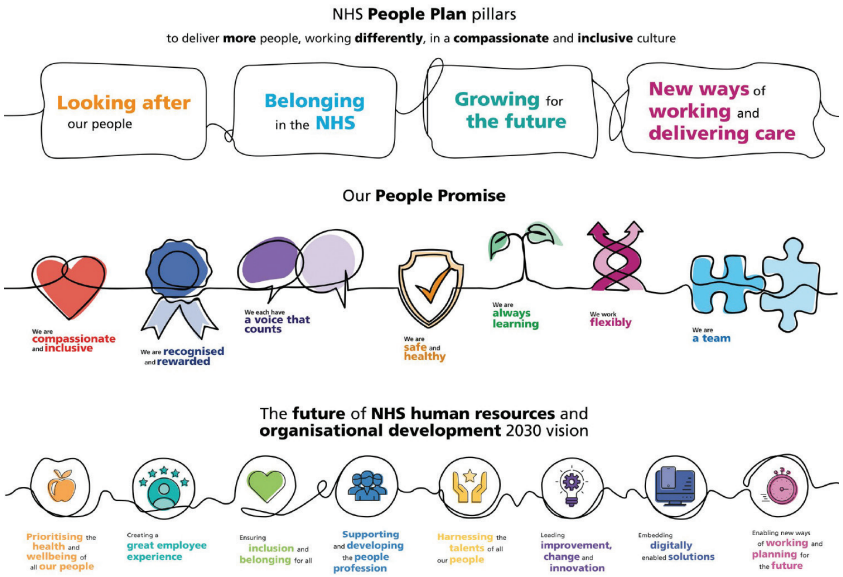
In April 2021 DCH Board approved the Trust Strategy and the focus on three strategic goals: People, Place and Partnership.

The intention of the People pillar is to truly value our staff. Our people are our most important asset, and we want everyone to feel valued, welcomed, respected, that they belong, and they matter. We recognise the link between high levels of staff satisfaction, an inclusive culture and improving patient experience, outcomes and reducing health inequalities.

The Trust vision is also about being at the heart of improving the wellbeing of our communities and staff are part of that local community. The People Plan aligns to our Social Value Pledge to be a model employer, contributing to the local economy through employment opportunities and principles of good work.

The People Plan also contributes to DCH's commitment to reducing impact on the environment and supporting better health and wellbeing of our local communities. This will be delivered through digital innovation in people process and practice and maximising opportunities to collaborate and work in partnership across Dorset Integrated Care System (ICS).

DCH's People Plan aligns to the NHS People Plan and embeds the elements of the NHS People Promise to support the NHS Long Term Plan. Delivery of the plan will seek to maximise opportunities highlighted by The Future of the NHS HR and OD report.



The strategic context

Attracting and retaining staff with the right skills to deliver high quality care is an NHS wide challenge. Dorset has additional challenges due to an older than average population and high levels of out-migration by talented young people. The rurality and cost of living in Dorset also impacts workforce supply and mobility.

The NHS long term plan sets out that by 2030 the NHS will be fundamentally different from the service we work in today. The world of work is changing at pace, with growing evidence of links between staff wellbeing, care quality and retention. This is evolving alongside digital technologies, automating tasks, remote working and new advances based on artificial intelligence. Existing ways of working, models of care and organisational boundaries are being transformed, and the NHS and DCH must adapt to the changing needs and expectations of our population and our workforce.

Workforce supply challenges are likely to continue for several years, and the NHS in Dorset and DCH is facing a significant underlying financial deficit. The DCH People Plan must address workforce supply challenges and improve retention and availability to reduce the high costs of temporary workforce spend.

The transformation in care models across Dorset ICS and set out in our own clinical plans provides opportunity for workforce transformation and the introduction of new roles and new ways of working. This is an opportunity to improve workforce supply, increase efficiency and improve patient outcomes and reduce health inequalities.

An inclusive culture, where everyone feels valued and respected with opportunities for career development is fundamental to retaining existing staff, improving availability for work, and attracting new recruits. We have successfully recruited doctors and nurses from overseas to address our workforce supply gaps and we must continue with this approach in the absence of domestic supply. It is projected that by 2025 nearly 25% of our staff could be from minority ethnic communities, a rise of 14%. To support ALL staff to thrive at DCH we need to continue to move forward on the journey of inclusive culture development started in 2020. In addition to supporting staff experience, this approach improves understanding of inclusion and equity that is at the heart of how we consider and address health inequalities.

Our experiences during COVID-19 tested almost every aspect of the NHS, our people, and our service delivery. We rapidly transformed how we work: many of our people adopted new ways of working, including digital; some were redeployed to areas of need; some were asked to work as part of new multi-disciplinary teams or brand-new service developments; and some were advised by the government to shield and stay safe at home. Hardly any role was unaffected as we met the challenge of a global pandemic and the safety and wellbeing of our staff remained critical throughout this period. Staff supported each other and went the extra mile for their colleagues; teams supported one another and became even more important to people's experiences of work.

COVID-19 has not gone away. New phases of the pandemic, pent up demand and a backlog of care now puts enormous pressure on our services and teams. Sustained pressure built up over two years means our people are tired and stress and anxiety and symptoms of burnout are increasing. We need to support the recovery of our staff at the same time as recovering our services and our underlying financial position. These goals are interconnected as creating inclusive environments where people feel valued means that psychological safety improves, and innovation can thrive. Quality improvement from innovation then engenders a sense of autonomy, belonging and control that is the foundation of wellbeing.

This People Plan provides a roadmap for people recovery that supports service recovery, reduces high-cost temporary spend and enables delivery of our Clinical Plan and Trust Strategy.

The vision

The high-level vision and principles for people at DCH was co-created by our workforce as part of the Trust Strategy development. Following this, clinicians and support services worked together to outline clinical plans to deliver the DCH vision and the people requirements that underpin this.

Divisions, care groups and departments will be expected to use this plan as a roadmap to develop their own local people plans to deliver clinical priorities.

High level principles for People are defined within DCH Trust Strategy as:

- **We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes**
- **We will create an environment where everyone feels they belong, they matter, and their voice is heard**
- **We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves**
- **We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect**

How we will achieve this

Each People Principle has been broken down into a short number of goals that will be achieved over a period of 1-3 years.

1 We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes

- DCH has a clear understanding of workforce requirements based on clinical strategy and demand and capacity planning. We will:
  - Continue to actively participate in system workforce planning
  - Embed workforce planning by building competence at line management level
  - Ensure effective use of the medical workforce through proactive job planning
- DCH is marketed and recognised as a highly attractive place to develop a long-term career for international recruits from all professions. We will:
  - Develop a CESR academy to support locally employed doctors (LEDs) who meet the criteria to join the specialist register
  - Create parity of experience for LEDs and training grades
  - Provide pastoral support and clear career pathways for all international recruits
- DCH is marketed and recognised locally as a highly attractive place to develop long term clinical and non-clinical careers, contributing to population wellbeing and adding social value across Dorset. We will:
  - Continue to work across the ICS to develop flexible employment models to attract people to and keep people in Dorset
  - Develop and share clear career pathways for all professions
  - Accelerate growth of apprenticeship pathways, with a focus on hard to recruit support services
  - Utilise DWP initiatives, traineeships, supported internships and other local workforce opportunities to feed into apprenticeship pathways
  - Gain accreditation as a real living wage employer adding social value by contributing to financial wellbeing
- DCH Workforce availability and efficiency will be maximised by providing a healthy working environment and accessible resources to support wellbeing. We will:
  - Work across the ICS to maximise efficiencies for wellbeing and Occupational Health services
  - Build the foundations of a healthy workplace through the development of skills, systems, and structures to support effective people management practices
  - Provide a stepped approach to a range of preventative and responsive wellbeing resources to ensure staff needs are met in the most timely and appropriate way

How we will achieve this

2 We will create an environment where everyone feels they belong, they matter, and their voice is heard

- DCH managers are competent and confident in management practice and inclusive leadership as a prerequisite for appointment (or within first six months in post). We will:
  - Actively drive efficient system solutions to consistent inclusive leadership development and management competence
  - Build a sustainable model to continue to spread current Inclusive Leadership development to all leaders across DCH
  - Define management competence at DCH to deliver quality, operational, finance and people effectiveness and develop multi channelled approaches to delivery via a Management Matters programme
- Talent Management processes and approaches are inclusive, and values based to increase diversity across the organisation. We will:
  - Spread existing Trust wide, values-based recruitment approaches to attract diverse candidates across entry level roles
  - Improve the approach to appraisal and use this as the vehicle for succession planning
  - Use the Management Matters programme to equip managers to have appraisal and talent discussions that value every individual
- The staff voice at DCH is strong and valued and there are clear links to action to improve staff experience. We will:
  - Further embed staff feedback channels, including the quarterly People Pulse and Freedom to Speak Up
  - Continue to grow management competence in listening and responding to concerns
  - Support and strengthen staff networks, using feedback to drive improvements in staff experience.

3 We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves

- Staff at DCH feel psychologically safe to raise concerns. We will:
  - Learn from excellence in developing managers to create an environment in which staff feel safe to speak out in all areas
  - Support staff to recognise and challenge behaviours that are not in line with Trust values
- Quality Improvement (QI) methodology is further embedded across the Trust supporting the foundations of staff wellbeing – autonomy, belonging and control and delivery of outstanding care. We will:
  - Continue to build Quality Improvement skills by working with the Transformation Team as part of the Management Matters programme
  - Scale and spread Learning from Excellence as a model to support QI
  - Continue to build on inclusive access to education and training and promote a culture of ownership and accountability for training to keep our staff and patients safe.

4 We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect

- DCH Trust values are at the forefront of everything that we do. We will:
  - Strengthen onboarding and probationary experiences to further enhance inclusion and belonging, equipping people with knowledge and skills for a long-term career with DCH
  - Offer a suite of developmental practices including mentoring, reciprocal mentoring, individual and team coaching to help people and teams be their best selves
  - Further embed and spread just learning approaches across people practice
- The knowledge and skills of our workforce are further enhanced by the Education, Training and Development opportunities that we provide. We will:
  - Work to build adequate time and resources for trainers to deliver high quality training
  - Continue to adapt to provide access to education and development in response to changing workforce requirements
  - Build principles of differential attainment into all education, learning and development practice
  - Enable opportunities for greater inter professional training and development to improve patient outcomes.

5 Transactional People Processes as a Strategy Enabler

- People systems, processes and practice are inclusive, just, efficient, and effective. We will:
  - Work collaboratively across the ICS to develop improvements in efficiency and effectiveness of transactional people processes and practices
  - Deliver systems and process changes to improve temporary staffing solutions and reduce use of high-cost nursing agency
  - Build on the Transforming People practices programme to secure inclusion and just culture at the heart of HR at DCH
  - Design and implement consolidated and simplified transactional people services, including policies, establishment controls and recruitment approval processes
  - Use digital technology to automate elements of the recruitment process, reducing time to hire and improving candidate experience
  - Continue to work across the ICS and internally with Estates to find solutions to accommodation challenges.

Outputs and measures

Each People Principle has been broken down into a short number of goals that will be achieved over a period of 1-3 years. Each goal has several defined inputs and outputs. Outputs are linked to KPIs. Many KPIs are measured monthly through the People Performance dashboard. Others are measured by quarterly pulse survey data and National Staff Survey data in addition to internal reporting. Progress on the People Plan will be monitored through the People and Culture Committee (PCC). Interim milestones will be developed and the PCC work plan will be refreshed to link to assurance on action to deliver the People Plan.

Priority	Goal	Inputs	Outputs and Measures	22/23	23/24	24/25
We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes	DCH has a clear understanding of workforce requirements based on clinical strategy and demand and capacity planning	Actively participate in system workforce planning Embed workforce planning by building competence at line management level Ensure effective use of the medical workforce through proactive job planning	Workforce Planning to be included in Management Matters Programme by December 2022			
			Five Year workforce plans to be implemented for all services and staff groups by March 2024			
			100% of medical job plans to be recorded on Healthrota and reviewed at least annually by March 2023			
	DCH will be recognised as a highly attractive place to develop a long-term career for international recruits from all professions	Develop a CESR academy to support locally employed doctors (LEDs) to join the specialist register Ensure parity of experience for LEDs and training grades Provide pastoral support and clear career pathways for all international recruits	Reduction in vacancy rate from 6.32% to below 5% by March 2024			
			Reduction in turnover from 8.7% to 7% by March 2024			
			Improvement in National Staff Survey question relating to recommending DCH as place to work from 66% to 72% by March 2025			
			Overall engagement score in National Staff Survey and Quarterly Pulse Survey will be 7.3 or above by March 2024			
			Improvements in qualitative data from international recruits via quarterly staff listening events from April 2022 onwards			
	DCH will be recognised locally as a highly attractive place to develop long term clinical and non-clinical careers, contributing to population health and wellbeing across Dorset	Develop and share clear career pathways for all professions Work across the ICS to develop flexible employment models to keep people in Dorset Grow apprenticeship pathways, with a focus on hard to recruit support services Utilise DWP initiatives, traineeships, supported internships and other local workforce opportunities to feed into apprenticeship pathways Gain accreditation as a real living wage employer contributing to individual and population financial wellbeing	Trust-wide apprenticeship approach incorporating DWP initiatives, traineeships, supported internships and other local workforce opportunities implemented by March 2023 and a 20% increase in apprenticeships by March 2025			
			Reduction of staff who leave DCH within 12 months of joining by 50% by March 2025			
			Improvement in National Staff Survey question relating to opportunities for flexible working from 56% to 60% by March 2025			
			Clear career pathways developed for all professions by March 2024, linking to the apprenticeship strategy where appropriate. Priority focus (22-23) to be given to AHP and HCA pathways to respond to immediate workforce shortages			
			By March 2025, in line with our Social Value pledge, 80% of recruits into permanent and training roles at DCH will be from within the Dorset area			
			Gain accreditation as a real living wage employer by March 2023			
	DCH Workforce availability and efficiency will be maximised by providing a healthy working environment and accessible resources to support wellbeing	Build the foundations of healthy workplace through the development of skills, systems, and structures to support effective people management practices Provide a stepped approach to a range of preventative and responsive wellbeing resources to ensure staff needs are met in the most timely and appropriate way Work across the ICS to maximise efficiencies for wellbeing and Occupational Health services	Management Matters Programme for new and aspiring managers to be in place by October 2022			
			Sickness absence reduces from 4.79% to 3.75% by March 2025			
			Improvement in National Staff Survey question relating to staff satisfaction in immediate managers taking a positive interest in their health and wellbeing from 72% to 77% by March 2025			

Priority	Goal	Inputs	Outputs and Measures	22/23	23/24	24/25
We will create an environment where everyone feels they belong, they matter, and their voice is heard	DCH managers are competent and confident in management practice and inclusive leadership as a prerequisite for appointment (or within 1st six months in post)	Actively drive efficient system solutions to consistent inclusive leadership development and management competence Build a sustainable model to continue to spread current Inclusive Leadership development to all leaders across DCH Define management competence at DCH and develop multi channelled approaches to delivery via a Management Matters programme	Assess the quality of recruitment and onboarding at 12-month mark and obtain 90% satisfaction rate by March 2023			
			Improvement in National Staff Survey question relating to opportunities for career development for all staff from 56% to 65% by March 2025			
			Improvement in National Staff Survey question relating to staff who have personally experienced discrimination at work from manager or other colleague from 7% to 5% by March 2025			
			Improvement in National Staff Survey question relating to the organisation acting fairly regarding career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age from 61% to 65% by March 2025			
			The response to the National Staff Survey question relating to recommending DCH as place to work from ethnically diverse and disabled staff to be the same if not better than the overall survey results by the end of March 2025			
	Talent Management processes and approaches are inclusive, and values based to increase diversity across the organisation	Implement Trust wide, values-based recruitment approaches to attract diverse candidates Improve the approach to appraisal and use this as the vehicle for succession planning Use the Management Matters programme to equip managers to have appraisal and talent discussions that value every individual	The diversity of our workforce to increase, in senior roles (8a+) by 100% by March 2025 (an increase from 4 to 8)			
			Appraisal rates to return to the Trust target of 90% whilst maintaining the current levels of satisfaction with the appraisal process (95%) by the end of March 2023			
			The response to the National Staff Survey question - my immediate manager values my work to increase from 75% to 80% by March 2025			

Priority	Goal	Inputs	Outputs and Measures	22/23	23/24	24/25
	The staff voice at DCH is strong and valued and there are clear links to action to improve staff experience	Further embed existing staff feedback channels, including the quarterly People Pulse and the Freedom to Speak Up process Support and strengthen the staff networks, capturing and utilising feedback on experience	95% of FTSUG concerns raised are resolved within three weeks by March 2023			
			Staff networks membership to increase each year			
We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves	All Staff at DCH feel psychologically safe to raise concerns	Help managers to create an environment in which staff feel safe to speak out Support staff to recognise and challenge behaviours that are not in line with Trust values	Principles of psychological safety, allyship and bystander to upstander embedded in induction, management and leadership development and FTSUG roadshows by December 2022			
	Quality Improvement methodology is embedded across the Trust supporting the foundations of staff wellbeing – autonomy, belonging and control	Include Quality Improvement skills in the Management Matters programme and provide ongoing support via the Organisational Development Team Scale and spread Learning from Excellence as a model to support QI	Improvement in National Staff Survey question relating to making improvements at work from 59% to 64% by March 2024			
			Learning from Excellence data to be included in People Dashboard from April 2022 onwards			
We continue to create collaborative and multi-disciplinary professional team working to maximise skills, knowledge, and respect	DCH Trust values are at the forefront of everything that we do	Develop the onboarding and probationary experiences to enhance inclusion and belonging Improve inclusive access to education and training and promote a culture of ownership and accountability for training to keep our staff and patients safe Offer a variety of developmental practices including mentoring, reciprocal mentoring individual and team coaching to help people and teams be their best Further embed and spread just and learning approaches across people practice	Reduction in turnover from 8.7% to 7% by March 2024			
			Leavers in first 12 months (126) reduced by 50% by March 2025			
			A 10% reduction in formal management processes each year because of a just and learning approach			

Priority	Goal	Inputs	Outputs and Measures	22/23	23/24	24/25
	The knowledge and skills of our workforce are further enhanced by the Education, Training and Development opportunities that we provide	Ensure adequate time and resources are allocated to trainers to deliver high quality training Provide access to new courses or content in response to changing workforce requirements Build principles of differential attainment into all education and learning and development practice	Overall engagement score in National Staff Survey and Quarterly Pulse Survey will be 7.3 or above by March 2024			
			Improvement in National Staff Survey question relating to access to the right learning and development opportunities from 59% to 64% by March 2025			
			The answers relating to clinical supervision, educational supervision, local teaching, and overall satisfaction in the annual GMC survey to increase to 90% by March 2025			
Transactional People Processes as a Strategy Enabler	People systems, processes and practice are inclusive, just, and efficient and effective	Work collaboratively across the ICS to develop improvements in efficiency and effectiveness of transactional people practices, including temporary staffing solutions and processes Build on the Transforming People practices programme to secure inclusion and just culture at the heart of HR at DCH Design and implement consolidated and simplified transactional people services, including policies, establishment controls and recruitment approval processes Use digital technology to automate elements of the recruitment process, reducing time to hire and improving candidate experience	The time to hire (from vacancy to start date) to be reduced by one week for all posts by December 2023			
			All HCA vacancies will be filled, and HCA Tier 1 agency use removed by March 2023			
			All operational HR Policies reviewed and simplified by March 2025			
			Establishment and recruitment control processes simplified and, where possible automated, to maximise efficiency and user satisfaction by March 2023			

For queries or more information about our People Plan please call **01305 254622**
or email **HumanResources@dchft.nhs.uk**

Dorset County Hospital – Digital Data and Technology Plan 2022 -2025

1 Introduction

At Dorset County Hospital (DCH) we aspire to provide outstanding care for people in ways that matter to them. The Trust strategy was developed by seeking the views of the people who are central to delivery, our staff. The views of patients, service users and community groups were also integral to strategy development.

In April 2021 DCH Board approved the Trust strategy and the focus on three strategic goals: People, Place and Partnership.

The intention of the Digital Data and Technology plan is to be an active component of each of these goals. Supporting our People and the communities they care for, ensuring accessibility to our Place for everyone by working in Partnership with all System Partners. We recognise the importance of data and information to our staff in supporting safe decision making, and the benefits of modern technology to empower our communities to interact with their care in confidential, appropriate and affordable ways that are easy to use. We understand the need to provide modern, secure technology and strive to deliver a high standard baseline of delivery to meet the expectations of the organisation.

Our data analytics services contribute to the wellbeing of our local communities through award winning advanced toolsets that provide intelligence to Public Health Dorset for their Population Health Management agenda as well as our specific Trust provided services.

We strive to engage suppliers as partners, building longstanding co-value relationships that benefit the Trust and our local communities, where possible making sure technology and innovation support our environmental commitment.

Our approach at DCH is aligned to the local Dorset digital ambitions and the national What Good Looks Like Framework.

2 The strategic context

New technologies and innovation continue to reshape every aspect of our lives. In healthcare the challenge facing traditional ICT or Informatics teams is how to make that transition from the back office to standing side by side with care professionals to support a 'digital as usual' way of working. The covid-19 pandemic has advanced digital transformation from between 5 and 7 years in the NHS.

This is not to say that robots and computers are here to take over from trained and experienced staff. Healthcare is a very personal and, by definition, caring service best delivered by empathetic and capable people. The challenge we set ourselves in the digital team is how we support those people.

How do we make sure that the right information is with the right person at the right time in the right place? How do we ensure that the basic fabric of our services are always there and available when needed? How do we provide effective digital solutions that are designed to support care professionals at the point of care tasks? How do we safely introduce new innovations or ways of working?

How do we do all of that and design it around our local communities who will have varying degrees of digital capability?

We have been on a trajectory at the Trust to raise our basic services to a stable and acceptable standard. With these stable but dynamic foundations in place we can leverage greater benefits and services.

Responsibility sits with us to ensure all the services we provide are fit for purpose, the most appropriate fit for the demands of the organisation and a sustainable element of our landscape by design. Together with our System Partners we will deliberately move towards a more joined up application landscape leveraging not only economies of scale, but efficiencies for our staff and a common exemplary service to our communities.

Our digital data and technology services together with those of our System Partners will drive the interoperability of data and mobility of staff across all care settings. To succeed we must not operate independently of our System Partners, but in concert with them.

For DCH our strategic digital aims can be described as:

- Create a landscape by design that supports optimal care, patient experience and staff usability
- Ensure our digital data and technology landscape is maintained to the highest sustainable standard applying best practice to our processes with robust cyber resilience
- Embedding clinical safety as standard
- We will promote digital skills and awareness to support our staff in their roles, and our patients as we improve and expand our digital patient services
- We will support innovation and encourage new solutions

3 The vision

Dorset County Hospital adopts the best available technology; delivers transformational change in the way we deliver our services and empowers our local community where appropriate to safely manage their care at home. Dorset County Hospital is an exemplar for how digital, data and technology are embedded throughout the organisation, our partners and our local communities through user centred design at every stage.

4 How we will achieve this

Each of our aims will be achieved through tactical programmes of work where possible. This will enable appropriate tracking of progress, but also allow judgements to be made on changes to priorities and direction. This will ensure informed decision making. Initially we have set objectives over the next three business years.

1 Create a landscape by design that support the optimal care, patient experience and staff usability

- Landscape by design means we will architect an application or collection of applications that best meets the operational needs of the Trust in the context as part of the Dorset ICB against the national objectives for architectures. We will:
    - Be a driving force in the ICB Enterprise Architecture Group
    - Ensure DCH operational and strategic needs can be met through the new landscape
    - Ensure any architecture is financially sustainable and also supports our environmental commitments as a Trust
- Ensure the landscape supports optimal care. We will:
    - Include clinicians and patients in the design and management of our applications and digitisation through user centred design principles
    - Ensure appropriate clinical safety diligence
    - Expand a community of digital champions across the Trust
- Ensure we support patient experience. We will:
    - Patient facing digital services are co-designed with our communities
    - Ensure optimal processes for accessing our services
    - Optimise the use of technology to support patients outside of our direct care setting
- Ensure we support staff experience. We will:
    - Expand a community of digital champions across the Trust
    - Include clinicians and patients in the design and management of our applications and digitisation through user centred design principles
    - Expand existing training services and introduce alternative ways to learn

2 Ensure the landscape is maintained to the highest sustainable standard applying best practice to our processes with robust cyber resilience

- DCH will have a high level of digital compliance and ensure our cyber stance exceeds expectations. We will:
    - Strive to achieve 100% on the annual Data Security and Protection Toolkit audit
    - Ensure our internal audit results are always minor advisories
    - Take advantage of nationally and regionally provided initiatives for improving our cyber stance
    - Ensure that our technical teams receive the necessary training to keep our infrastructure and application estate up to date with the latest technologies and methodologies.
    - Work with colleagues in Finance and Procurement to bid successfully for additional funding sources
    - Work with colleagues in Finance to ensure appropriate funding to enable the team to deliver the digital ambitions of the Trust

3 Embedding Clinical Safety as standard

- Raise the profile and quality of digital clinical safety for all our applications and processes. We will:
    - Improve the strength of our digital clinical safety process
    - Align our process to the wider ICB taking advantage of System wide processes and network of resources
    - Provide information and training where required on the importance of digital clinical safety

4 We will promote digital skills and awareness to support our staff in their roles, and our patients as we improve and expand our digital patient services

- Education and support of our staff is vital to the successful use of digital data and technology in our Trust. We will:
    - Ensure that all Digital Data and Technology staff receive appropriate training on current industry solutions and standards

- Ensure that all clinical, professional, administrative and operational staff receive digital training appropriate to their roles
- Ensure that appropriate cyber awareness campaigns exist to support our staff at work, but with skills that transfer into their private lives too

- Support our staff to engage patients with appropriate digital and technology solutions to manage their conditions and others they care for. We will:
  - Work with our strategic partners to obtain technology on behalf of those who do not have access to technology themselves
  - Continue to work with and support our colleagues in Dorset Council with their campaigns to end digital isolation and inequalities in Dorset
  - Support our staff in how to engage technology and solutions to support their patients, and train them on how to train and induct the public

5 We will support innovation and encourage new solutions

- Technology and smarter use of data and information will help us access new ways of working. We will:
  - Make the best use of resources from across the System to leverage experience to raise awareness and accelerate implementation of new technologies.
  - Make greater use of the DiiS (Dorset Intelligence and Insight Service) and its advancing toolsets to support real world evidence-based research that will improve patient pathways and care
  - Create an application landscape that allows controlled efficient interfacing of multiple technologies and supports our ability to harness emerging solutions

4 Outputs and Measures

Each objective has been broken down into a short number of goals that will be achieved over a period of 1-3 years. Each goal has several defined inputs and outputs. Outputs are linked to KPI's. We will create a simple monitoring dashboard to demonstrate our progress against the objectives. Progress on our delivery will be at the Digital Programme Group meeting, and other Committees as required. It is accepted that over the course of the period covered by this plan other significant pieces of work will arise from time to time that will impact our plan course through changes to priorities.

Priority	Goal	Inputs	Assurance & Metrics	22/23	23/24	24/25
Create a landscape by design that support the optimal care, patient experience and staff usability	Landscape by design means we will architect an application or collection of applications that best meets the operational needs of the Trust in the context as part of the Dorset ICB against the national objectives for architectures.	Be a driving force in the ICB Enterprise Architecture Group Ensure DCH operational and strategic needs can be met through the new landscape Ensure any architecture is financially sustainable and also supports our environmental commitments as a Trust	Ensure we are represented at the System Enterprise Architects Group and that considerations are included in the design and every future iteration. Feedback through DIPG.			
			Ensure we establish and maintain a network of clinical digital leads/champions, that is regularly communicated with, and provide opportunities for regular updates and engagement meetings. Feedback through DIPG and to SLG.			
			Maintain close alliance with Procurement and Finance colleagues to establish the best solution for DCH and our targets. Feedback through FPC and RAC as appropriate			
	Ensure the landscape supports optimal care.	Include clinicians and patients in the design and management of our applications and digitisation through user centred design principles	Continue with regular care group and divisional engagement meetings and expand the scope of discussion to all Digital Data and Technology subject areas and include research and innovation as appropriate.			

		Ensure appropriate clinical safety diligence Expand a community of digital champions across the Trust	Align our clinical safety with the emerging CSO processes across the System and increase the number of Digital Clinical Safety trained staff across the Trust. Established in year one, then through annual requalification and training.			
			Ensure we establish and maintain a network of clinical digital leads/champions, that is regularly communicated with, and provide opportunities for regular updates and engagement meetings. Feedback through DIPG and to SLG.			
	Ensure we support patient experience.	Patient facing digital services are co-designed with our communities Ensure optimal processes for accessing our services Optimise the use of technology to support patients outside of our direct care setting	Build on the System Digital Public Engagement Group and where appropriate use that forum for DCH specific design and solution evaluation work.			
			Improve our User Experience considerations in the design of services though use of more digital public engagement group work and focussed staff sessions for internal changes.			
			Introduce more technology to support care for our patients at home, with at least three new technologies adopted in the next three years.			
	Ensure we support staff experience.	Expand a community of digital champions across the Trust Include clinicians and patients in the design and management of our applications and digitisation through user centred design principles	Ensure we establish and maintain a network of clinical digital leads/champions, that is regularly communicated with, and provide opportunities for regular updates and engagement meetings. Feedback through DIPG and to SLG.			
			Continue with regular care group and divisional engagement meetings and expand the scope of discussion to all Digital Data and Technology			

		Expand existing training services and introduce alternative ways to learn	subject areas and include research and innovation as appropriate.			
			Create more bit sized online courses by 23/24 and expand the size of the training team to cater for increased digital skills awareness and application training.			
Ensure the landscape is maintained to the highest sustainable standard applying best practice to our processes with robust cyber resilience	DCH will have a high level of digital compliance and ensure our cyber stance exceeds expectations.	Strive to achieve 100% on the annual Data Security and Protection Toolkit audit Ensure our internal audit results are always minor advisories Take advantage of nationally and regionally provided initiatives for improving our cyber stance Ensure that our technical teams receive the necessary training to keep our infrastructure and application estate up to date with the latest technologies and methodologies. Work with colleagues in Finance and Procurement to bid successfully for additional funding sources Work with colleagues in Finance to ensure appropriate funding to	Show a continued improvement in our annual DSPT return every year, never having more than 5 unmet items. Demonstrated in the DSPT submission score.			
			Assurance for Audit results through audit reports and appropriate committees.			
			Critically review System, regional and national offerings for Cyber initiatives and confirm use of or adherence to relevant initiatives through appropriate committees.			
			Establish clear development plans for each member of staff and reviewed at least twice a year. Maintain appropriate membership of key learning bodies is available to all.			
			Through DIPG, regular departmental meetings and ultimately FPC confirm status of finances and applied for additional sources of funding.			

		enable the team to deliver the digital ambitions of the Trust				
Embedding Clinical Safety as standard	Education and support of our staff is vital to the successful use of digital data and technology in our Trust.	Improve the strength of our digital clinical safety process Align our process to the wider ICB taking advantage of System wide processes and network of resources Provide information and training where required on the importance of digital clinical safety	Add more trained qualified staff to the Clinical Safety function			
			Once agreed implement a common change and release process with our System Partners that contains Clinical Safety as a critical milestone action point			
			Through divisional and programme meetings raise awareness of digital clinical safety.			
We will promote digital skills and awareness to support our staff in their roles, and our patients as we improve and expand our digital patient services	Education and support of our staff is vital to the successful use of digital data and technology in our Trust.	Ensure that all Digital Data and Technology staff receive appropriate training on current industry solutions and standards Ensure that all clinical, professional, administrative and operational staff receive digital training appropriate to their roles Ensure that appropriate cyber awareness campaigns exist to support our staff at work, but with skills that transfer into their private lives too	Maintain membership of training platform sponsored by HEE for the South West, and explore BCS membership for appropriate members of the team to enable use of the SFIA+ development solution.			
			To deliver appropriate training expand the size of the digital training team and introduce more bitesize self-learn online courses/refreshers			

	Support our staff to engage patients with appropriate digital and technology solutions to manage their conditions and others they care for.	Work with our strategic partners to obtain technology on behalf of those who do not have access to technology themselves Continue to work with and support our colleagues in Dorset Council with their campaigns to end digital isolation and inequalities in Dorset Support our staff in how to engage technology and solutions to support their patients, and train them on how to train and induct the public	So reduce inequality on access to technology have at least one new scheme a year in place to provide technology solutions to support our community.			
			Empower our digital team to volunteer as appropriate to be Digital Champions through the Dorset Council initiative.			
			Ensure we establish and maintain a network of clinical digital leads/champions, that is regularly communicated with, and provide opportunities for regular updates and engagement meetings. Feedback through DIPG and to SLG.			
We will support innovation and encourage new solutions	Technology and smarter use of data and information will help us access new ways of working.	Make the best use of resources from across the System to leverage experience to raise awareness and accelerate implementation of new technologies. Make greater use of the DiiS (Dorset Intelligence and Insight Service) and its advancing toolsets to support real world				

		evidence-based research that will improve patient pathways and care Create an application landscape that allows controlled efficient interfacing of multiple technologies and supports our ability to harness emerging solutions				

Meeting Title:	**Board of Directors**
Date of Meeting:	**30th March 2022**
Document Title:	**Committee Effectiveness Review**
Responsible Director:	**Mark Addison, Trust Chair**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	*Not Confidential*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Prior consultation and discussion by respective committees.	February and March 2022	• Annual committee priorities to be developed and agreed • Terms of Reference to be updated and presented in May 2022 • Committee work programmes to be reviewed and agreed
Committee Chairs' meeting	March 2022	Final amendments and submission to Board.

Purpose of the Paper	The purpose of the report is to present the outcome of the annual committee review of effectiveness and to note that respective Committee Priorities, Work Programme and revised Terms of Reference will be returned to the Board for approval in May 2022. The report provides a collective summary of the Board subcommittee effectiveness reviews for the Board's consideration, providing assurances on the system of internal governance and control. The finding s of respective committee reviews will be used to inform further planned discussions of the respective Committee Priorities.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	Good governance practice determines that committees of the Board of Directors should undertake an annual review of their effectiveness in order to inform changes to their terms of reference, priorities and work programmes for the forth coming year, so demonstrating effective leadership and supporting delivery of the overall strategy objectives and risk mitigation. Each Committee has undertaken a review of effectiveness using an appreciative enquiry approach and the model questionnaire contained within the Audit Committee Handbook 2014. There have been a number of Director portfolio changes in year resulting in changes to committee membership and the impact of the pandemic has impacted priorities and the committee work programmes. Common themes across all committee reviews, has been the need to strengthen and develop reporting to committees, providing a succinct cover sheet for reports and to improve the timeliness of the publication of papers. The committees plan to further discuss the findings from respective reviews to inform further review of Terms of reference, Committee Priorities and Work Programmes for the forthcoming year. These will be presented to the Board for approval in May 2022.							

	The Board is asked to note this report.
Action recommended	The Board of Directors is asked to: 1. **NOTE** the outcome of the committee effectiveness review and that Committee Priorities, Terms of Reference and work programmes will be presented in May 2022 for approval.

Governance and Compliance Obligations

Legal / Regulatory	Y	Committees of the Board are required to undertake an annual review of their effectiveness
Financial	N	
Impacts Strategic Objectives?	Y	Committees monitor the Trust's performance and delivery of the Strategy which informs their programmes of work
Risk?	Y	Committees seek assurances on controls and mitigations to manage risks to delivery of the Strategy which informs their programmes of work
Decision to be made?	N	
Impacts CQC Standards?	Y	Supports delivery of the Well Led standard
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Board Committee Performance Review – March 2022

Introduction

As part of the Board of Directors' corporate governance and performance management arrangements, committees that the Board has established undertake an annual review of their performance and Terms of Reference and report these to the Audit Committee. This requirement provides assurance to the Board that its committees are working effectively and provides information to the Board of Directors for use in the Board's annual review of committee performance and effectiveness. This paper reflects the key points arising from the committee annual reviews undertaken during 2021/22 in relation to the period April to March 2022 in order to inform planned discussion by the Board and inform the respective reviews of committee Priorities, Terms of Reference and Work Plans.

Annual reviews of committee performance and effectiveness for 2021/22 were completed using the performance checklist and effectiveness questionnaire contained within the fifth edition of the Audit Committee Handbook published in the autumn 2014 as a basis for respective reviews. An Appreciative Enquiry approach was adopted in order to invite comment and suggestions on areas for committee development.

Board Committees

In accordance with the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, the Trust Board has formally established the following Committees and delegated authority to these via agreed Terms of Reference:

- Risk and Audit Committee
- Finance and Performance Committee
- Quality Committee
- People and Culture Committee

The membership of Board Committees was reviewed in year following changes within both the Executive management team and the Non-Executive membership of the Board of Directors. These changes did not adversely impact delivery of Committee Work Programmes or quoracy / attendance at meetings which remained good throughout the change period.

COVID Pandemic

The Board of Directors approved that the operation of Board meetings and subcommittees during the reporting period be necessarily amended in light of national guidance to 'reduce the burden' on Executive and operational teams in

order to release capacity to address the pandemic crisis, support the elective recovery programme and meet increasing urgent care demands. Respective subcommittee Terms of Reference were temporarily amended in order release executive capacity and to enable subcommittees to focus on key risks and decision making. Both the performance and financial management regimes remained significantly altered nationally throughout the year. Committees have reported that they have remained sighted on key risks and mitigations throughout the year and acknowledge the need to refocus attention on longer term financial sustainability both within the Trust and across the wider system as the NHS emerges from the pandemic and the Integrated Care System is established.

The mode by which meetings were executed remained by teleconference in the main and maintained focus on delivering best care and the safety and wellbeing of staff, patients and the public. Divisional representation and attendance at subcommittee meetings was not required at committees during the latter part of the year as the Omicron wave reached its peak.

Committee Reviews

The Audit Committee Handbook 2014 was used to form the basis of the 2021/22 Committee reviews undertaken during Quarter 4 2021/22 and included:

- Attendance and Quoracy
- Membership
- Reporting to the Trust Board
- Meeting the Terms of Reference and work undertaken by the Committee
    - The Audit Committee Handbook 2014 Committee performance evaluation checklist was amended to reflect each Committee Terms of Reference and used as the basis for the self-assessment exercises
    - Table 1 below reflects the business transacted by each committee in line with their respective Terms of Reference / Work programmes.
- Review of areas for improvement and recommendations

Committee and Strategic Risk Review Process

The Audit Committee Handbook 2014 was published in autumn 2014. The Audit Committee Handbook provides guidance on Board reporting arrangements, production of Annual Reports, review of work plans and other best practice guidance and was used as the basis for the subcommittee reviews in 2021/22.

The Board Assurance Framework (BAF) provides a register of risks to the Trust's Strategic Objectives, controls and mitigations. The Trust refreshes its strategy in year and the BAF has been reviewed to reflect the refreshed Strategic Objectives. The Trust has adopted the 'If, then, so' approach to risk articulation, promoting greater understanding of the risk, mitigating actions and assurances. Scrutiny and monitoring of the risks contained within the BAF pertinent to respective committee

portfolios, has been undertaken by the Board sub-committees with oversight of the overall system of internal controls being maintained by the Risk and Audit Committee. the BAF and mitigating action is undertaken by the Risk and Audit Committee.

Director Portfolio Changes

The Chief People Officer took up post in April 2021. A new Non-Executive Director and Chair of the Risk and Audit Committee commenced in December 2021 following the retirement of the previous incumbent. A new Non-Executive Director and an Associate Non-Executive Director commenced with the Trust in January 2022.

Executive Changes included the appointment of a new Chief Operating Officer in December 2021 and the appointment of the Deputy Chief Executive Officer as Interim Chief Executive Officer in February 2022. In March 2022, the Chief Nursing Officer was appointed as Deputy Chief Executive Officer. At the end of March 2022, the Trust Chair's term of Officer will be extended for a period of 12 months following approval by the Council of Governors.

NHSE/I Guidance – Enhancing Board Oversight

In December 2021, NHSE/I published the guidance *'Enhancing Board Oversight - A new approach to Non-Executive Director champion roles.'* This guidance proposes that trusts consolidate the number of formal NED Champion roles, and makes suggestions as to the most appropriate Board committee to discharge the responsibilities of other previous NED Champion roles.
The following NED Champion roles were retained by the Board:

- Maternity Safety Board Champion – Sue Atkinson
- Wellbeing Guardian – Margaret Blankson
- Freedom to Speak Up NED Champion – Dave Underwood
- Doctors' Disciplinary NED Champion (Statutory requirement) – Ad hoc appointments on a case by case basis.
- Security Management NED Champion – Stephen Tilton

The following responsibilities were remitted to the following committees and respective committee Terms of Reference have been refreshed to include these for the forthcoming year:

Quality Committee

- Hip fractures, falls and dementia
- Palliative and end of life care
- Resuscitation
- Learning from deaths
- Health and safety
- Safeguarding
- Safety and risk
- Lead for children and young people

Audit and Risk Committee

- Counter fraud
- Emergency Preparedness

Finance and Performance Committee

- Procurement
- Cybersecurity

People and Culture Committee

- Security management – violence and aggression

Table 1 – Board Committee Reviews at a Glance for Period April 2021 to March 2022

	Audit and Risk Committee	Finance and Performance Committee	Quality Committee	People and Culture Committee
Attendance and Quoracy	Met on six occasions. Committee has been quorate on 5 out of 6 occasions.	Met on 12 occasions. Committee has been quorate on all occasions.	Met on 12 occasions. Committee has been quorate on 11 out of 12 occasions.	Met on 12 occasions. Committee has been quorate on all occasions.
Membership	• Three Non-Executive Directors • Chief Finance Officer • Medical Director and/or Chief Nursing Officer • Chief Executive (for Annual Report and Accounts)	• Four Non-Executive Directors • Chief Executive Officer • Chief Finance Officer • Chief Operating Officer • Director of Strategy, Transformation and Partnerships • Director of Workforce	• Four Non-Executive Directors • Chief Executive Officer • Chief Nursing Officer • Medical Director • Chief Operating Officer	• Three Non-Executive Directors • Chief Executive Officer • Chief Operating Officer • Medical Director • Chief Nursing Officer • Director of Strategy and Transformation • Director of Workforce
Attendance	• Head of Corporate Governance • Internal and External Audit representation at each meeting • Anti-Fraud Specialist	• Head of Corporate Governance • Divisional Directors • No additional co-opted members	• Head of Corporate Governance • Divisional Clinical Directors • Divisional Associate Directors of Nursing • No additional co-opted members	• Head of Corporate Governance • Head of Education • Head of Workforce • Head of HR Operations • Head of Diversity and Inclusion • Divisional Directors • No additional co-opted members
Board Reporting	• Escalation Report provided post meeting	• Escalation Report provided post meeting	• Escalation Report provided post meeting	• Escalation Report provided post meeting
Meeting Terms of Reference / Summary of Work Undertaken	• Internal Audit reports on a range of activities within the Internal Audit Plan • External Audit review of financial statements and Annual Governance Statement	• H1 and H2 financial plans • Performance reporting of key quality and safety metrics • elective recovery and waiting lists • Business case approval and oversight • Capital Programmes	• Development of the Clinical Plan • Review of quality and safety metrics • Monitoring quality impact arising from long waiting times and increasing numbers of patients with' No Reason to Reside'. • Maternity safety	• Development of the People Plan • Review and development of the People Dashboard • HR policies • Education and leadership development

	Audit and Risk Committee	Finance and Performance Committee	Quality Committee	People and Culture Committee
	• Progress reports on Anti-Fraud activities • Board Assurance Framework • Head of Internal Audit Opinion • Policy approval	• Development of the Digital Plan	• Board Assurance Framework and Corporate Risk Register • Complaints, claims and inquests • Sub-committee reports and work plan approval • Infection prevention and Control Monitoring • Patient Experience • Safeguarding and serious case reviews • Learning from Death Reports • Medicines Management Updates • DCHFT response to national report findings • Divisional Presentations	• Recruitment and retention – including overseas • Bank and Agency usage • Equality Diversity and Inclusion • Staff networks • WRES and WDES reporting oversight • Board Assurance Framework and Workforce risks • Divisional Presentations
Review of Terms of Reference	Annual review to be approved in March 2022	Annual review to be approved in March 2022	Annual review to be approved in March 2022	Annual review to be approved in March 2022
Cycle of Business	Annual review to be approved in March 2022	Annual review to be approved in March 2022	Annual review to be approved in March 2022	Annual review to be approved in March 2022
Areas for Development	• Action Logs should be updated prior to meetings • Auditors could be invited to utilise the Trust Front Sheet reports in order to provide succinct summaries • The pandemic has impacted the ability of some members to attend • The consistency in the quality of front sheets and reports could be improved	• Greater clarity of risk mitigations when performance is off track • The need for a clearer statement of purpose to drive improvements • The need to refocus aims and objectives as we emerge from the pandemic • The need for greater challenge on performance and finance • Occasional communication gaps with other committees on	• Understandably, the timing of meeting paper submission and publication needs to be improved as we emerge from the pandemic • Action Logs should be updated prior to meetings • The consistency in the quality of front sheets and reports could be improved to ensure that they are concise.	• The committee could be more forward looking and more clearly state its aims and objectives • The work plan needs to reflect improvement action areas other than OD • To develop a greater understanding of the financial and operational aspects to facilitate wider discussion • Occasional communication gaps with other committees

	Audit and Risk Committee	Finance and Performance Committee	Quality Committee	People and Culture Committee
	to ensure that they are concise.	operational finance and escalations and the need to assure onward communications below the divisional triumvirate • Understandably, the timing of meeting paper submission and publication needs to be improved as we emerge from the pandemic • The Action Log should be updated prior to each meeting • The consistency in the quality of front sheets and reports could be improved to ensure that they are concise.		on operational finance and escalations and the need to assure onward communications below the divisional triumvirate • Understandably, the timing of meeting paper submission and publication needs to be improved as we emerge from the pandemic • Action owners to be enabled to provide updates • The consistency in the quality of front sheets and reports could be improved to ensure that they are concise.

Conclusion

All committees of the Board have completed an annual review and self-assessment of performance using a standardised approach in 2021/22. The impact of the COVID-19 pandemic has been a common theme impacting the normal operation of committees throughout the year.

Attendance has remained good throughout 2021/22, albeit that the majority of meetings were conducted via teleconferencing arrangements. All committee meetings have been quorate allowing committee business to be appropriately transacted. Each committee has appropriately encouraged attendance by management representatives although no committee has needed to co-opt membership in order to facilitate its understanding of the business to be transacted.

Each committee has continued to meet its Terms of Reference and has delivered a comprehensive programme of work on behalf of the Board, providing timely reporting of issues via Escalation Reports following each meeting. Changes in Executive Director portfolios and to Non-Executive membership of the Board of Directors did not adversely affect the operation of committees although the national changes to the performance and finance regimes due to the pandemic, were necessarily reflected in reporting of these elements to subcommittees. Committees are aware of the need to refocus on the underlying deficit position as a normalised income and performance regime is resumed in the coming year and this focus will be intrinsic is all aspects of committee business going forward.

The Internal Audit programme was maintained as far as has been reasonably possible given the pandemic and progress on action delivery was commended by the Risk and Audit Committee in light of the extreme pressures services had faced throughout the year. The Trust was subject to an independent external review of its Well Led arrangements during Quarter 3 which was undertaken by PriceWaterhouseCoopers. The report was favourable overall but emphasised the need to refocus on the financial underlying position at the Trust and across the system and to ensure proactive communications and engagement with system partners regarding the Trust's strategic intentions. A comprehensive External Audit Value for Money Audit was completed during Quarter 4.

Each committee welcomes the planned return to business as usual post pandemic and the return of divisional representation and attendance at meetings. Committees have identified a small number of areas for development and implementation during 2021/22. Common themes are summarised as follows:

- Completion of Action Log updates prior to respective committee meetings and the timely circulation of papers to enable time to read and digest the content before meetings.
- Refocus on the financial considerations of items under discussion given the anticipated challenges in the coming year.

- The consistency and quality of Front sheets for committee papers could be improved in order to focus attention and discussion at committees.
- The need for committees to be assured on onward communication of key messages beyond the Divisional triumvirate.

Other areas for specific committees to address include

- Greater clarity on the level of risk when performance is of track
- The need to ensure a forward thinking approach
- The attendance of some members at committees (understandably due to COVID) needs to improve as the NHS emerges from the pandemic

These recommendations will be incorporated within subcommittee work programmes for 2022/23.

Recommendations

The Board is asked to note the findings of Board sub-committee annual effectiveness reviews and to note that sub-committee Terms of Reference and Cycles of Business that the address areas of development identified, will be returned to the Board for approval in May 2022 for approval.

Trevor Hughes

Head of Corporate Governance

March 2022

Appendices – Committee Effectiveness Questionnaires – Consolidated

Committee Effectiveness Self-Assessment Questionnaire 2021/22

Risk and Audit Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy	XXXX	X				Clear Alignment to our strategy All answers given in context of the NHS having altered governance arrangements and TOR for sub-board committees due to the emergency response to the covid-19 pandemic.
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives	XXXX	X				
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or on the committee's work programme	XXX	XX				Could we be addressing the underlying deficit more pro-actively?

4	The Committee receives regular reports on strategic risk mitigations and reviews effectiveness of internal control systems	XXX	XX				Delayed in relation to the new Trust strategic and oversight of the strategic risks & BAF development
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board	XXX	XX				See above
Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and this is understood by members	XXXX	X				
7	The Committee has set a clear cycle of business to support delivery of the Work Plan	XXX	XX				Noting comment at bottom in regard to Cyber/Info governance
8	Aims and objectives are clearly defined and measureable	XXXX	X				
9	The Committee is clear about the level of authority/delegated power from the Board	XXXX	X				
10	The Clinical Audit programme and regular progress updates are reviewed by the committee	X	XXXX				Due to covid the clinical audit plan was paused for some audits and therefore impacted the plan This still needs further development and is progressing

11	The committee produces an annual report to the Board on it activities and review of internal control processes to support of signing the Annual Governance Statement	XXX	X				I have not had sight of this to date but assume that it has historically been prepared
12	The committee has a clear programme of work and understands it role in scrutinizing and approving the Annual Report, Accounts and Quality Account	XXX	XX				Noting impact of refreshed processes due to covid on annual quality account
Part 2: Quality Assurance							
13	Committee members have the appropriate skills and expertise to understand the information they receives	XXXX	X				Good mix and depth of skills and knowledge
14	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	XXXX	X				Ut supra
Part 3: Quality of the Committee/Management Relationship							
15	Committee members clearly understand their role	XXXX	X				
16	There is effectiveness communication between Committee, other committees managing strategic risk and the Trust Board	XXXX	X				This has improved during the past couple years with good integration between committees

17	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	XXXX	X				
18	There is effective communication of committee decisions to staff/managers	X	XXX				As with other committees perhaps an area for us to seek explicit assurance Some gaps due to covid context Not experienced this to date
Part 4: Effectiveness of the Committee Processes and Meetings							
19	The Committee makes effective use of its meetings	XXX	XX				
20	The content of the agenda is sufficiently focused on systems of internal control	XXX	XX				
21	Committee papers are available in sufficient time to enable adequate preparation for meetings		XXXX X				Generally, yes. Covid context meant some papers were delayed due to access the timely data/information needed for the report There are some late additions/amendments. Ideally 3-4 working days before the meeting would be of benefit,

							especially for those members attending all committee meetings
22	The Action Log is appropriately updated in readiness for each meeting.	XXX	XX				Could be improved with more proactive process to get updates
23	Reports and briefings are concise and clearly identify the issue and required actions by the committee	X	XXXX				Both internal and external auditors use their own 'templates' which can be verbose and repetitive. They do not use the DCH required 'front sheets' which aim to provide a succinct summary of key points of the paper Summary pages could be more concise and detail exact requirements for the committee
24	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	XXX	XX				Current COVID situation has impacted some attendees which is understandable.
25	Committee members feel free to participate in proceedings without undue inhibition.	XXXX	X				
26	Decisions of the Committee are executed in a timely manner	XXX	XX				
27	The frequency of meetings is appropriate	XXX	XX				

Part 5: External Audit							
28	There is a clear External Audit Plan approved by the committee and progress is regularly reviewed	XX	XXX				Brief discussions to date but in hand for the 21/22 audit
29	The External Audit annual letter is reviewed by the committee	XX	XX				Not yet experienced
Part 6: Internal Audit							
30	The Internal Audit Plan is agreed by the committee and regular progress reports and follow up reports are received	XXX	XX				
31	The Committee receives regular benchmarking information	XXXX	X				
32	The Committee receives the Head of Internal Audit Opinion	XX	XX				Not yet experienced
Part 7: Counter Fraud							
33	The Counter Fraud work programme is agreed by the committee and regular progress reports are received	XXX	XX				Only had one interaction to date
34	The annual counter fraud self-assessment is approved by the committee prior to submission	XXX	X				Not yet experienced
Suggestions made for improving the Committee Effectiveness							

Should we also explicitly have a part of this review that addresses Information Governance and Cybersecurity?

Encouraging internal and external auditors to use the DCH 'front sheets' to summarise the salient points and purpose of the papers would be useful (and similarly any other people bringing papers to the committee)

Committee Effectiveness Self-Assessment Questionnaire 2021/22

– Finance and Performance Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy	xxxxx	x				Clear alignment to strategy All answers given in context of altered governance due to covid pandemic and emergency response
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives	xxxxx	x				

3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or the committee's work programme	xxxx	xx				
4	The Committee receives regular reports on strategic risk mitigations	xxxx	x	x			It could tighten up on the risk mitigation when performance if off track and consider escalations more related to the strategic risks
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board	xxxx	x	x			See above
Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and is understood by members	xxx	xxx				Suggest some gaps for improvement on its purpose to drive improvement
7	The Committee has set a clear cycle of business to support delivery of the Work Plan	xxxx	x	x			I like the fact that the work plan sets out the monthly review as well as the quarterlies etc.
8	Aims and objectives are clearly defined and measureable	xxx	xx		x		During the pandemic, these have been challenging areas for perfectly understandable reasons. There will certainly be increasing focus on these as we progress out of the pandemic, in particular on recovery,

							performance targets, CIP and the underlying deficit. Could be clearer on this
9	The Committee is clear about the level of authority/delegated power from the Board	xxxxx	x				
Part 2: Quality Assurance							
10	Committee members have the appropriate skills and expertise to understand the information they receives	xxxx	xx				The process in place for ensuring the Board are kept abreast of key strategic issues are addressed via Board development sessions and the broad range of NHSEI workshops, briefings and events. There is also a significant amount of forums delivered by key NHS and health & social care organisations that provide detailed materials. Committee members also have access to Executive team and Divisional Heads of Service should further information be sought. Further skills in challenging the position and performance (operational and finance) as occasionally accepts position

							rather than probes. Needs more skill in NHS waiting list management A good balance of skills
11	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	xxxx	xx				A good balance of skills See above
Part 3: Quality of the Committee/Management Relationship							
12	Committee members clearly understand their role	xxxxx	x				
13	There is effectiveness communication between Committee, other committees and the Trust Board	xxx	xxx				Occasional gaps in communication with PCC and Board on operational and financial escalations
14	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	xxxx	xx				
15	There is effective communication of committee decisions to staff/managers	xxx	xx	x			As with PCC we should perhaps assure ourselves of the onward communication of decisions - Is this perhaps an RAC role?

							Communication below divisional triumvirate to care group level could potentially be improved Impacted upon due to covid governance and pandemic response
Part 4: Effectiveness of the Committee Processes and Meetings							
16	The Committee makes effective use of its meetings	xx	xxx	x			Where necessary, to streamline the committee's business during the pandemic and to protect staff resources, agendas have been trimmed to ensure only essential matters are discussed; others have been deferred where appropriate. For those not sitting on Quality Committee the opportunity to raise issues on the performance report can on occasion be fleeting as many on the committee have just reviewed the same report in Quality (possibly more a note to self!)

							Could spend more time on key performance risks with a deeper assessment of the plans
17	The content of the agenda is strategically focused and relevant	xxxx	x	x			Could spend more time on key performance risks with a deeper assessment of the plans
18	Committee papers are available in sufficient time to enable adequate preparation for meetings			xxxxx	x		Due to Covid pressures on divisional teams, reports are often forwarded late to the Governance team which, results in NED's not having a sufficient amount of time to go through all the papers. This will hopefully be addressed as the current situation alters. Some slippage in timing of papers has been inevitable over the past year Divisional reports are quite often last minute or even oral – no doubt reflecting high operational pressures Operational pressures impact this Impacted upon in getting data for timely writing of papers and submission

19	The Action Log is appropriately updated in readiness for each meeting.	xx	xxx	x			Could be a more proactive process to support update on actions before the committee
20	Reports and briefings are concise and clearly identify the issue and required actions by the committee	x	xxx	xx			Reports are not always clearly presented and front sheets not always included. PC leads are working with Divisional leads to improve and develop this area. We have been working on this in all committees for some time, but there is still a variety of approaches to report writing. The cover sheet in all cases should be sufficient to determine what the main issues are and to set out required action, with a recommendation. This does take time and thought which has been at a premium over the past year. Difficult though it is, committee chairs, lead execs and the secretariat should all encourage a continuing focus in this area. Reports are improving and still scope for more distillation of information

21	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	xxxxx	x				
22	Committee members feel free to participate in proceedings without undue inhibition.	xxxx	xx				
23	Decisions of the Committee are executed in a timely manner	xxx	xxx				
24	The frequency of meetings is appropriate	xxxx	x				
Suggestions made for improving the Committee Effectiveness							
Continue to improve conciseness of papers. Improve cascade of decision making and reasoning beyond divisional triumvirate							

Committee Effectiveness Self-Assessment Questionnaire 2021/22

– Quality Committee

		Strongly agree	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**	**What works well? / what can be improved in these areas?**
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy	xxxxxxx					Clear on the assurance it seeks and alignment to key strategies

2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives	xxxxxx	x				Note: Covid and the amended governance has impacted on some of the work plan, therefore assessment has taken that into context
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or the committee's work programme	xxxxxx	x				See above
4	The Committee receives regular reports on strategic risk mitigations	xxxxx	xx				Where relevant and triangulates or refers to more suitable sub-board committee
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board	xxxxxx	x				
Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and is understood by members	xxxxxx	x				Evidenced by PWC assessment
7	The Committee has set a clear cycle of business to support delivery of the Work Plan	xxxxxx	x				Within the context of covid being applied
8	Aims and objectives are clearly defined and measureable	xxxx	xxx				

9	The Committee is clear about the level of authority/delegated power from the Board	xxxxxx	x				
Part 2: Quality Assurance							
10	Committee members have the appropriate skills and expertise to understand the information they receives	xxxxx	xx				A formidable mix and depth of knowledge The process in place for ensuring the Board are kept abreast of key strategic issues are addressed via Board development sessions and the broad range of NHSEI workshops, briefings and events. There is also a significant amount of forums delivered by key NHS and health & social care organisations that provide detailed materials. Committee members also have access to Executive team and Divisional Heads of Service should further information be sought
11	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	xxxxx	xx				As above
Part 3: Quality of the Committee/Management Relationship							

12	Committee members clearly understand their role	xxxxxx	x				
13	There is effectiveness communication between Committee, other committees and the Trust Board	xxxxxx	x				
14	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	Xxxxxx x					
15	There is effective communication of committee decisions to staff/managers	xxxxx	xx				
Part 4: Effectiveness of the Committee Processes and Meetings							
16	The Committee makes effective use of its meetings	xxxxxx	x				
17	The content of the agenda is strategically focused and relevant	xxxxxx		x			Increased limitations on strategic due to covid context
18	Committee papers are available in sufficient time to enable adequate preparation for meetings		xx	xxxx	x		Generally, yes. Some slippage in timing of papers has been inevitable over the past year and some papers have only appeared on the morning of the meeting Due to Covid pressures on divisional teams, reports are often forwarded late to the Governance team which, results in NED's not

							having a sufficient amount of time to go through all the papers. This will hopefully be addressed as the current situation alters Operational pressure has impacted this Papers are as best as possible due to external factors impacting on timeliness of some papers – eg covid context, data not available via business intelligence, operational emergency escalated pressures impacting on capacity to create full papers in time.
19	The Action Log is appropriately updated in readiness for each meeting.	xxx	xx	xx			Process to getting updates could be improved and seems not so proactive. Some papers are received late or there are late amendments.
20	Reports and briefings are concise and clearly identify the issue and required actions by the committee	x	xxx	xx			Front sheets are still not used well by all and some reports have too much detail that should be in appendices

							We have been working on this in all committees for some time, but there is still a variety of approaches to report writing. The cover sheet in all cases should be sufficient to determine what the main issues are and to set out required action, with a recommendation. This does take time and thought which has been at a premium over the past year. Difficult though it is, committee chairs, lead execs and the secretariat should all encourage a continuing focus in this area Reports are not always clearly presented and front sheets not always included. PC leads are working with Divisional leads to improve and develop this area. Summary pages could be more concise and highlight specific areas for discussion/action.
21	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	xxxxxx	x				

22	Committee members feel free to participate in proceedings without undue inhibition.	xxxxx	xx				On the whole agree: occasionally limited due to time constraints due to covid context governance arrangements
23	Decisions of the Committee are executed in a timely manner	xxxxx	xx				
24	The frequency of meetings is appropriate	xxxxxx	x				

Suggestions made for improving the Committee Effectiveness

See comments above re using front sheets more effectively – i.e. to summarise the salient point(s) of the paper and what is needed form the committee. Senior manager leads should ensure these 'front sheets' are utilised appropriately prior to signing off papers to be sent to the committee.

The effectiveness review needs to be place in 2021/2022 on an ongoing pandemic that needed executive and operational teams focus. Considering this, and as supported by PWC observations, the committee has performed well and focused on quality improvement and sustained safety.

Committee Effectiveness Self-Assessment Questionnaire 2021/22

– People and Culture Committee

		Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	What works well? / what can be improved in these areas?
Part 1: Strategy and Risk							
1	The Committee is clear about its assurance role in respect of the strategy	Xxxx	x				Clear alignment to our strategy All answers given in context of the NHS guidance amended governance related to the covid pandemic. Occasional gaps in assurance role as occasionally does not interrogate data only accepts it
2	The Committee Work Plan sets out a clear and comprehensive programme of assurance work that is aligned to relevant strategic objectives	xxxx	X				I think that it would be good to reflect in the work plan our routine monthly reviews as well as the quarterly's and annual/bi annual
3	The committee is sighted on the strategic risks impacting delivery of the relevant strategic objectives or the committee's work programme	xxx	Xx				Could we do more forward looking?

4	The Committee receives regular reports on strategic risk mitigations	Xxxx	x				
5	There is a robust and timely risk escalation process that escalates strategic risks to the Board	Xxxxx					
Part 2: Degree of Fulfilment of the Committee's Responsibilities							
6	The purpose of the Committee is clearly articulated and is understood by members	Xxxxx					
7	The Committee has set a clear cycle of business to support delivery of the Work Plan	xxx	Xx				Receives reports but not clear in its cycle of business in the action and work for improvement other than OD elements, potential gap in the work plan
8	Aims and objectives are clearly defined and measureable	xxx	Xx				Receives reports but not clear in its cycle of business in the action and work for improvement other than OD elements, potential gap in the work plan
9	The Committee is clear about the level of authority/delegated power from the Board	Xxxxx					
Part 2: Quality Assurance							

10	Committee members have the appropriate skills and expertise to understand the information they receives	Xxxx	x				The process in place for ensuring the Board are kept abreast of key strategic issues are addressed via Board development sessions and the broad range of NHSEI workshops, briefings and events. There is also a significant amount of forums delivered by key NHS and health & social care organisations that provide detailed materials. Committee members also have access to Executive team and Divisional Heads of Service should further information be sought Some gaps in expertise in understanding the workforce financial and operational aspects means these can go under discussed or cross referenced occasionally
11	Committee attendees have the relevant skills to conduct committee business and clearly understand their role	Xxxx	x				Some gaps in expertise in understanding the workforce financial and operational aspects means these can go under

							discussed or cross referenced occasionally
Part 3: Quality of the Committee/Management Relationship							
12	Committee members clearly understand their role	Xxxxx					
13	There is effectiveness communication between Committee, other committees and the Trust Board	Xxxx	x				Good and clear escalation and regular co-ordination when required with other committees See 10, gap in cross reference from PCC to FPC/QC and RAC
14	Decision making or discussion is not dominated by single agenda items or individuals inappropriately	xxxx	X				
15	There is effective communication of committee decisions to staff/managers	xxx	Xx				Perhaps an area we should explicitly assure ourselves of Within covid constraints
Part 4: Effectiveness of the Committee Processes and Meetings							
16	The Committee makes effective use of its meetings	Xxxx	x				Committee could explore deeper dives on areas with the strategy
17	The content of the agenda is strategically focused and relevant	Xxxxx					

18	Committee papers are available in sufficient time to enable adequate preparation for meetings	x	x	Xx	x		On occasion papers arrive at the last moment – providing little time for review – that said I believe that committee members strive to review papers delivered with even a few hours notice. Due to Covid pressures on divisional teams, reports are often forwarded late to the Governance team which, results in NED's not having a sufficient amount of time to go through all the papers. This will hopefully be addressed as the current situation alters. Noting not all data is available to support more timely reports on occasions Late papers and amendments should be reduced as much as possible
19	The Action Log is appropriately updated in readiness for each meeting.	xxx	Xx				Chair tends to give an update to most actions rather than action owner, which means less challenge can be provided by the chair – one area for development

20	Reports and briefings are concise and clearly identify the issue and required actions by the committee	x	Xxx				Reports are not always clearly presented and front sheets not always included. PC leads are working with Divisional leads to improve and develop this area. Report has developed with a potential gap on the mitigation of the 'so what' aspect to presenting the data Improvements to summary page should be developed
21	Committee members attach the appropriate level of seriousness to preparing for and attending Committee meetings	Xxxxx					
22	Committee members feel free to participate in proceedings without undue inhibition.	xxxx	X				
23	Decisions of the Committee are executed in a timely manner	xxxx	X				
24	The frequency of meetings is appropriate	Xxxxx					
Suggestions made for improving the Committee Effectiveness							

Meeting Title:	Board of Directors
Date of Meeting:	30 March 2022
Document Title:	**Chief Executive's Report**
Responsible Director:	Nick Johnson, Interim Chief Executive
Authors:	Natalie Violet, Corporate Business Manger to the Chief Executive Laura Symes, Interim Corporate Business Manager to the Chief Executive

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	22/03/2022	Approved

Purpose of the Paper	For information.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	This report provides the Board with further information on strategic developments across the NHS and more locally within Dorset. It also includes reflections on how the Trust is performing and the key areas of focus. The key developments nationally are as follows: • The Health and Care bill is due to have its third reading in the House of Lords on 23 March 2022. Over the past few months there have been calls for amendments to the bill regarding workforce, mental health, and end of life care. • The Government published the health and social care integration white paper with proposals for a single accountable person, shared outcomes, and increasingly pooled NHS and social care budgets at place level. • The NHS Race and Health Observatory published a rapid review into ethnic health inequalities across a range of areas including key priorities set by the independent health body. The report highlighted ethnic inequalities in access to, experiences of, and outcomes of healthcare as longstanding problems in the NHS, and are rooted in experiences of structural, institutional, and interpersonal racism. • The Government announced a new taskforce to level-up maternity care and tackle disparities. Maria Caulfield, Minister for Patient Safety and Primary Care, and Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer, have established the Maternity Disparities Taskforce which will tackle disparities in maternity care experienced by women from ethnic minority groups and those living in deprived areas. • The Government have confirmed people aged 75 years and older, residents in care homes for older people, and those with weakened immune systems will be offered a spring booster of the COVID-19 vaccine. • The Government are reconsidering the legislation requiring vaccination as a condition of deployment and a further review is to be undertaken. This means that the regulations will not be implemented from 01 April 2022. • The Delivery plan for tackling the COVID-19 backlog of elective care was published by NHS England and NHS Improvement. The plan was developed with expert contributions from a wide range of partners, to set out a progressive agenda for how the NHS will recover elective care over the next three years. • The Government released its Living with COVID-19 plan. The document							

	sets out how the Government has and will continue to protect and support citizens by enabling society and the economy to open more quickly than many comparable countries; using vaccines; and supporting the NHS and social care sector. It also sets out how England will move into a new phase of managing COVID-19. • The news has been dominated with the Russian invasion of Ukraine since 24 February 2022. The NHS is providing care to Ukrainian children with cancer and the Government are supporting Ukraine with medical items. The organisation continues to feel the impact of an increasing COVID wave which is further impacting on staffing and bed availability, as well as exacerbating the shortages in community and social care, further reducing our ability to discharge people to other care settings. We have had to step down elective activity and continue to use day surgery for inpatients. Lots of work is going on to alleviate the immediate pressures; we have stepped up our incident management arrangements, with a dedicated workforce cell, and we will continue to proactively manage the incident internally and with our health and care partners. Our teams have gone above and beyond in response to this latest wave, we continue to stress the importance of good Infection, Prevention, and Control measures, the need for rest where possible and access wellbeing support if needed.
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 – March 2022

Strategic Update

National Perspective

Health and Care Bill
The Health and Care bill is due to have its third reading in the House of Lords on 23 March 2022. Over the past few months there have been calls for amendments to the bill.

A coalition of almost 90 health and care organisations, including NHS Providers, called for stronger provisions on workforce planning and issued a briefing ahead of committee stage in the House of Lords in January 2022. In November 2021, MPs rejected the amendment tabled by the Rt. Hon. Jeremy Hunt to strengthen workforce planning despite cross-party support and backing from the coalition of almost 90 sector organisations. The amendment has now been re-tabled by Baroness Cumberlege, supported by Lord Hunt of King's Heath, Baroness Brinton, and Lord Stevens of Birmingham. With the aim to mandate the regular publication of independent assessments of current and future health and care workforce numbers, helping to close the data gap and strengthen accountability and transparency on workforce planning.

The Centre for Mental Health has been working with other organisations to put forward changes to the Health and Care Bill to ensure it gives equal priority to mental health and reducing health inequalities. They want to ensure that the new Integrated Care Boards take mental health as seriously as physical health and are accountable for tackling inequalities in their areas. In January 2022, they jointly produced a briefing with the Mental Health Foundation in support of amendments to the bill.

In February, it was confirmed the Government will back an amendment from Baroness Finlay to the Health and Care Bill in the House of Lords. Dying people will be given an explicit legal right to healthcare for the first time in NHS history, requiring every part of England to provide specialist palliative care.

Health and Social Care Integration White Paper
On 09 February 2022, the Government published the health and social care integration white paper - Joining up care for people, places and populations. NHS Providers published a briefing which summarises its proposals for a single accountable person, shared outcomes, and increasingly pooled NHS and social care budgets at place level. It also sets out initial analysis of the implications for Trusts.

Each place is expected to have a single person accountable for delivering shared outcomes at place level by Spring 2023 (either an individual with a dual role across health and care, or an individual lead for a place-based governance arrangement), and a "significant and, in many cases, growing proportion of health and care activity and spend" overseen and funded through the place-based partnership.

Following the publication of this white paper, the Government will work with stakeholders to develop a framework with a focused set of national priority outcomes and an approach which places can use to develop and agree additional local priority outcomes. Implementation of shared outcomes will begin from April 2023, and there will be mandatory reporting against them.

Ethnic Inequalities in Healthcare: A Rapid Evidence Review
On 14 February 2022, the NHS Race and Health Observatory published a rapid review into ethnic health inequalities across a range of areas including key priorities set by the independent health body. The report highlighted ethnic inequalities in access to, experiences of, and outcomes of healthcare as longstanding problems in the NHS, and are rooted in experiences of structural, institutional, and interpersonal racism. This report is the first of its kind to analyse evidence of ethnic health inequality through the lens of racism. The university-led rapid review focussed on priorities set by the Observatory relating to ethnic inequalities in mental health, maternal and neonatal health, digital access, genetic testing and genomic medicine and the NHS workforce.

New Maternity Disparities Taskforce
On 23 February 2022, the Government announced a new taskforce to level-up maternity care and tackle disparities. Maria Caulfield, Minister for Patient Safety and Primary Care, and Professor Jacqueline Dunkley-Bent OBE, Chief Midwifery Officer, have established the Maternity Disparities Taskforce which will tackle disparities in maternity care experienced by women from ethnic minority groups and those living in deprived areas.

This comes as data shows black women are 40% more likely to experience a miscarriage than white women, and deprived areas can have higher rates of still births. The Government has taken action to halve the rate of stillbirths, neonatal deaths, maternal deaths, and brain injuries by 2025. The latest figures show the stillbirth rate has reduced by over 25% since 2010 and the neonatal mortality rate has reduced by 29%, surpassing the ambition for a 20% reduction by 2020. However, while progress has been made, disparities continue to persist and the reasons for which remain unclear.

The taskforce will identify the barriers faced and how the Government can continue to improve care to further reduce the number of stillbirths and maternal deaths. It will seek to do so by looking to consider and support evidence-based interventions for the following areas:

- Improving personalised care and support plans for mothers
- Addressing how wider societal issues impact maternal health, working with experts in other Government departments
- Improving education and awareness of pre-conception health when trying to conceive, such as taking supplements before pregnancy and maintaining a healthy weight
- Increasing access to maternity care for all women and developing targeted support for women from the most vulnerable groups
- Empowering women to make evidence-based decisions about their care during pregnancy such as the development of a new digital framework, which provides women with support to make informed decisions during labour

NHS Chief People Officer
On 01 March 2022, NHS England announced Prerana Issar, NHS Chief People Officer, will be stepping down from her role. Prerana has been instrumental in setting up the NHS England and NHS Improvement People Directorate, becoming our first Chief People Officer and creating the NHS People Plan. Prerana has made an important contribution to developing an inclusive and diverse culture within the NHS as a whole; leading important developments in this area while also leading the People Directorate through the pandemic. Em Wilkinson-Brice will continue as Acting Chief People Officer during this interim period.

New COVID Recovery Trial Results
On 03 March 2022, The RECOVERY Trial (Randomised Evaluation of COVID-19 Therapy) announced that baricitinib, an anti-inflammatory drug normally used to treat rheumatoid arthritis, reduces the risk of death when given to hospitalised patients with severe COVID-19. The benefit was in addition to those of dexamethasone and tocilizumab, two other anti-inflammatory treatments which have previously been shown to reduce the risk of death in these patients.

Race 2.0 – Time for Real Change
On 10 March 2022, NHS Providers publish Race 2.0 - Time for real change, highlighting the scale and scope of the challenge to improve racial equality across the NHS, alongside the commitment of Boards, Trust leaders and NHS Providers to drive real change in this area. The report highlights Trust leaders' views on what constitutes good practice. Ten key priorities were identified, including: building closer engagement with staff and community networks, fostering safe spaces, better education, focusing on personal values and behaviours, and openly challenging discrimination.

Further COVID Vaccination Booster Campaign
The Government have confirmed people aged 75 years and older, residents in care homes for older people, and those with weakened immune systems will be offered a spring booster of the COVID-19 vaccine. Appointments will be available from the National Booking Service shortly.

Local Relevance

Vaccination as a Condition of Deployment
On 31 January 2022, Sajid Javid, Secretary of State for Health and Social Care, announced the regulations making vaccines a condition of deployment for health and social care staff are set to be revoked, subject to public consultation and Parliamentary approval. The Government are reconsidering the legislation requiring vaccination as a condition of deployment and a further review is to be undertaken. This means that the regulations will not be implemented from 01 April 2022.

While the legal requirement on deployment is set to be revoked, those working in health and social care still have a professional duty to get vaccinated and have their booster. The Government will work closely with Royal Colleges and professional regulators to strengthen guidance and consult on updates to the Department of Health and Social Care's Code of Practice for regulated providers to strengthen the requirements in relation to COVID-19.

Locally, vaccinations and boosters continue to be available for staff at locations across the county. We will not be taking any further actions relating to vaccination as a condition of deployment until the outcome of the review has been confirmed. However, 96% of all our staff at DCH have been fully vaccinated; one of the highest vaccination rates in the country.

Elective Recovery
On 08 February 2022, the Delivery plan for tackling the COVID-19 backlog of elective care was published by NHS England and NHS Improvement. The plan was developed with expert contributions from a wide range of partners, to set out a progressive agenda for how the NHS will recover elective care over the next three years. The plan focuses on restoring elective performance in the longer term including expanding capacity, a reduction in waiting times, and transforming the delivery of care to reduce the elective backlog. It details how the NHS will take the opportunity to capitalise on current success and embed new ideas to ensure elective services are fit for the future.

As part of the Elective Recovery Programme, recovery, on 17 February 2022, Sir James Mackey, National Director of Elective Recovery NHS England & Improvement, announced a web based My Planned Care Patient Platform has been developed at pace to create the opportunity to provide patients with:

- Information specific to a range of conditions to enable a better understanding of supporting their own health while on the waiting list
- Waiting list information to enable people to better understand how long they may be waiting.

The platform will initially comprise 137 acute hospital sub-sites where people can find information relating to their elective care. The platform will host local support information developed within each Trust ensuring that people have access to guidance and support recommended by local clinicians and approved through each Trust's clinical governance processes. It will also include information on the waiting times for each acute provider.

The initial version of the My Planned Care NHS platform went live on 24 February 2022, with Sir James Mackey asking for Trusts support in ensuring that the platform provider specific clinical content is complete by 31 March 2022. Information pertaining to DCH can be found here.

COVID-19 Response: Living with COVID
On 23 February, the Government released its Living with COVID-19 plan. The document sets out how the Government has and will continue to protect and support citizens by enabling society and the

economy to open more quickly than many comparable countries; using vaccines; and supporting the NHS and social care sector. It also sets out how England will move into a new phase of managing COVID-19.

The global pandemic is not yet over, and the Government's Scientific Advisory Group for Emergencies (SAGE) is clear there is considerable uncertainty about the path that the pandemic will now take in the UK. The document therefore also sets out how the Government will ensure resilience, maintaining contingency capabilities to deal with a range of possible scenarios.

In response to the Government's living with COVID-19 plan, David Finch, Assistant Director of Healthy Lives at the Health Foundation, suggested the Government's overriding principle in launching this plan appears to be the need to reduce public spending on the management of COVID-19. Acknowledging this is understandable given the huge resources that have gone into the pandemic and the pressing need for major investment across public services as the country recovers but warns the right balance of support is needed.

Locally, Sam Crowe, Director of Public Health for Dorset, said the latest national announcements signal a new phase of the pandemic as we learn to live safely with COVID-19, but stressed the importance of remembering the virus has not gone away. Whilst we are in a much better place now, there are still risks, particularly for those who are more vulnerable to the virus, and we need to remain cautious for a while longer. Those who test positive will continue to be advised to self-isolate for five full days and then follow the guidance until they have received two negative test results on consecutive days.

The Humanitarian Crisis in Ukraine

The news has been dominated with the Russian invasion of Ukraine since 24 February 2022. Sajid Javid, Secretary of State for Health and Social Care, released a statement that he is appalled by the atrocities we have seen in Ukraine and the despicable attacks being carried out on innocent civilians. He is proud that the UK is offering lifesaving medical care to Ukrainian children, who have been forced out of their home country by the Russian invasion while undergoing medical treatment.

On 13 March 2022, the Government announced it brought 21 Ukrainian children with cancer to receive care through the NHS. The children will undergo an assessment to understand their specific health needs before getting treatment at an appropriate NHS hospital. The vital and in many cases lifesaving cancer treatment will be provided free of charge by the health service across hospitals in England. This intervention is part of the Government's wider humanitarian response to the Ukraine conflict with more than 650,000 medical items already delivered to Ukraine. Amanda Pritchard, NHS England Chief Executive, said the situation in Ukraine is deeply shocking and saddening, and the NHS will continue to help in any way it can, whether that is by working with Government to provide medical supplies directly to Ukraine, or in this instance, by making sure these children with life-threatening cancers get the crucial treatment they need.

The National Cyber Security Centre (NCSC) urged organisations in the UK to bolster their cyber security resilience in response to malicious cyber incidents as a result of the ongoing situation in Ukraine. Locally, we have no immediate concerns, we provided assurance to the national teams that we are up to date with our security stance, and we are comfortable that our backups are not infected and therefore viable if required.

We understand it may be a difficult and worrying time for our colleagues at DCH who have family members and loved ones in Ukraine and continue to remind our staff of the support we have available at the Trust. We have a dedicated Health and Wellbeing Section on StaffNet and on our public website. This includes a wealth of information on a variety of support services, including 24-hour telephone support with Vivup, on-site counselling and a self-assessment tool.

Climate Change Report – NHS Providers

In February 2022, NHS Providers published a report on climate change highlighting the central role the NHS has in efforts to reduce carbon emissions and respond to the sustainability agenda more broadly, harnessing its considerable economic and social value, and the support and enthusiasm of its

workforce. The report suggests Trust leaders should consider how their Boards can obtain, and access, sufficient experience, and expertise in this area. The report urges ownership across Trust's leadership and embedding this as 'business as usual' within organisations.

Locally, we have been continually improving the environmental performance of the Trust. Working within the Integrated Care System, we will be at the heart of improving the wellbeing of our communities, and will be in a strong position to achieve the NHS's net zero carbon targets as set out in our Green Plan 2022/23 - 2024/25. We have Sustainability Champions who help promote sustainability in the areas they work in. Thanks to them we are achieving amazing things like reducing unnecessary plastic in our procedural packs, saving electricity by turning equipment off when it is not in use and re-homing thousands of pounds worth of equipment to prevent it from going to landfill.

In early February, the main contractor on the Dorset County Hospital construction project, Willmott Dixon, donated 600 tree whips to be planted in the new community woodland at Kings Road in Dorchester. Willmott Dixon team members helped to plant the whips during a morning alongside staff from Dorchester Town Council and volunteers from People First Dorset, Employ My Ability, The GAP Ecotherapy Project, Thomas Hardye School and Dorset Mind. Willmott Dixon has pledged to plant more than 10,000 trees a year over the next decade.

Draft Terms of Reference of the COVID-19 Public Inquiry

In Autumn 2021, the Government announced there was to be a national public inquiry into the pandemic. The Rt Hon Baroness Heather Hallett DBE was appointed as Chair of the Public Inquiry into the COVID-19 pandemic in December 2021 with the scope of the inquiry expected to be published in the spring 2022.

The Trust's response to the announcement of the national inquiry was to establish a task and finish group, led by the Chief Operating Officer with key senior membership from corporate support services and clinical services, to consider preparations for the Trust's possible involvement and to ensure that relevant records were preserved. A Term of Reference for the COVID task Group was agreed in December 2021. Whilst the Trust has implemented arrangements to preserve the relevant records contained within key digital accounts where staff had left the Trust, it has not been possible to significantly progress other areas of the Task Group's work programme until the scope of the inquiry was made known.

On 10 March 2022, the draft terms of reference for the inquiry were published outlining the aims of the inquiry:

- To examine the response and impact of the pandemic across the four UK nations in order to provide a factual account.
- To identify lessons learned in order to inform preparations for any future pandemics.

No timescales have yet been outlined other than a consultation of the inquiry terms of reference closes on 07 April 2022, comments can be submitted online, and Public Hearings will commence in Spring 2023.

Locally, the inquiry draft Terms of Reference will be discussed by the COVID Task Group in order to more fully develop response plans and is provided to senior leadership groups within the Trust and the Board of Directors for information and comment. The task group will identify any additional resources required to deliver the Trust's response to the inquiry and ensure that staff involved in the process are adequately supported. The task group has no decision-making authority and recommendations from the group will be presented to the Senior Leadership Group for a decision

NHS England Chief Executive Visit to University Hospitals Dorset

In February, I was able to attend University Hospitals Dorset, to meet Amanda Pritchard, NHS Chief Executive, and system colleagues as part of an opportunity to showcase the innovative and collaborative work underway across the Dorset system. Amanda had a tour of the Dorset Cancer Centre at Poole Hospital and was impressed by the Dorset Health Village.

Secretary of State for Health and Social Care Visit to the South West Region
In February, Sajid Javid, Secretary of State for Health and Social Care, visited the South West region to see how it's tackling the COVID backlog as part of his 'Road to Recovery' tour. Staff at University Hospitals Dorset were invited to talk about how the facility is playing as a vital part in tackling hospital waiting lists as well as increasing the volume of life-saving screening as part of Dorset's Think Big initiative.

NHS Digitalisation
On 24 February 2022, Sajid Javid, Secretary of State for Health and Social Care, set the NHS several new technology targets including a push to get 90% of all Trusts on to Electronic Patient Records (EPRs) by the end of 2023. The remaining 10 percent of Trusts without EPRs must be in the implementation phase by December 2023. He also requested for 75% of all adults in England to have downloaded the NHS App by March 2024. Locally, all health organisations across the Dorset system already have EPRs.

In addition, Tim Ferris, Transformation Director for NHS England, has requested that all Integrated Care Systems (ICSs) are to set out detailed plans for a single or 'converged' EPR. Very few ICSs comprise Trusts which all use the same EPRs, and many ICSs have Trusts which use a lot of different patient record systems across their hospitals. Locally, this may be more of a challenge to achieve with partner organisations in the system using different platforms.

Dorset HealthCare CEO Arrangements
Eugine Yafele, Chief Executive of Dorset HealthCare, is leaving to take up a new role as Chief Executive of University Hospitals Bristol and Western NHS Foundation Trust the end of April. From May, Dawn Dawson, Director of Nursing, Therapies and Quality, will become Acting Chief Executive, pending the recruitment of a permanent successor to Eugine.

Dorset ICS Update
Patricia Miller commenced in her role as Chief Executive Designate of the Dorset Integrated Care Board (ICB) on 01 February 2022. The development of the ICB and Integrated Care Partnership continue with a strong focus on the recruitment of Non-Executive Directors and Executive Directors and developing the governance and accountability structure.

DCH Performance

Operational Performance
The organisation continues to feel the impact of an increasing COVID wave which is further impacting on staffing and bed availability, as well as exacerbating the shortages in community and social care, further reducing our ability to discharge people to other care settings. We have had to step down elective activity and continue to use day surgery for inpatients. Lots of work is going on to alleviate the immediate pressures; we have stepped up our incident management arrangements, with a dedicated workforce cell, and we will continue to proactively manage the incident internally and with our health and care partners. Our teams have gone above and beyond in response to this latest wave, we continue to stress the importance of good Infection, Prevention, and Control measures, the need for rest where possible and access wellbeing support if needed.

Ian Mew – On Big Thank You
On 24 February 2022, Dr Ian Mew, Consultant Anaesthetist, was on BBC's The One Show in a surprise interview with Hairy Bikers star Dave Myers regarding his incredible work at DCH, Dorset and Somerset Air Ambulance and Doc Bike.

This month we launched our Your Future Hospital programme public engagement We are sharing the latest plans for our site development with you and the wider community to get feedback before we submit an outline planning application to Dorset Council.

Emergency Department Refurbishment
The refurbishment of the Emergency Department (ED) is progressing well, with two new clinical areas now in use. The alterations, carried out by Willmott Dixon Construction, include two extensions - one in the courtyard at the rear of ED and one at the front entrance - as well as refurbishment of the existing ED. It will provide a new entrance and waiting area, larger resuscitation rooms, bigger cubicles, and many other improvements. The two new areas are now in use, offering bigger cubicles, more space and new medical equipment. Work is still underway and being carried out in stages to minimise disruption and make sure the ED remains open 24/7.

2021 Maternity Survey
Our Maternity Unit has been recognised as one of the best in the country in the latest national survey results. The 2021 Maternity Survey, published by the Care Quality Commission, summarises the experiences of over 23,000 women who gave birth during January and February 2021. This was during the third COVID-19 national lockdown, so the survey results this year reflect women's experiences of care during the pandemic.

As well as delivering individual hospital reports, the CQC publishes a report which focuses on variation in results for care during labour and birth. We were identified as performing 'better than expected'. This is because the proportion of women who answered positively to questions about their care during labour and birth was significantly above the national average. We performed the same or better than other hospitals in all the survey categories. Particularly high scores were achieved for treating people with respect and dignity, having trust and confidence in staff, and the cleanliness of the environment.

Inclusive Leadership Programme
Ebi Sosseh, Trust Inclusion Lead, is building on the foundations of our Inclusive Leadership Programme to make 'Let's Talk Inclusion' a regular campaign across the Trust. The aim is to create a culture of discussion and information sharing around belonging and maximising the potential of every member of staff.

Voluntary Veterans Network
We have relaunched the Voluntary Veterans Network as the new Armed Forces Community Network which is open to all Trust employees that support the Armed Forces community. The group is a safe, supportive, and confidential forum for sharing experiences, networking, and discussing identified issues that affect members of staff and their families from the Armed Forces Community across the Trust.

New Mural in the Diabetes Centre
Staff at our Diabetes Centre have for some time been asking for a Mural to brighten up their waiting area. In order to fulfil this request, we worked with Weymouth College to find a Fine Art degree student who was able to fulfil the brief. The brief was to create a large-scale painting at DCH's Diabetes Centre with a positive feel, encouraging activity and heathy living and using only water-based paints in order to meet fire safety requirements. We were lucky enough to find Fronde Crennell, a mature student who has completely immersed herself in Arts in Hospital activity over the past few months, volunteering with a couple of exhibition changeovers and generally seeing how and why we work.

NHP Visit Dorset
On 17 March 2022, we welcomed the national New Hospital Programme (NHP) team to DCH as part of their tour of Dorset. The NHP is the national initiative aiming to deliver 40 'new' hospitals and DCH has been allocated approximately £77m to build a new Emergency Department and Critical Care Unit. The visit was an opportunity to showcase the real need for the investment and the brilliant work that is going into developing the plans and the business case.

Nick Johnson
Interim Chief Executive
22 March 2022

Meeting Title:	Board of Directors
Date of Meeting:	30 March 2022
Document Title:	**Recovery Overview**
Responsible Director:	Nick Johnson, Interim Chief Executive
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**
Interim Chief Executive	23/03/2022	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: People Recovery • The People Recovery Steering Group meet this month and discussed several items including the prioritisation of safe rest spaces for staff, wellbeing walk arounds, external coaching provision, Dignity and Respect training, and access to wellbeing offers. • The organisation saw a decrease in the overall sickness percentage in January by 0.06% to 4.79%. • The top reason for absence in January remained Anxiety/Stress/Depression. This was followed by Infectious diseases (which includes COVID-19). This was not unexpected with 146 confirmed staff COVID-19 positive cases in January. • The on-site counselling service remains a busy service with continued uptake from staff. The present waiting time for routine onsite counselling has reduced further, to seven days. All urgent staff cases were seen within 24 to 48 hours of contact. Service Recovery • The organisation did not achieve the 89% target to meet the Elective Recovery Fund in February. • There is a direct correlation between the volume of no reason to reside patients and a decline in elective clock stopping activity. This is most apparent since January, where the volume of no reason to reside patients has exceeded 50 daily. • February's referral to treatment waiting list data indicates 56.08% of patients who identify as white are treated within 18 weeks. 54.41% of from an ethnic minority are treated within 18 weeks. • Work continues to analyse waiting list data for those patients from an ethnic minority or with a learning difficulty. • In February the total waiting list size increased by 401 patients compared to the previous month. This takes the total waiting list size to 5,278 below trajectory. • At the end of February, there were 1,719 patients waiting over 52 weeks for treatment. This is a decrease of 14 patients compared to the previous month and is 81 fewer than trajectory. • At the end of February, there were 211 patients waiting over 104+ weeks, this is 7 patients less than trajectory.							

	This is the final report for 2021/22 and therefore a request for approval is being sought to cease the production of this report for Trust Board meetings. The recovery reporting is now embedded into both the People and Culture Committee and Finance and Performance Committee who will escalate to Trust Board if necessary.
Action recommended	The Trust Board is recommended to: 1. **NOTE** the information provided. 2. **DISCUSS** and **APPROVE** the proposal to cease the production of this report from 2022/23.

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	30 March 2022
Report Title	**Recovery Overview**
Author	Natalie Violet, Corporate Business Manager to the Chief Executive
Responsible Executive	Nick Johnson, Interim Chief Executive

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 and is requesting approval cease the production of this report for Trust Board meetings. The recovery reporting is now embedded into both the People and Culture Committee and Finance and Performance Committee who will escalate to Trust Board if necessary.

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 focus of the 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.

Operational matters which cannot be satisfactorily resolved at local department level or through the appropriate channels and procedures can be referred to the People Recovery Steering Group if necessary.

The last meeting took place in March 2022 and items discussed during the meeting included:

- The benefits and need to prioritise safe rest spaces for staff and the impact on health and wellbeing should the withdrawal of free hot drink from the canteen go ahead as planned.
- A timetable for a safe relaunch of wellbeing rounds, prioritising areas based on 'hot spot' and people pulse feedback and following discussion with Divisions. The relaunch will need to be approved by the Incident Management Team.
- Ensure the requirement for external coaching provision for senior managers in included in the wider coaching proposal for DCH

- The communication and roll out plan for the mandatory Dignity and Respect at work course for bands 2-6 and devise roll out plan.
- Offering an online course (such as the MerseyCare Respect and Civility Awareness course) to band 7 and above to compliment the content within the Inclusive Leadership Programme.
- Arrange a task and finish group to align all elements of our wellbeing offer, including counselling and Employee Assist Programme provision, to ensure that staff access the right support at the right time.
- Ensuring pertinent elements of the wellbeing intranet site can be accessed via the internet and the need to review the feasibility of DCH or system wellbeing App.
- The need to provide the onsite counselling service with a leaflet outlining the various ways in which staff can raise patient care/safety concerns so that he can provide this to staff when issues of this nature are raised during counselling.

The next meeting is scheduled for early May 2022.

Looking After Our People
The organisation saw a decrease in the overall sickness percentage in January by 0.06% to 4.79%. There was a further reduction in long term sickness of 0.79% to 2.09%. This was mirrored across all Divisions. Of the seven Divisions, four Divisions saw a decrease in overall sickness levels including the Family and Surgical Services Division. The top reason for absence in January remained Anxiety/Stress/Depression. This was followed by Infectious diseases (which includes COVID-19). This was not unexpected with 146 confirmed staff COVID-19 positive cases in January.

The on-site counselling service remains a busy service with continued uptake from staff. 198 sessions were delivered in February to 92 members of staff, with 69% of staff seen receiving two or more support sessions. The present waiting time for routine onsite counselling has reduced further, to seven days. All urgent staff cases were seen within 24 to 48 hours of contact.

4.0 Service Recovery

Elective Recovery Fund (ERF)
For the second half of 2021/22, the planning 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. This will be covered in the financial report, below is the volume of clock stops as this is what impacts the performance KPI's of the waiting list.

A clock stop is where the patient is either treated or discharged and therefore is no longer on the incomplete waiting list. DCH performances well when monitored against the volume of clock stopping events.

Activity type	Target from Oct	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Clock stops	89%	94.68%	92.76%	102.82%	85.96%	97.10%	99.82%	90.20%	106.61%	108.27%	90.36%	85.88%

Table 1 – percentage of clock stops, by month

Further analysis of clock stopping activity, when split by non-elective (outpatients) and elective (day case and inpatients) shows year to date, DCH has delivered 97.63% of non-elective clock stops in 2021/22 compared to 2019/20, yet 90.64% of elective clock stops. There is a direct correlation between the volume of no reason to reside patients and a decline in elective clock stopping activity. This is most apparent since January, where the volume of no reason to reside patients has exceeded 50 daily.

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. February's referral to treatment waiting list data indicates 56.08% of patients who identify as white are treated within 18 weeks. 54.41% of from an ethnic minority are treated within 18 weeks. There are 204 patients of the total waiting list from ethnic minorities, 1.19%.

February's diagnostic waiting list data indicates 89.63% of patients who identify as white have their diagnostic procedure completed within 6 weeks. 93.33% of patients from ethnic minorities have their diagnostic procedure completed within 6 weeks. There are 45 patients of the total waiting list from ethnic minorities, 0.92%.

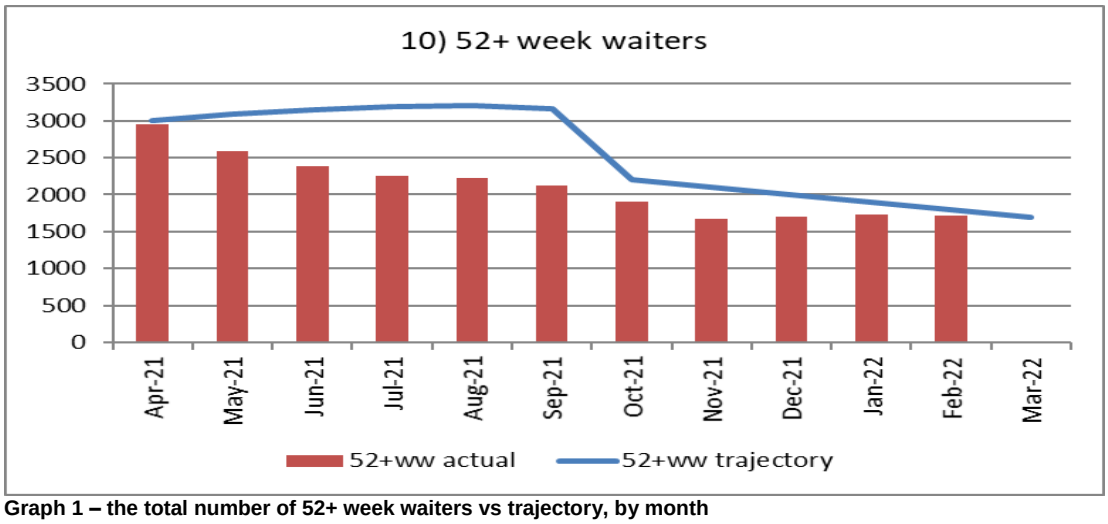
There are several patients with an unknown ethnicity recorded on our Patient Administration System (PAS). Our Information Assurance Team continue to work with services to improve the collection of ethnic group data on PAS.

We are now able to identify patients on our waiting lists with a learning disability flag. There are 131 patients on the referral to treatment waiting list with a learning disability flag. 62.60% of these patients have been treated with 18 weeks in February 2022, this compares to 56.76% for patients without a learning disability flag. There are 24 patients on the diagnostic waiting list with a learning disability flag. 87.50% of these patients have had their diagnostic procedure within 6 weeks in February 2022, this compares to 89.52% for patients without a learning disability flag.

BI Teams across the system are working on automated reporting for deprivation waiting times.

Elective Waiting List Size
In February the total waiting list size increased by 401 patients compared to the previous month. This takes the total waiting list size to 5,278 below trajectory.

At the end of February, there were 1,719 patients waiting over 52 weeks for treatment. This is a decrease of 14 patients compared to the previous month and is 81 fewer than trajectory.



Graph 1 – the total number of 52+ week waiters vs trajectory, by month

As part of the second half of 2021/22 planning submission, a 104+ week wait trajectory was also required. At the end of February, there were 211 patients waiting over 104+ weeks, this is 7 patients less than trajectory.

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 trajectory REVISED										210	218	227
104+ww actual	20	41	70	91	117	161	189	185	216	202	211	
Variance	20	41	70	91	117	161	20	-7	1	-8	-7	

Table 2 – total number of 104+week waiters vs trajectory, by month

The latest performance by provider can be found in Appendix A, the slide was taken from the Regional Recovery Steering Group pack on 19 March 2022.

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.

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 reduction in waiting list size and those patients waiting beyond 52 weeks compared to 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.

Unfortunately, the organisation is currently feeling the impact of an increasing COVID wave which is further impacting on staffing and bed availability, as well as exacerbating the shortages in community and social care, further reducing our ability to discharge people to other care settings. We have had to step down elective activity and continue to use day surgery for inpatients. Lots of work is going on to alleviate the immediate pressures; we have stepped up our incident management arrangements, with a dedicated workforce cell, and we will continue to proactively manage the incident internally and with our health and care partners. Our teams have gone above and beyond in response to this latest wave, we continue to stress the importance of good Infection, Prevention, and Control measures, the need for rest where possible and access wellbeing support if needed.

6.0 Future Reports

This is the final report for 2021/22 and therefore a request for approval is being sought to cease the production of this report for Trust Board meetings. The recovery reporting is now embedded into both the People and Culture Committee and Finance and Performance Committee who will escalate to Trust Board if necessary.

Latest Performance by Provider

		Bath And North East Somerset, Swindon And Wiltshire STP			Bristol, North Somerset And South Gloucestershire STP			Cornwall And The Isles Of Scilly Health & Social Care Partnership (STP)		Devon STP				Dorset STP				Gloucestershire STP		Somerset STP		South West
		Great Western Hospitals NHS Foundation Trust	Royal United Hospitals Bath NHS Foundation Trust	Salisbury NHS Foundation Trust	Avon and Wiltshire Mental Health Partnership NHS Trust	North Bristol NHS Trust	University Hospitals Bristol and Weston NHS Foundation Trust	Cornwall Partnership NHS Foundation Trust	Royal Cornwall Hospitals NHS Trust	Northern Devon Healthcare NHS Trust	Royal Devon and Exeter NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospitals Plymouth NHS Trust	Dorset County Hospital NHS Foundation Trust	Dorset Healthcare University NHS Foundation Trust	South Western Ambulance Service NHS Foundation Trust	University Hospitals Dorset NHS Foundation Trust	Gloucestershire Health and Care NHS Foundation Trust	Gloucestershire Hospitals NHS Foundation Trust	Somerset NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust	
Diagnostics	Jan-22	45.9%	37.9%	2.4%		45.4%	39.5%	82.2%	39.1%	60.8%	41.5%	41.3%	29.2%	17.1%	31.3%		18.3%		20.9%	33.5%	23.0%	35.8%
A&E 4 Hour Performance (exc. pilot sites)	Feb-22	76.7%	61.9%	76.3%		51.5%	64.8%		78.8%	71.8%	67.2%	60.5%		64.7%		97.9%		99.5%	58.6%	79.7%	88.3%	70.4%
A&E 12 Hour Trolley Waits (inc. pilot sites)	Feb-22	77	1	0		367	844	0	577	9	65	123	274	11	0	0	52	0	394	83	0	2,877
RTT 18 Week Performance (Incomplete)	Jan-22	60.1%	64.2%	68.8%		65.6%	58.7%	94.5%	66.5%	59.1%	51.8%	55.5%	61.8%	55.8%			60.9%		71.0%	60.3%	65.9%	61.4%
RTT Total Waits (Incomplete)	Jan-22	28,338	31,579	18,826		37,210	53,909	770	35,804	17,750	64,848	34,123	40,345	16,717			53,148		57,721	31,995	11,110	533,993
RTT 52 Week Plus (Incomplete)	Jan-22	626	1,286	662		2,284	3,599	0	1,400	1,300	5,942	2,572	2,994	1,730			2,775		1,266	1,692	700	30,826
RTT 52 Week Plus (Incomplete) - % of Total WL	Jan-22	2.2%	4.1%	3.5%		6.1%	6.7%	0.0%	3.9%	7.3%	9.2%	7.5%	7.4%	10.3%			5.2%		2.2%	5.3%	6.3%	5.8%
RTT 104 Week Plus (Incomplete)	Jan-22	0	4	7		184	336	0	44	15	633	182	488	202			295		1	131	22	2,544
RTT 104 Week Plus (Incomplete) - % of Total WL	Jan-22	0.0%	0.0%	0.0%		0.5%	0.6%	0.0%	0.1%	0.1%	1.0%	0.5%	1.2%	1.2%			0.6%		0.0%	0.4%	0.2%	0.5%
Cancer 2 Week Wait Performance (All Suspected)	Jan-22	90.4%	72.0%	77.4%		41.4%	71.0%		76.6%		67.1%	45.9%	83.0%	52.5%			62.5%		87.2%	66.1%	69.5%	68.9%
Cancer 2 Week Wait Performance (Breast Symptoms)	Jan-22	90.0%	89.2%	26.2%		6.9%			1.1%		15.8%	38.6%	37.1%	65.2%			15.4%		89.7%	22.5%	89.8%	44.1%
Cancer 31 Day Wait Performance (First Treatment)	Jan-22	86.3%	88.3%	96.9%		79.2%	91.1%		97.7%		92.0%	94.9%	93.8%	97.1%			96.2%		94.2%	89.6%	87.0%	91.9%
Cancer 31 Day Wait Performance (Surgery)	Jan-22	90.0%	85.7%	100.0%		55.7%	73.5%		90.9%		75.6%	96.9%	83.7%	100.0%			86.8%		88.2%	91.7%	78.6%	81.1%
Cancer 31 Day Wait Performance (Drug)	Jan-22	94.4%	85.7%	100.0%		92.3%	97.3%		100.0%		97.2%	100.0%	98.8%	97.5%			100.0%		99.4%	100.0%	100.0%	98.8%
Cancer 31 Day Wait Performance (Radiotherapy)	Jan-22		96.8%				97.9%		100.0%		97.7%	97.2%	98.8%				98.5%		99.4%	93.6%	100.0%	98.0%
Cancer 62 Day Wait (Consultant Upgrade)	Jan-22	75.0%	100.0%	75.9%		83.3%	86.2%		44.4%	100.0%	81.3%	100.0%	72.3%	82.5%			71.4%		75.0%	83.1%	93.5%	81.0%
Cancer 62 Day Wait (Screening)	Jan-22	87.0%	64.0%	23.5%		50.0%	39.1%		74.4%		33.3%	80.0%	70.4%	61.3%			85.2%		85.9%	72.4%	77.8%	70.4%
Cancer 62 Day Wait (Standard)	Jan-22	83.2%	55.4%	82.8%		56.9%	68.1%		86.7%	0.0%	64.0%	57.9%	66.2%	58.3%			71.6%		65.8%	60.8%	70.0%	67.4%
Cancer 28 Day Faster Diagnosis	Jan-22	68.0%	65.7%	70.5%		47.1%	70.0%		68.2%		74.0%	54.6%	72.7%	66.7%			60.0%		76.5%	70.3%	72.2%	68.0%

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**30th March 2022**
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)	22nd March 2022	See committee escalations

Purpose of the Paper	To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance Scorecard** The reporting month of February 2022 continued to experience significant patient flow restrictions. The number of patients with no reason to reside exceeded a daily average of over 60, with some days exceeding 80. This, combined with increased covid rates, has led to further deterioration of the 4-hour emergency standard. The impact of the continued increase of no reason to reside is felt throughout the hospital, with elective inpatient and day case activity falling. Day surgery areas continue to be used as a ward and at times throughout the month, it has not been possible to decant day surgery from the night before, resulting in theatre cancellations. Despite the flow challenges, the trust continues to perform well in cancer and achieved the waiting list size trajectories. The trust has also recovered diagnostic performance, following a short-term staffing gap, caused by non-covid related sickness. Ambulance handover delays, while increasing, still remains one of the best performers in the South West. NHS England has announced a three-tier oversight and support framework for providers that have been identified as at risk, for 104+ elective week waiters. Providers in tier one will have a weekly meeting with the Secretary of State and those in tier 2 and 3, a lower level of scrutiny, managed by the Regional NHS England team. DCH has one of the highest proportions of long waiters, against the size of the total waiting list, but has consistently delivered month-on-month improvement and on the trajectory. As a result, DCH has not been put in any of the three tiers, a significant statement of confidence in our recovery to date. **Escalation Reports** The March Board sub-committees met as follows: Monday 21st March: People and Culture Committee Tuesday 22nd March: 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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Q1	Q2	Q3	Q4	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	5 (0.6)	3 (0.3)	6 (0.7)	6 (0.6)	4 (0.4)	3 (0.2)	9 (0.4)	12 (0.5)	15 (0.5)	7 (0.3)	43 (0.4)	↑	
NEW Harm Free Care (Safety Thermometer)	**95%**	Local Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**N/A**	
Never Events	**0**	Contractual (National Requirement)	0	0	1	0	0	0	0	0	1	0	1	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	0	0	1	0	0	0	2	1	0	3	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	9	10	9	3	5	3	26	23	22	8	79	**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	0	1	3	0	2	0	6	6	4	2	18	↑	
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)	2 (0.2)	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	1 (0.0)	1 (0.0)	2 (0.0)	1 (0.0)	4 (0.1)	↑	
Emergency caesarean section rate			21.5%	23.0%	15.9%	24.4%	23.1%	21.7%	22.6%	N/A	20.1%	15.9%	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)	88.6%	68.1%	N/A	N/A	N/A	N/A	95.0%	90.3%	68.1%	N/A	88.5%	↓	
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)	87.5%	96.4%	87.2%	94.7%	100%	82.4%	92.6%	91.8%	93.2%	90.3%	92.4%	↓	
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%	60.5%	N/A	N/A	N/A	N/A	84.9%	86.6%	60.5%	N/A	80.3%	↓	
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)	100%	79.5%	87.1%	83.3%	100%	81.3%	87.5%	95.9%	83.0%	88.9%	88.7%	↓	
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	N/A	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 expected deaths)**	Contractual (Local Quality Requirement)	1.14	1.14	N/A	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)	100.6	102.1	103.7	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)	107.8	112.9	118.0	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	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)	49.6%	89.9%	90.2%	80.4%	83.4%	82.0%	58.3%	59.3%	86.8%	82.7%	70.3%	↓	
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)	83.7%	89.8%	98.0%	94.7%	100.0%	97.0%	80.9%	83.7%	94.2%	98.2%	91.6%	↓	
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	34	26	36	19	24	29	64	114	81	53	312	↓	
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	95.1%	93.1%	93.8%	93.5%	93.6%	91.6%	93.9%	94.0%	93.5%	92.6%	93.6%	↓	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	86.4%	86.2%	86.8%	87.9%	87.4%	80.4%	86.9%	85.0%	86.2%	86.8%	85.9%	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	93.3%	93.3%	93.8%	93.8%	94.6%	93.0%	93.6%	92.7%	93.6%	93.8%	93.4%	↓	
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	NA	

Metric	Threshold/ Standard	Type of Standard	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Q1	Q2	Q3	Q4	YTD	Movement on Previous Perior	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)	**56.5%**	**55.4%**	**56.1%**	**55.6%**	**55.8%**	**56.8%**	**56.4%**	**56.5%**	**55.4%**	**55.8%**	**55.4%**	↓	
RTT Incomplete Pathway Waiting List size	**Trajectory Feb-22 = 17608**		**19120**	**18773**	**17802**	17024	16727	17128	**17928**	**19120**	17024	17128	17128	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**59.7%**	**38.1%**	**52.9%**	**63.8%**	**52.5%**	**70.9%**	**67.0%**	**52.7%**	**51.2%**	**61.5%**	**57.5%**	↑	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**52.5%**	**7.0%**	**52.2%**	**61.8%**	**65.2%**	88.7%	**4.5%**	**24.2%**	**46.8%**	**76.6%**	**34.2%**	↑	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	98.5%	**92.3%**	96.9%	97.9%	97.1%	98.0%	96.1%	97.4%	**95.6%**	97.5%	96.5%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	**92.3%**	100.0%	100.0%	100.0%	100.0%	**83.3%**	**93.9%**	**93.8%**	100.0%	**93.8%**	95.2%	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	100.0%	100.0%	**97.4%**	**96.3%**	**97.5%**	100.0%	100.0%	100.0%	**97.6%**	98.6%	99.0%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	100.0%	-	-	-	-	-	-	100.0%	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**72.1%**	**70.7%**	**80.8%**	**63.1%**	**58.3%**	**63.1%**	**76.5%**	**72.2%**	**72.0%**	**60.9%**	**71.3%**	↑	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**70.6%**	**76.5%**	**71.4%**	**77.8%**	**61.3%**	**85.7%**	**65.7%**	**73.6%**	**75.0%**	**65.8%**	**69.7%**	↑	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**92.4%**	**94.8%**	**95.7%**	**91.2%**	**82.9%**	**89.5%**	**81.0%**	**87.8%**	**94.8%**	**82.9%**	**84.3%**	↑	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**64.0%**	**60.3%**	**61.5%**	**60.3%**	**59.8%**	**54.4%**	**75.2%**	**62.9%**	**60.3%**	**59.8%**	**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)	**76.3%**	**72.6%**	**74.0%**	**72.0%**	**69.6%**	**64.7%**	**82.9%**	**76.2%**	**72.6%**	**69.6%**	**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	**4.38%**	4.77%	4.79%	4.85%	4.79%	N/A	3.4%	4.38%	4.80%	4.79%	4.3%	↑	
Appraisal rate	**90%**	Internal Standard reported to FPC	**72%**	**72%**	**71%**	**69%**	**67%**	**67%**	**78%**	**74%**	**71%**	**67%**	**73%**	↔	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	7.6%	8.5%	8.1%	8.7%	9.0%	9.7%	8.0%	8.0%	8.40%	9.4%	8.4%	↓	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,819.8	2,837.0	2,875.4	2,881.0	2,881.6	2,908.1	2,790.6	2,791.7	2,864.5	2,894.8	2,830.0	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**6.6%**	**5.7%**	**5.3%**	**6.3%**	**6.8%**	**6.6%**	**7.4%**	**7.0%**	**5.8%**	**6.7%**	**6.7%**	↑	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**12,443.5**	**11,378.7**	**11,601.2**	**11,692.1**	**11,497.0**	**12,246.0**	**11,141.7**	**11,611.1**	**11,557.3**	**11,871.5**	**11,508.7**	↓	
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	**89%**	**89%**	**89%**	90%	91%	91%	**88%**	**89%**	**89%**	**91%**	**89%**	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,217**	**2,192**	**2,285**	**1,924**	**2,312**	**1,990**	**6,490**	**6,315**	**6,401**	**4,302**	**23,508**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£2,299,055**	**£2,127,545**	**£2,424,665**	**£2,080,224**	**£2,184,836**	**£2,090,209**	**£6,872,694**	**£6,635,041**	**£6,632,434**	**£4,275,045**	**£24,415,214**	↓	
Surplus/(deficit) (year to date)	**2021/22 = £349 YTD M11 = £(185)**	Local Plan	**(592)**	**(1,215)**	**(721)**	**(578)**	**(340)**	(125)	**(717)**	**(592)**	**(578)**	(125)	(125)	**N/A**	**N/A**
Cash Balance	**2021/22 - M11 = 14,365**		14,761	20,591	17,291	17,369	16,807	27,061	15,841	14,761	17,369	27,061	27,061	↑	
CIP - year to date (aggressive cost reduction plans)	**H2 target - £1,506 M10 target £1,004k**	Local Plan	N/A	231	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	N/A	N/A	N/A	Yet to be decided	N/A	**N/A**	**N/A**
Agency spend YTD	**2021/22 = No Annual value YTD M11 = £8,114**		**6,338**	**7,328**	**8,207**	**9,032**	**9,995**	**10,959**	**3,206**	**6,338**	**9,032**	**10,959**	**10,959**	**N/A**	**N/A**
Agency % of pay expenditure			**8.1%**	**7.5%**	**7.8%**	**7.7%**	**7.6%**	**7.6%**	**8.3%**	**8.4%**	**7.7%**	**7.6%**	**7.6%**	↔	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Rating Key

- **Achieving Standard**
- **Not Achieving Standard**

Key Performance Metrics Summary

	Metric	Standard	Jan-22	Feb-22
Quality	MRSA hospital acquired cases post 48hrs (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)
	E-Coli hospital acquired cases (Rate per 1000 bed days)	**81**	3 (0.3)	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	**4 (0.4)**	**3 (0.2)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	2	0
	SHMI - Rolling 12 months (**Nov-20 to Oct-21**)	**<1.14**	1.14	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (**Dec-20 to Nov-21**)	**100**	**103.7**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**55.8%**	**56.8%**
	RTT Incomplete Pathway Waiting List size	**Trajectory Feb-22 = 17608**	16,727	17,128
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**58.3%**	**63.1%**
	Maximum 6 week wait for diagnostic tests	**99%**	**82.9%**	**89.5%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**69.6%**	**64.7%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,184,836**	**2,090,209**
	Surplus/(deficit) (year to date)	**2021/22 = £349 YTD M11 = £(185)**	**(340)**	(125)
	CIP - year to date (aggressive cost reduction plans)	**H2 target - £1,506 M10 target £1,004k**	Yet to be decided	Yet to be decided
	Agency spend YTD	**2021/22 = No Annual value YTD M11 = £8,114**	**9,995**	**10,959**

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 21st February 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• The Oversea Staff Network had been launched • The need for recurrent revenue funding to support the delivery of digital capital schemes was escalated. • The Guardian of Safe Working Hours and Health and Wellbeing Reports were deferred until March 2022. • Discussion of the People Plan invited further consideration by members prior to discussion and approval of the plan by the Board of Directors in March 2022.

Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports:
	• People Performance Report and Dashboard noting increasing levels of sickness absence, the launch of the new Overseas Staff Network, a reduction in Appraisal compliance rates and an increase in Agency expenditure linked to an increase in Covid self-isolation.
	• Divisional Reports from:
	  ○ Family and Surgical Services Division noting the new dashboard format of the report.
	  ○ Business Intelligence / Health Informatics noting the need for recurrent revenue to support delivery of capital schemes
	  ○ Estates and Facilities noting the implementation of a number of service restructures and a reduction in the use of flexibly employed staff
	• Vaccination as a condition of Employment noting the excellent staff vaccination rate of 96%at DCH and no further action nationally pending further consultation.
	• The Health and Wellbeing Update was deferred to March 2022.
	• Education, Training and Development Update noted the challenges of providing adequate supervision and maintaining the supernumerary status of students
	• The Guardian of Safe Working Hours Quarter 3 Report was deferred to March 2022
	• Critical Care Recruitment Update
	• The Workforce Risk Report noted police involvement in a violence and abuse incident
	• Escalation Reports from the following subgroups:
	  ○ Local Medical and Dental Negotiating Committee

Decisions made by the Committee	• None

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

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 21st March 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• National Staff Survey Results – embargoed until 30th March 2022 • Guardian of Safe Working Hours Report • Gender Pay Report
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • People Performance Report and Dashboard noting increasing numbers of staff becoming unwell or isolated due to COVID, the importance of maintaining staff wellbeing at the current pressured time within services, improvements in the number of staff recommending DCH as a place to work and the need to consider further messaging to address patient / public harassment of staff. • The Health and Wellbeing Update noting funding for the Counselling service and a review of measures to more appropriately support / signpost staff. • Transforming People Practices Workstream Report • The Guardian of Safe Working Hours Quarter 3 Report • National Staff Survey Results above the national average across all nine themes • Committee Effectiveness Review noting that the Terms of Reference, Committee Priorities and annual work programme would be presented for approval in May 2022. • Escalation Reports from the following subgroups: ○ Partnership Forum
Decisions made by the Committee	• The Urgent and Integrated Care Divisional Report was deferred until April 2022 • The Safe Staffing Return was deferred until April 2022. • The Gender Pay Report was approved for submission and publication
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil new
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: 22nd February 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Maternity safety report and positive feedback from the CNST Maternity Incentive Scheme • Review of the draft Clinical Strategy • Quality and safety key performance metrics to be proposed at the next meeting • No falls resulting in severe harm or death • Learning from excellence roll out in the Trust

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Noted Trust remains on routine surveillance (no escalations low level monitoring) from the system Quality Surveillance Group
	  ○ The revised quality dashboard metrics would be submitted to the Committee in March for approval
	  ○ Overall quality and safety position remains consistent, although there was an increase in C.Diff locally
	  ○ Positive feedback re Emergency Department received from Dorset HealthWatch, awaiting final report
	  ○ No reason to reside continues to be a challenge and risk
	  ○ One grade 3 reportable pressure ulcer retrospectively reported
	• Maternity Safety Report noting
	  ○ Exploration underway re a system to provide second-hand phones to women who experience digital poverty
	  ○ Exploration underway of more environmentally friendly alternatives to Entonox
	  ○ 10% refund confirmed for the CNST Maternity Incentive Scheme
	  ○ Improvements in staff experience of using BadgerNet
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting improvements in typing times; updates on the action plan arising from the MHRA visit, noting close monitoring of this for assurance.; noted improvements in stroke standards
	  ○ Family and Surgical Services Division noting updates to a recent Never Event
	• Paediatric Peer Review Update provided, and assurance received
	• National Patient Strategy Update received
	• Draft Clinical Strategy - noting ongoing work to develop the strategy
	• Draft CQUINS 2022/23 as part of the CCG contract shared
	• Transformation Update
	• Sub-Committee Minutes and Escalations were noted from
	  ○ Infection Prevention and Control Group
	  ○ Medicines Committee
	  ○ Clinical Practice Group
	  ○ Safeguarding Adults and Children Group

	○ Patient Experience Group
Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Increased no criteria to reside patients impacts the recovery plan and meeting of the constitutional standards
Items / issues for referral to other Committees	• Nil new to note

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 22nd March 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Feedback and updated data received from Dr Foster shows that the Trust falls within the expected range for pressure ulcers identified in mortality data • Coding backlog is improving due to an agreement with AH to reduce the depth of coding being undertaken. This will improve the accuracy of the SHMI. • Assurance provided that updated actions arising from the Ockenden and Kirkup reports were in a good position. • Continued pressure due to the high number of patients with no reason to reside.

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ The Trust remains on routine surveillance (no escalations low level monitoring) from the system Quality Surveillance Group, and a recent review meeting from the CQC raised no concerns
	  ○ Overall quality and safety position remains positively consistent, although there was an increase in C.Diff locally, which reflects the national position.
	  ○ Mixed sex accommodation continues to be a concern, due to issues with bed capacity. No complaints have been received from patients
	• Maternity Safety Report and Ockenden Update noting
	  ○ Work continues to provide benchmarking data
	  ○ Satisfactory evidence and assurances provided for the Trust's position in relation to the Ockenden and Kirkup reports
	  ○ No incidents requiring a root cause analysis for the reporting month
	  ○ Business case for SCBU staffing is near completion
	• Patient feedback from national surveys highlighted communications, noise at night and patient information as key areas for improvement
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting the business case for a Hyper Acute Stroke Unit (HASU) and the impact of patients with no reason to reside.
	  ○ Family and Surgical Services Division noting the steps being taken to improve the culture in theatres.

Decisions made by the Committee	• Nil as the Committee was not quorate due to operational pressures
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Increased no reason to reside patients impacts the recovery plan and meeting of the constitutional standards

Items / issues for referral to other Committees	• Nil new to note

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 22nd February 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Financial challenges arising from a return to commissioning contract and income arrangements in the coming year, elective recovery targets and the underlying deficit position of the Trust and wider system. • Service pressures exacerbated by patient flow issues persist and the increasing urgency to reorganise No Reason to Reside arrangements. • Significantly improved performance in respect of ambulance handovers. • Approval of the draft Operational Plan.

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Performance Report noting
	  ○ continued service pressures resulting in OPEL 4 declaration by the Trust and wider system
	  ○ improved ambulance handover performance
	  ○ significant numbers of patients remaining in hospital with 'No Reason to Reside'
	  ○ diagnostic service performance adversely impacted by staff absences and equipment losses
	• Finance Report noting Year to Date performance was in line with the plan and a refreshed focus on the underlying deficit position and Cost Improvement challenge.
	• Operational Plan
	• The Draft Digital Plan would be presented to the committee in March 2022.
	• Divisional Exception Reporting
	  ○ Urgent and Integrated Care Division highlighted improvements on ambulance handover performance
	  ○ Family Services and Surgical Services Division noting the continuing need for staff to self-isolate as necessary to protect patients and staff despite national changes to COVID Regulations.

Decisions made by the Committee	The following items were approved by the committee: • Draft Operational Plan noting delegated Authority to the Chief Executive, Chief Finance Officer and Chief People Officer for further iterative submissions of the plan to NHSE/I as these were outside committee timeframes.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Trust and system underlying deficit position in the coming year.

Items / issues for referral to other Committees	• None

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 22nd March 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Clinical Waste Contract for Board approval. • Long term lease of South Walks House for Board approval and to request delegation to the Executive to sign and seal the lease post Board approval. • Digital Contract with Fortrus is recommended to the Board • Interventional Cardiology Contracts for approval. • Your Hospitals Programme Outline Planning Application is recommended to the Board. • The clinical coding imperative • Performance as detailed below

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• The Digital Plan would be circulated to members
	• Increasing numbers of COVID cases affecting both the number of patients in hospital and staffing levels
	• Performance Report noting
	  ○ A new format to the report to facilitate greater understanding and triangulation of the data
	  ○ Increased activity arising from increased numbers of 'walk ins'.
	  ○ continued patient flow issues impacting the four hour performance target and ambulance handover times
	  ○ achievement of elective Referral to treatment targets for those patients waiting 52 and 104 weeks
	  ○ the need to cancel some elective work
	  ○ good performance against cancer standards
	  ○ a recovery in diagnostic services performance.
	• There was no divisional representation at the meeting due to unprecedented operational pressures
	• Finance Report noting Year to Date performance was in line with the plan and concerns about the significant financial challenges faced in the year ahead arising from the underlying deficit position and cost improvement requirements.
	• Operational Plan noting the need to achieve a break even position in the coming year across the system, a reduction in COVID funding, the efficiency target, increased activity targets and the need to reduce Agency expenditure.
	• Committee Effectiveness Review noting that the Terms of Reference, Committee Priorities and annual Work Plan would be reviewed and approved in may 2022.
	• ED15 Update

Decisions made by the Committee	The following items were approved by the committee: • Clinical Waste Contract

	• South Walks House long term lease • Digital Contract with Fortrus • Interventional Cardiology Contracts • Your Hospitals Programme Outline Planning Application
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Trust and system underlying deficit position in the coming year.
Items / issues for referral to other Committees	• None

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NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 22nd March 2022

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• The Board Assurance Framework bi-monthly update was received noting the need to include timescales for risk mitigations. • High levels of fraud awareness amongst staff and a willingness to raise suspicions were noted • Timescales for mitigations of for high scoring risks to be included within the Board Assurance Framework (BAF) and the need to further develop a cohesive approach to the inclusion of health inequalities and net zero carbon ambitions • Strategic Estates Plan risks also to be reflected in the BAF

Key issues / other matters discussed by the Committee	The committee received and noted the following reports:
	• Internal Audit Progress Report noting:
	  ○ significant assurance on the DCH Subco Governance process noting positive escalations and communications with the Trust and moderate assurance on effectiveness noting the need to further develop the company risk register.
	  ○ Moderate assurance in relation to the Data Protection and Security Toolkit Audit with a high degree of confidence in effective completion of the requirements within the remaining three months prior to submission.
	• The draft Internal Audit Plan 2022/23
	• The Counter Fraud progress update noted changes to the risk assessment requirements and a high degree of counter fraud awareness amongst Trust staff. No areas of concern were highlighted.
	• External Audit Plan outlining the scope of the current year-end audit and process including the valuation of buildings and land and Value for Money assessments.
	• The Corporate Risk Register was received.
	• Declarations of Interest and Gifts and Hospitality Registers.
	• Update on actions to improve cyber resilience.

Decisions made by the Committee	The committee supported the approval of the following: • The Internal Audit Plan 2022/23. • Charitable Funds would not be consolidated within the Trust's Accounts on the basis of immateriality. • Charitable Funds restructure proposal promoting unrestricted funds arrangements • Accounting Policies and Areas of Estimation • Going Concern Statement

	The meeting was not quorate due to operational pressures and the committee agreed to seek and record approvals from members not present outside the meeting in order that next steps could be taken.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Timescales for mitigations of for high scoring risks to be included within the Board Assurance Framework (BAF) and the need to further develop a cohesive approach to the inclusion of health inequalities and net zero carbon ambitions • Strategic Estates Plan risks also to be reflected in the BAF
Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Charitable Funds Committee

Date of Meeting: 28 February 2022

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• Dorset County Hospital Charity finances impacted by pandemic, as per UK charity sector. DCH Charity Financial Review (Q3) held by Charity Strategy Group (1.2.22) and report and recommendations submitted to Charitable Funds Committee 28.2.22.
Key issues / matters discussed at the Committee	**DCHC Financial review (Q3)** • **DCH Charity Financial Review (Q3)** The Reserves position at the end of Dec 2021 (M9) showed a surplus of £36k above the target of £200k. The DCHC budget has been adjusted down from £670K target (Q2) to £585K (Yr end). The reforecast is based on income year to date and NHSCT Stage 3 grant (£65K) now moved to 2022/23. Major grant and legacy income still expected in Q3/4. CFC content with current reforecast. Final review at Q4 (Apr 2022). • **DCH Charity Risk Register review (Q3)** Reserves policy risk rating revised down from 16 (High) to 12 (Moderate). No other changes to current risk ratings. Next review Q4 (Apr 22) **DCHC Charitable Funds Committee (28.2.22)** • **DCH Charity Finance/Income** reports (M10 Jan 2022) received. • **DCHC Business Plan 22/23** including key fundraising activities and budgets; supported by CFC. Submit to Board (Mar 22) for approval. • **DCHC Capital Appeal Plan (ICU/ED)** Draft Capital Appeal Plan supported by CFC. Submit to Board (Mar 22) for approval. • **DCH Charity Governance review:** - Charitable Funds Committee Terms of Reference updated; approved by Board (Corporate Trustee) in Jan 2022. - Review of DCH Charity Governing documents – no changes proposed. - DCH Charity Funds re-structure proposal supported by Charitable Funds Committee. Submit to Risk & Audit Committee to note (22.3.22) and Board (30.3.22) for approval.

Decisions made by the Committee	• **DCHC Business Plan 22/23** including key fundraising activities and budgets; supported by CFC. • **DCHC Capital Appeal Plan (ICU/ED)** Draft Capital Appeal Plan supported by CFC. • **DCHC Governance Group** DCH Charity Funds re-structure proposal supported by Charitable Funds Committee.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• **DCHC Business Plan 22/23** including key fundraising activities and budgets. Submit to Board (30.3.22) for approval. • **DCHC Capital Appeal Plan (ICU/ED)** Submit to Board (30.3.22) for approval. • **DCH Charity Funds re-structure proposal** Submit to Risk & Audit Committee to note (22.3.22) and Board (30.3.22) for approval.

Meeting Title:	Board of Directors
Date of Meeting:	30 March 2022
Document Title:	**Dorset Integrated Care System Overview**
Responsible Director:	Nick Johnson, Interim Chief Executive
Author:	Laura Symes, Corporate Business Manager to the Chief Executive

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Interim Chief Executive	22/03/2022	Approved

Purpose of the Paper	The purpose of this report is to provide the Board of Directors with an overview of the Dorset Integrated Care System from a performance, quality, and finance perspective.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	Highlights include: Performance: • Emergency activity remains high with SWAST being on the highest level of alert since mid-June. • Hospital bed occupancy remains consistently above 95% due to a high proportion of patients who do not meet the clinical criteria to reside. • COVID outbreaks continue in acute and community hospital settings with daily outbreak meetings in place. Care home outbreaks continue to be significant in number. • The referral to treatment waiting list saw a reduction in patients waiting over 52 weeks in December, by 326 patients. Urgent work is underway to deliver pathways for those inconvenienced and other long waiters. • Cancer performance continues to be challenged for University Hospitals Dorset, receiving a significant increase in referral numbers. Dorset County Hospital referral rate has steadied, with less spikes but the rate is higher than the recovery trajectory. • The backlog of patients waiting over 62 days remains a challenge for both organisations however when compared nationally the Wessex Cancer Alliance continues to have the lowest number of patients waiting over 62 days. Quality: • Numbers of COVID outbreaks remain high in care homes, with a number of new outbreaks also being identified by hospital providers. • Mortality coding remains an area of focus at Dorset County Hospital following deterioration in the Summary Hospital-level Mortality Indicator (SHMI). Internal discussions on improvement continue and an anticipated trajectory to manage the backlog is expected. • In Infection Control, a project has commenced to provide resilience to the Dorset system with a mutually agreed process for FFP3 fit testing. • Dorset has been recognised at regional and national level for the collaborative working on implementation of the requirements as an Integrated Care System. • University Hospitals Dorset and Dorset County Hospital Maternity Units received quality assurance visits from the Clinical Commissioning Group							

	during December 2021. • The Clinical Commission Group has sought legal advice regarding the number of young people who are challenging their age and have been taken into care by Bournemouth, Christchurch, and Poole Council. Finance: • At month 9 all organisations are expecting to deliver the breakeven position for both the second half and the full financial year, as planned. • The modified financial regime for the second half of the year increased the financial risk to the NHS bodies, with a total of £29.8M of risks initially identified within the planning round. • The system planned to achieve £16.3M Elective Recovery Fund income in the second half of the year, matched by expenditure of the same amount, in addition to first half of the year achievement. This level of income is now not expected to be earnt, and expectations have reduced to an income of £9.7M. • The NHS system delivered £5M efficiency savings in the first half of the year but to achieve a balanced financial position for the second half of the year requires delivery of £29.8M. • NHS system Capital Departmental Expenditure Limit envelope will be met this financial year, with an underspend in other capital funding arising in Dorset Healthcare and University Hospitals Dorset.
Action recommended	The Trust Board is recommended to: 1. **Note** the information provided.

Governance and Compliance Obligations

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

Title of Meeting	Board of Directors
Date of Meeting	30 March 2022
Report Title	**Dorset Integrated Care System Overview**
Author	Laura Symes, Corporate Business Manager to the Chief Executive
Responsible Executive	Nick Johnson, Interim Chief Executive

1.0 Introduction

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

The information is taken from meeting papers from the Dorset System Senior Leadership Team meeting held on 24 February 2022.

2.0 Performance

At the end of December 2021, emergency attendance activity was slightly above that seen in 2020; however, this is below 2019 levels. 999 activity is gradually reducing and is now in line with 2020/21, although January dropped below both previous years' activity; SWAST have been at their highest alert level (REAP Black) since mid-June. Significant pressure remains and the system continues to experience increased levels of handover delays beyond 60 minutes. Improvements have been made in waits in excess of 4 hours at Poole and Bournemouth Emergency Departments, however they still remain high.

Hospital bed occupancy remains consistently above 95% due to a high proportion of patients who do not meet the clinical criteria to reside. The Discharge & Flow Cell are meeting four times per week to monitor against the trajectory and maximise discharge numbers, as well as Regional Discharge touchpoints on a Wednesday and Thursday. Community hospitals are phasing an increase in their beds in the coming weeks together with utilising block-booked beds in care homes, however they have had COVID suspensions in place, meaning risk assessments need to be undertaken for any admissions.

COVID outbreaks continue in acute and community hospital settings with daily outbreak meetings in place. Care home outbreaks continue to be significant in number, and the outbreaks are longer in length due to the impact of the level of transmission from the community. In the last month there has been an increase of the number of supportive Incident Management Team (IMT) meetings held, to ensure our care homes in Dorset have access to support and guidance during outbreaks.

The referral to treatment waiting list reduced marginally in December (by 14 cases). Increases were experienced across all specialties, with the exception of Ophthalmology and Trauma & Orthopaedics. The system saw a reduction in patients waiting over 52 weeks in December, by 326 patients. Urgent work is underway to deliver pathways for those inconvenienced and other long waiters.

In diagnostic performance the waiting list increased by 890 in December and is at the highest point for over 2 years. Those waiting over 6 weeks have risen to 12.8% of the total waiting list (from 6.8% in November). Despite this the Dorset system remains in a strong position in the region.

Cancer performance continues to be challenged for University Hospitals Dorset, receiving a significant increase in referral numbers in November. The size of their patient tracking list (PTL) in November remained above 3,600 (12th largest PTL nationally). Dorset County Hospital's referral rate has steadied, with less spikes but rate is higher than the recovery trajectory. In December their PTL has reduced to 1,100, this decline has continued in January with it reaching 1,000.

The backlog of patients waiting over 62 days remains a challenge for both organisations however when compared nationally the Wessex Cancer Alliance continues to have the lowest number of patients waiting over 62 days.

3.0 Quality

The number of COVID outbreaks remain high in care homes, with a number of new outbreaks also being identified by hospital providers.

Currently there are differences in the application of guidance between Bournemouth, Christchurch, and Poole Council and Dorset Council, which is affecting the use of block booked beds. A robust risk assessment process is in place which all system partners contribute to access and review risk of admissions on an individual basis. The number of care homes currently under suspension is reducing the access to beds for the system to enable adequate flow. A whole Dorset process is being explored with support of system partners.

Mortality coding remains an area of focus at Dorset County Hospital following deterioration in the Summary Hospital-level Mortality Indicator (SHMI). Internal discussions on improvement continue and an anticipated trajectory to manage the backlog is expected.

In Infection Control, a project has commenced to provide resilience to the Dorset system with a mutually agreed process for FFP3 fit testing. Currently colleagues from University Hospitals Dorset are offering training to support the pressures within primary care and care homes.

Dorset has been recognised at regional and national level for the collaborative work on implementation of the requirements as an Integrated Care System. The key risk highlighted is that there may not be sufficient engagement of staff to effect change through transition in a pressurised system.

University Hospitals Dorset and Dorset County Hospital Maternity Units received quality assurance visits from the Clinical Commissioning Group (CCG) during December 2021. There was good assurance regarding the knowledge and management of risks both to individual women and to the delivery of the service within the units. Challenges from the implementation of the new electronic records system in Dorset County Hospital have been well managed with excellent leadership from the team. Learning has been shared for the system goes live at University Hospitals Dorset.

From April 2022 the 60-day requirement for completion of serious incident reports will be removed by NHS England & Improvement, and Trusts will be able to agree timescales locally, continuing the approach adopted in Dorset since the start of the pandemic.

In safeguarding, Dorset and Bournemouth, Christchurch, and Poole local authority adult safeguarding teams are working collaboratively with the CCG Safeguarding Team in planning the proposed implementation of Liberty Protection Safeguards, the code of conduct is awaiting publication.

The CCG has sought legal advice regarding the number of young people who are challenging their age and have been taken into care by Bournemouth Christchurch and Poole Council; clarification is being sought regarding the status, age assessment, GP registration and the placement of young people in the Bournemouth, Christchurch, and Poole area in order that the CCG can undertake their statutory responsibilities.

4.0 Finance

At month 9 all organisations are expecting to deliver the breakeven position for both the second half and the full financial year, as planned.

The modified financial regime for the second half of the year increased the financial risk to the NHS bodies, with a total of £29.8M of risks initially identified within the planning round. These risks include delivery of efficiency schemes and of not achieving the expected level of Elective Recovery Fund (ERF) income as well as cost pressures such as prescribing and Personal Health Commissioning. Risks have been mitigated in part by additional non-recurrent funding connected with the fixed cost of running ERF

(£16.7M) and increased discharge services (£3.6M). The remainder of the risks identified within the planning round are being managed across the system via non-recurrent flexibilities.

The system planned to achieve £16.3M ERF income in the second half of the year, matched by expenditure of the same amount, in addition to the first half of the year achievement. This level of income is now not expected to be earnt, and expectations have reduced to an income of £9.7M. This is driven by non-elective pressures seen across the system and the reduced income level does not represent additional risk to the system as the associated activity and cost is not occurring.

The NHS system delivered £5M efficiency savings in the first half of the year but to achieve a balanced financial position for the second half of the year requires the delivery of £29.8M. This increase is reflective of the increased national expectation on all systems, including a greater level of savings required for those that had a deficit position pre-COVID. The system is not currently forecasting full achievement of this level of savings, with a balance of £2.8M yet to identify that currently requires mitigation via non-recurrent flexibilities.

NHS system Capital Departmental Expenditure Limit (CDEL) envelope will be met this financial year, with an underspend in other capital funding arising in Dorset Healthcare and University Hospitals Dorset.

Meeting Title:	Board of Directors Part 1
Date of Meeting:	30 March 2022
Document Title:	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 2021 – Dec 2021)**
Responsible Director:	Chief Medical Officer
Author:	Kyle Mitchell, Guardian of Safe Working

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	21 March 2022	

Purpose of the Paper	The production of a quarterly Guardian of Safe Working (GoSW) report to the Board is a requirement of the 2016 Junior Doctor Contract.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	A summary of key issues relating to safe working hours and rota gaps for Junior Doctors in training for quarter 3 (2021/2022)							
Action recommended	The Board is asked to: 1. **NOTE and APPROVE** the GoSW paper.							

Governance and Compliance Obligations

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

Title of Meeting	**People and Culture Committee**
Date of Meeting	**21 February 2022**
Report Title	**Quarterly Guardian Report of Safe Working report: Doctors in Training (Oct 2021 – Dec 2021)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Exception Reports continue to be submitted at rates roughly in line with activity before the Covid-19 pandemic.
- Educational supervisor engagement remains excellent with prompt and constructive resolution of Exception Reports.
- No Exception Reports in this quarter constituted Immediate Safety Concerns.
- The Guardian raises no issues relating to safe working of junior doctors during this quarter.

2. Introduction

All eligible doctors in training at the Trust between October and December 2021 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract") and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW).

All work schedules provided to doctors in training within the Trust between April 2021 and September 2021 complied with contractual commitments under the 2016 Contract.

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

3. High level data

Number of training post (total):	184
Number of doctors in training post (total):	160.4
Annual average vacancy rate among this staff group:	16.4 (10.2%)

Exception reports

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Geriatric medicine	0	15	15	0
Respiratory Medicine	0	10	10	0
Trauma & Orthopaedics	0	9	9	0
Gastroenterology	0	9	8	1
Medical oncology	0	9	9	0
General Surgery	0	5	5	0
Cardiology	0	3	3	0
Acute Medicine	0	2	2	0
GP with Medical On Calls	0	2	2	0
Total	0	64	63	1

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	38	37	1
FY2-CT2 (SHO)	0	23	23	0
ST3-8	0	3	3	0
Total	0	64	63	1

4. Work schedule reviews

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

Exception Reports taken to Level 1 Work Schedule Review

Specialty	F1
Cardiology	1
Geriatric Medicine	4

Rota	Total
AP 2021 F1 Medical 01/12/21 - 05/04/21	3
AP 2021 F1 Medical – 04/08/21	2

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

5. Vacancies

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

6. Fines

6.1 There were no fines levied during this period.

7. Qualitative information

7.1 The total number of exception reporting is not high. It is less than one per day submitted by a workforce of 160 junior doctors. Under-reporting of true working patterns undoubtedly continues. In this quarter, efforts have continued, on the part of the Medical Director, DME, GoSW, GMC regional liaison officer, and local BMA representatives, to encourage exception reporting and this remains an embedded element of Trust induction. Separating variations in report submission, from variations in working patterns, remains impossible (see Appendix 2). However, the small number of work schedule reviews undertaken, and the absence of any Immediate Safety Concerns, suggest that, on most days and for most doctors, individual work schedules match up with actual clinic demands.

7.2 Informal discussion in those specialties with the highest rate of submission of Exception Reports (Geriatric Medicine and Trauma & Orthopaedics) identified a common thread; the challenge of large numbers of patients medically safe for discharge but still in hospital. Whilst these patients do not need daily doctor reviews, there is a tendency to continue to invest junior doctor time in their care, including out-of-hours. In both specialties, efforts to streamline systems to avoid unnecessary medical engagement are ongoing and have full buy-in from the consultant staff.

7.3 A part of the Guardian role, not directly related to Exception Reporting, is to provide oversight of a Junior Doctors' Forum (JDF). Unfortunately, the well-attended and lively JDFs of pre-pandemic life appear a distant memory. The JDF is traditionally chaired by

trainee, formally appointed as a Chief Registrar, with protected time for medical leadership activity; this post is currently vacant. An informal hot snack was traditionally provided by the Guardian; this depends on having a venue that can accommodate food and this is not at present available. The JDF venue throughout the pandemic has been the Lecture Theatre and this is heavily booked limiting availability. The opportunity for informal discussions and presentation of points of view and experience; and a general opportunity to build relationships and understanding; is painfully missing in the current format of JDF. The Guardian has discussed the options of reverting to a pre-pandemic format with food in the Junior Doctors' Mess, but a consensus dismissed this as being not yet appropriate as social distancing was not achievable.

8. Issues arising

8.1 In this quarter, the Guardian has not observed or identified systemic, cultural or work pressure issues which put doctors at risk.

9. Summary

9.1 An element of flexibility has always been part of how all doctors, including those in training, work. The 2016 Contract formalises arrangements to recognise, record and remunerate this. The Guardian has identified no breaches in the Trust's compliance with these contractual arrangements and no specific concerns regarding the safe working components of the 2016 Junior Doctors Contract.

10. Recommendation

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

APPENDICES

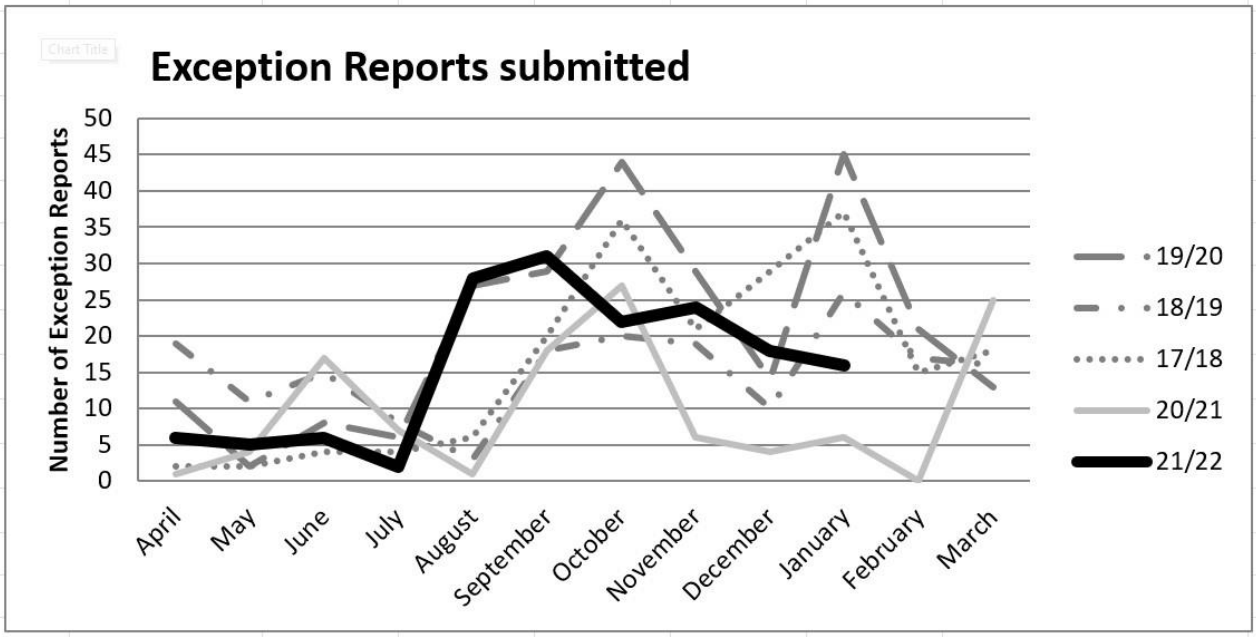
QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

OCTOBER 2021 – DECEMBER 2021

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Oct21	Nov21	Dec21	Average Q3
Paediatrics	ST3	Sept	0.2	0.2	0.2	0.2
Paediatrics	ST4+	Sept	1.2	1.2	1.2	1.2
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	0	0	0	0.0
ED	ST3+	Sept and Feb	0.4	0.4	0.4	0.4
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	1	1	1	1.0
Surgery	ST3+	Oct	1	1	1	1.0
Orthopaedics	ST3+	Sept	0	0	0	0.0
Anaesthetics	CT1/2	Aug	1.2	1.2	1.2	1.2
Anaesthetics	ST3+	Aug and Feb	0.4	0.4	0.4	0.4
Medicine	CT1/2	Aug	2.8	2.8	2.8	2.8
Medicine COE	ST3+	March	0	0	0	0.0
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	1	1	1	1.0
Medicine Resp	ST3+	Aug	1	1	1	1.0
Medicine Cardio	ST3+	Feb	1	1	1	1.0
Medicine Renal	ST3+	Aug	1	1	1	1.0
Haematology	ST3+	Sept	0	0	0	0.0
Med/Surg	FY1	Aug	1	1	1	1.0
Med/Surg	FY2	Aug	0	0	0	0.0
GPVTS	ST1	Aug & Feb	1.8	1.8	1.8	1.8
GPVTS	ST2	Aug & Feb	0.4	0.4	0.4	0.4
GPVTS	ST3	Aug & Feb	0	0	0	0.0
Orthodontics	ST3+	March	0	0	0	0.0
			16.4	16.4	16.4	16.4

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



Meeting Title:	Board of Directors Part 1
Date of Meeting:	30th March 2022
Document Title:	**Board Assurance Framework**
Responsible Director:	Nick Johnson – CEO
Author:	Ciara Darley – Senior Programme Manager

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

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	18th Jan 22	• Add risk to include a staffing plan to support coding • Consider mechanism to highlight risks which maintain high scores, e.g. finance • Add associated Committees for each risk and consider mechanism for periodic deep dives • Consider mechanism for identifying gaps in control
Executive Management Meeting	4th March 22	No actions
Risk and Audit Committee	22nd March 22	

Purpose of the Paper	The Board Assurance Framework (BAF) captures the risks which may impact on achieving the Trusts Strategic Objectives. The enclosed BAF highlights changes to risks scores in the last period, a summary can be found within the enclosure and Front-sheet.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The Board needs to understand the Trust's strategic objectives and the principal 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 in May 2021, with three new Strategic Themes – People, Place and Partnerships. Since its publication, a number of Strategic Objectives have been agreed and have been included within the revised BAF Template, which was approved at Trust Board in November 2021. The principal risks to achieving these strategic objectives have been identified and scored using the Trusts risk scoring matrix. The summary position of the BAF highlights the Strategic Theme of Place to contain the most risks. The following heat map offers an indication of how strategic risks are currently spread and highlights where risks scores have changed since the last circulation.							

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

Key

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

Updates to the BAF have been included with red text within the template to allow for easy identification by members of the Committee.

Changes have been summarised below:

Template updates:

- Committees' column added
- 'Responsible Director' changed to 'Accountable Executive'
- Section added to document gaps in controls and associated actions
- Risk articulation updated to 'if, then so' format in line with best practice

Updated Risk Scores:

Strategic Theme: People
Strategic Objective 3: We will improve safety and quality of care by creating a culture of openness, innovation and learning (risk ref: PE 3.2)
Risk description: If operational pressures continue then there will be less time for teams and staff to innovate and so the will and capacity for innovation will be stifled.

- *Risk score changed from 12 to 15*

Strategic Theme: Place
Strategic Objective 2: We will build sustainable infrastructure to meet the changing needs of the population (risk ref: PL 2.1)
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 score changed from 20 to 15*

Strategic Theme: Place

Strategic Objective 2: We will build sustainable infrastructure to meet the changing needs of the population (risk ref: PL 2.2)
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 score changed from 16 - 20*

Strategic Theme: Place
Strategic Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients (risk ref: 3.1)
Risk description: If we do not achieve a Dorset wide integrated electronic shared care record then we run the risk of not making the right information available to care professionals, so we will not be able to make sure the right information is available to the right person in the right place at the right time about the right patient increasing the likelihood of patient harm

- *Risk score changed from 6 – 3*

<u>New Risks</u>

Strategic Theme: Place
Strategic Objective 1: We will deliver safe, effective, and high-quality personalised care for every patient focussing on what matters to every individual (risk ref 1.11)
Risk description: If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through KPI's such as the Summary Hospital-level Mortality Index

- Risk score of 16 (4 x 4). Target risk score: 6

<u>Risks which have maintained a score of 20:</u>

- PE 1.2 - If we fail to attract and retain the right people with the right skills then more pressure on existing teams
- PL 1.1 - If there is a continuous inability to recruit or retain sufficiently skilled clinical staff to meet the demand of patients then will not be able to meet care standards required so will not meet the strategic ambitions on quality, personalised care and financial objectives.
- PL1.3 (added in December 2021) - If we continue to not achieve the national performance standards due to long waiting times then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.
- PL 1.5 - If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly, the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population
- PA 2.1 - If the Trust fails to deliver sustained financial breakeven and to be self-sufficient in cash terms then it could be placed into special measures by the regulator and need to borrow externally to ensure it does not run out of cash

Action recommended	The Board is recommended to: 1. Note the update 2. Raise any recommendations for the next reporting cycle

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: Mar-22

Summary Narrative

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

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

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

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

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

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

Risk Heatmap

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

Key

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

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	# People Risks: 7
People Objective 1 We will look after and invest in staff, developing our workforce, creating collaborative and multidisciplinary teams to support outstanding care and equity of outcomes													
PE 1.1	PCC QC FPC	CPO	Deputy CPO	**Risk description:** If we fail to create environments that support staff wellbeing then our ability to resource service recovery and ongoing delivery safe care are at risk	4	4	16	• People strategy • People performance dashboard • People Committee reports • People recovery steering group • Targeted wellbeing support • Wellbeing offer • System & national wellbeing offers	• People strategy (development) • People Dashboard - PCC • PCC reports • FPC reports • Divisional performance reviews • Quarterly people pulse survey • National staff survey • FTSUG reports • Staff listening exercises • Exit interviews	Good	Good	12	
								Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working Impact of pent up demand on the front door and pressures within system impacting workforce stress & anxiety - working across ICS					
PE 1.2	PCC	CPO	CPO	**Risk description:** If we fail to attract and retain the right people with the right skills then more pressure on existing teams	5	4	20	• People strategy development • Implementation of workforce business partner model • System attraction strategy • Resourcing function business case • Career pathways • CESR academy proposition • Locally employed doctor appraisal and development • Pilot site for national stay and thrive initiative & international nurse experience deep dive • OD team • Development of flexible & temporary staffing function • Inclusive leadership programme • Transforming people practices programme • Values based recruitment -HCA workforce	• People strategy (development) • People Dashboard - PCC • PCC reports & workplan • Divisional performance reviews • Recruitment control panel • System workforce plan	Good	Good	15	
								Gaps in Control and Actions: National workforce supply challenges - system workforce planning & new ways of working					
People Objective 2 We will create an environment where everyone feels they belong, they matter and their voice is heard													
PE 2.1	PCC	CPO	Head of OD	**Risk description:** If we fail to create a culture and environment where ALL stay feel valued, heard and that they belong then attraction, availability and retention will be compromised	4	3	12	• People strategy • EDI roadmap – culture transformation programme (inclusive leadership development, transforming people practices work streams) • Staff networks x 5 • FTSUG and champions • People performance dashboard as cultural barometer • Exit interviews	• People performance Dashboard - PCC • PCC workplan • PCC deep dives • Divisional performance reviews • EDI steering group • Exec sponsors for staff networks • Quarterly pulse survey • National staff survey • Junior dr survey	Good	Good	8	
								Gaps in Control and Actions:					
People Objective 3 We will improve safety and quality of care by creating a culture of openness, innovation and learning													
PE 3.1	People & Culture Committee and Quality Committee	CPO/CNO/CMO	CPO/CNO	**Risk description:** If People not feel safe to speak out about safety and care quality then the safety culture is effected and there can be increase in safety risks and harm, with a reduction in teamwork and quality improvement. In addition issues will not be addressed and patients and staff are at risk of harm.	4	2	8	• Trust strategy • Trust values • People strategy • Implementation of just & learning culture principles • Raising concerns policy • Whistleblowing policy • Trust induction • Leadership & management development • FTSUG and champions • Safety walkabouts • Ward accreditation framework • Incident reporting	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whistleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix	Good	Good	4	
								Gaps in Control and Actions:					
PE 3.2	QC	CEO	Deputy Director of Strategy	**Risk description:** If operational pressures continue then there will be less time for teams and staff to innovate and so the will and capacity for innovation will be stifled.	3	5	15	• Quality Improvement and Innovation Programme overall supports importance and value of innovation and learning and provides resource support • QSIR Training protected and supported by division • Transformation and Improvement team providing support • Research and Innovation strategy and plan • Engagement in Academic Health Science Network • Divisional Performance Meetings with focus on innovation	• S&T SLG reporting on QI programme and progress • Research and Innovation Governance • Divisional Performance Meetings	Good	Good	6	
								Gaps in Control and Actions:					
PE 3.3	PCC	CPO	Head of Education	**Risk description:** If operational pressures reduces capacity for learning then there could be a detrimental impact on placement experience, our ability to attract students, patient safety may be compromised and staff engagement may suffer	4	3	12	• People strategy • Appraisal policy • Medical appraisal • Study leave policy • Mandatory training KPI's • Practice education team • PCC reporting • Quality committee reporting • PCC and QC risk sharing & triangulation	• Mandatory training KPI's • Appraisal KPI's • Monthly performance review • PCC reports • QC reports • Medical and nursing revalidation • System education workstreams	Good	Good	8	
								Gaps in Control and Actions: Demand and capacity challenges - close monitoring and escalation					
PE 3.4	QC	CMO	CMO	**Risk description:** If DCH is not actively encouraging and pursuing research aims in line with the strategy then it will be a less attractive place for staff to work and research income will reduce. So DCH needs to actively encourage and facilitate staff to take part in existing projects and develop new ones.	3	2	6	• Strong clinical research and innovation programme. • Research Strategy in place for 2019-22 with plans to review in 2022.	• Reports to Quality Committee through the Urgent and Integrated Care division - with annual reporting to Board.	Good	Good	6	
								Gaps in Control and Actions:					

Risk Ref:	Committee/ Group:	Responsible Executive:	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance Evidence	Strength of Control	Strength of Assurance	Target Risk	# Place Risks: 17
Place Objective 1: We will deliver safe, effective and high-quality personalised care for every patient focussing on what matters to every individual													
PL 1.1	QIC (linkgulation with PCC)	CNO	CFO - Recruitment and retention and People Strategy	**Risk description:** If there is a continuous inability to recruit or retain sufficiently skilled clinical staff to meet the demand of patients then will not be able to meet care standards required so will not meet the strategic ambitions on quality, personalised care and financial objectives.	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 **Gaps in Control and Actions:** - International shortage of certain clinical professions. Action: part of the stay and thrive programme to improve experience and support of international recruits; workforce planning to grow talent and career pathways into health - Uncertainty over Health Education England funding that impacts upon training, education and funding support for pipeline roles. Action: Close liaison with HEE South West and regional workforce/ people supply work streams	• Sub board reports: PCC; QC & R&C • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT/Networks • Corporate risk register actions and tolerated/managed risk	Good	Strong	6
PL 1.2	QC	CNO	CNO - quality and safety CMO - Clinical Strategy and GIRFT CFO - Estates Strategy	**Risk description:** If the population demand is over the ability to create and deliver capacity that meets the constitutional standards and quality standards outline under the CQC regulatory framework then the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.	4	4	16	• Capacity planning • Commissioning of capacity • Clinical pathway 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 digital clinical framework • Clinical networks to support pathway design and resources based on population need **Gaps in Control and Actions:** - Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and collaboration workstreams	• Sub-board committee FPC, QC & PC • Estates master plan and associated business cases • Performance scorecard • External performance monitoring (CQC; OFRG; NHSEI) • Benchmarking data: clinical networks; GIRFT	Good	Strong	9
PL1.3	FPC	COO	Associate Director of Performance	**Risk description:** If we continue to not achieve the national performance standards due to long waiting times then we will not provide high quality care in ways that matter for our patients so the clinical strategy will not be delivered and therefore the objective of high-quality care that is safe and effective will not be met.	4	5	20	• 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 **Gaps in Control and Actions:** National Elective Recovery Plan sets out a 3 year plan towards achievement of NHS Constitutional Standards. When full details available including funding a structured and costed plan can be constructed which describes approach to full mitigation.	• Division and work stream action plans. External contracting reporting to CCG. Divisional exceptions at Quality Committee • Performance monitoring via weekly PTL meetings, fortnightly EPMG and monthly Divisional Performance Meetings (through to Sub-Board and Board)	Good	Good	12
PL 1.4	FPC	COO	Head of EPRR	**Risk Description:** If we don't have Emergency Preparedness and Resilience Plans then we will not have a defined programme to manage safe services and the triggers for altering those services under change services, therefore the objective of high-quality care that is safe and effective will not be met.	3	2	6	• Emergency Preparedness and Resilience Review Committee (EPRR) reporting, EPRR Framework and review and sign off by CCG and NHSE	• Reporting from EPRR Committee to Risk and Audit Committee and via assigned NED to Board. Yearly self assessment against EPRR core standards ratified by Local Health Resilience Partnership. Internal Audit reports	Good	Good	6
PL 1.5	FPC - performance QIC - Harm related concerns	COO	COO	**Risk description:** If our emergency and urgent care pathways do not meet the increase in unplanned attendances then patients will wait too long for appropriate care in emergency situations and therefore the objective of high-quality care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	4	5	20	• 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 medicine 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 **Gaps in Control and Actions:** System actions currently in development, low level of confidence actions will meet needs.	• Upward reporting and escalation from UECB to SLT and DCH Board. • Ward to Board reporting Home First Board and workstream documentation Home First (DCH) documentation Divisional reporting via Performance Meetings, FPC. Seasonal Surge Plan and reporting IMT Reporting ROI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	Good	12
PL 1.6	FPC - performance QIC - Harm related concerns	COO	COO	**Risk description:** If we fail to work with our partners on effective criteria to admit, criteria to reside, and discharge pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	3	4	12	• Home First Board membership • Urgent and Emergency Care Board - 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. • YSCE support front door and discharge-response • Clinical and People Strategies for front door response • Redesign of patient flows through the hospital with particular focus on ambulatory pathways and proactive discharge management **Gaps in Control and Actions:** System actions currently in development, low level of confidence actions will meet needs.	Home First Board papers UECB papers Divisional reporting to FPC Performance Report - FPC ROI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	Requires Improvement	9
PL 1.9	FPC	COO	COO	**Risk description:** If we do not provide as a minimum 35% of our outpatient activity away from the DCH site then we will not be delivering and designing care in a way which matters to patients or building on sustainable infrastructure and digital solutions to better meet the needs of our population.	2	1	2	• Outpatient Improvements (within Elective Care Board Programme) Clinical and People Strategies (including physical capacity required)	• Reports to SLG and through to Board via Strategy updates	Good	Good	2
PL 1.10	QC?	CMO	CMO	**Risk description:** If the Trust's SHMI is out of range then it will suggest excess deaths are occurring regardless of the actual cause. So this will cause reputational damage and invite inspections by regulators, which are not necessary if coding is the underlying correctable cause.	4	4	16	• Scrutinising other care quality indicators to assure standards of care • Ensuring accuracy and timeliness of clinical coding by reporting by exception to FPC **Gaps in Control and Actions:**	• Regular reports to Hospital Mortality group, Quality Committee and Board.	Requires Improvement	Good	8
PL 1.11	RAC	CIO	CIO	**Risk description:** If we do not deliver robust, accurate and timely coding then data submitted to NHSE and NHS Digital will not be reflective of the care delivered, so workload will be inaccurate and there will be a negative impact on reputation through KPI's such as the Summary Hospital-level Mortality Index.	4	4	16	The coding department is attempting to recruit a new full-time manager and to fill all existing vacancies. The current coding backlog is expected to be recovered before the annual data submission deadline of 19/5/22. **Gaps in Control and Actions:** Staffing plan to support timely and accurate coding Embed Primary Care feed to Coding to support a more accurate and deep initial diagnosis, positively impacting the SHMI and reducing pressures on Clinicians and Coders.	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	6
Place Objective 2: We will build sustainable estate structure to meet the changing needs of the population													
PL 2.1	FPC	CFO	Strategic Estates Project Director	**Risk description:** If we do not commit sufficient resources to New Hospital Project and wider strategic estates development then plans and business cases will not be robust so we will not receive funding to deliver	5	3	15	• Full Programme Structure in place with dedicated team • NHP Project Board, Clinical Assurance Group, • Finance and Performance Committee into Trust Board - Lobbying of NHSE/I/NHP team re. seed-funding at all levels **Gaps in Control and Actions:** • Regular reporting to FPC	• NHSEI SOC Approval; - NHSEI NHP Deep Dive re. OBC	Good	Good	10
PL 2.2	FPC	CFO	Deputy Director of Finance	**Risk description:** If we do not embed appropriate business case approval processes then plans will not be sustainable so we will not be able to meet the needs of patients and populations	4	5	20	• Working group to inform SLG decisions • Business case templates and corporate report front-sheets **Gaps in Control and Actions:** - Lack of adherence to and application of agreed processes - Lack of knowledge of agreed processes - No review/check of business cases against required templates	• Working Group papers • External approval of business cases e.g. NHP	Requires Improvement	Requires Improvement	10
PL 2.3	FPC	CFO	CFO	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting **Gaps in Control and Actions:**	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9
Place Objective 3: We will utilise digital technology to better integrate with our partners and meet the needs of patients													
PL 3.1	FPC	CIO	CIO	**Risk description:** If we do not achieve a Dorset wide Integrated electronic shared care record then we run the risk of not making the right information available to care professionals, so we will not be able to make sure the right information is available to the right person in the right place at the right time about the right patient increasing the likelihood of patient harm	1	3	3	Dorset Care Record project lead is the Director of Informatics at UHD. Project resources agreed by the Dorset Senior Leadership Team. Project structure in place overseen by ICS Digital Portfolio Director **Gaps in Control and Actions:**	• Reports to the Dorset System Leadership Team. Updates provided to Dorset Operation and Finance Reference Group and the Dorset Informatics Group.	Good	Good	3
PL 3.2	FPC/QC/RAC	CIO	CIO	**Risk description:** If we do not have adequate cyber security defences to protect the Trust's digital assets then we increase the likelihood of impact from a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Patching of perimeter defences, firewalls, servers, switches, desktop/laptop equipment, penetration tests and regular audits **Gaps in Control and Actions:**	• Annual Penetration Test Results and associated action plan • Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT • SIRO, Deputy SIRO, Information Security Manager, Data Protection Officer - all posts filled	Good	Good	9
PL 3.3	QC/RAC	CIO	CIO	**Risk description:** If Trust staff are not trained sufficiently to minimise targeted and social engineering threat attempts then we increase the likelihood of the impact of a cyber event, so the Trust will suffer partial or complete loss of digital services including access to critical applications, data and/or digitised processes.	3	4	12	Part of DSPT annual assurance, digital training team providing training for all new starters and annual refresh training where required. Regular phishing campaigns. **Gaps in Control and Actions:**	• Annual DSPT submission • Regular reports to Quality Committee, Risk and Audit Committee, Trust Board • Targeted training resulting from output of internal campaigns • Annual Internal Audits • Annual renewal of ISO27001 accreditation • Tools deployed by the Trust to monitor and report on cyber threats • Use of tools made available by NHSE to monitor alerts/threats i.e. CareCERT	Good	Good	9
Place Objective 4: We will listen to our communities, recognise their different needs and help create opportunities for people to improve their own health and wellbeing and co-designing services													
PL 4.1	Quality Committee	CNO	Alison Mabin - Patient Engagement Jo Vardey Maternity - inform partners	**Risk description:** If we fail to engage and work with partners and stakeholders to effectively maximise the opportunities to engage and co-design with our communities then services will not be meeting the needs of those that use them.	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 Learning Disability Nurse • 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 **Gaps in Control and Actions:** - Capacity of internal team to expand co-design and engagement is limited, even with working collaboratively with others in the system through networks. Action: Continue to maximise other resources and support where able and focus upon priorities to mitigate.	• PEG actions/ notes • Patient feedback • Healthwatch reports • CQC reports • Maternity Voices reports • Complaints including local MPs • Patient engagement data •Local independent groups reports or complaints • Dos Data and Public Health reports • Health Inequalities data	Good	Good	4
PL 4.2	QC	CNO & CMO	CIO - digital and BI Alison Mabin - Patient feedback CMO - AHSN CEO/Director of Strategy - ICS	**Risk description:** If we fail to utilise population health data in a meaningful way to inform service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing	3	4	12	• DIS dataset • Partnerships in ICS with Public health and Local authority at PCACE level • Primary care Networks • Digital data sources with shared records • Business intelligence resources across the system • ICS Health Inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance **Gaps in Control and Actions:** - Gap in analytics of data capacity to support clinical leads: ACTION: part of the One Dorset approach to digital and business intelligence resources aligned to the ICS digital strategy development	• HI group reports and actions • Benchmarking data • Patient feedback • Partners feedback • Data • National published reports or network reports • ICS Clinical reference group notes • National audits on outcomes	Good	Good	4

Risk Ref:	Committee	Accountable Executive	Risk Owner	Risk Description/Risk Owner:	Consequence Score	Likelihood Score	Risk Score	Existing Mitigation/ Controls	Assurance/ Evidence	Strength of Control	Strength of Assurance	Target Risk Score	# Partnership risks: 11
Partnership Objective 1: We will contribute to a strong, effective Integrated Care System, focussed on meeting the needs of the population													
PA 1.1	Board	CEO	CEO/Director of Strategy	**Risk description:** If the Trust decision-making processes do not take due account of system elements then the Trust will not be able to engage proactively within the system so the impact of the Trust on the system will be diminished	4	2	8	• SLG and Corporate Governance includes system updates and information • Membership of Provider Collaboratives and system other forums • Board feedback and monitoring of system engagement **Gaps in Control and Actions:**	• SLG Meetings • Board and Committees • System Oversight Framework	Good	Good	8	
PA 1.2		CIO	CIO	**Risk description:** If the Trust does not embed population health data within decision-making which highlights health inequalities then the Trust will not know if it is delivering services which meet the needs of its populations	3	3	9	• Dorset Insight and Intelligence Service (DIIS) accessible and available to Trust • DIIS/BI dashboards on key trust metrics provided **Gaps in Control and Actions:** Funding being sourced for a Data Scientist to join the DiiS Team Funding being sourced to continue to provide the System PHM team which will benefit efforts at DCH Trust BI team to make more use of inequality data and wider determinants data available in the DiiS in DCH toolsets	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	Requires Improvement	6	
PA 1.3		CMO	CMO	**Risk description:** If robust departmental, care group and divisional triumvirate leadership does not facilitate genuine MDT working, then services will be less effective, so that poor patient outcomes are more likely	3	2	6	• Divisions supported by the Strategy and Partnerships Team (Estates/place based portfolio). • Development of the clinical strategy **Gaps in Control and Actions:**	• Reporting through SLG	Good	Good	6	
PA 1.4		CMO	CMO	**Risk description:** Recovery of waiting lists plus increasing workload within the hospital may impair our ability to contribute effectively to the objectives of the ICS	3	4	12	• Development of the Clinical and People Strategies, recognising the need for integrated working • Trust Board oversight and assurance of ICS Involvement in Elective Recovery Oversight Group with clinical leads present in key workstreams - MSK, Eyes, Endoscopy, ENT - opportunities noted and acted upon to share resource, space, ideas to maximise recovery as a system **Gaps in Control and Actions:**	• Monitoring and oversight of Trust Strategy and enabling strategies, reporting to Trust Board evidenced through papers and minutes - ECOG and associated workstream documentation	Requires Improvement/ Good	Good	6	
Partnership Objective 2: We will ensure best value for the population in all that we do and we will create partnerships with commercial, voluntary and social enterprise organisations to address key challenges in innovative and cost-effective ways													
PA 2.1	FPC	CFO	CFO	**Risk description**: If the Trust fails to deliver sustained financial breakeven and to be self sufficient in cash terms then it could be placed into special measures by the regulator and need to borrow externally to ensure it does not run out of cash	4	5	20	• ICS Financial framework and Financial Strategy. • Current short term plans delivering close to a breakeven and do not require external financing, but are heavily reliant on non recurrent funding. **Gaps in Control and Actions:** System summit progressing some transformational recovery actions and financial recovery support has been commissioned working across the system to develop a plan to get back into balance.	• ICS Financial framework and Financial Strategy • Reporting to Board, FPC and BVBCB.	Good	Requires Improvement	12	
PA 2.2	FPC	CFO	CFO	**Risk description**: If the Trust fails to deliver sufficient Cost improvements and continues to be efficient in national financial benchmarking then there will be increased focus from the regulator and a detrimental impact on reputation as well as highlighting financial sustainability concerns.	4	3	12	• Track record, PMO facilitating ideas for savings etc. • BVBCB, FPC and Board monitoring CIP plans and delivery **Gaps in Control and Actions:**	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	Good	9	
PA 2.3	QC	CEO	CEO	**Risk description:** If the Trust does not engage with commercial and VCSE sector partners then cost effective solutions to complex challenges will be restricted and so the Trust will be limited in the impact it is able to have	3	2	6	• Commercial and Partnerships Strategy and Plan • VCSE engagement via patient and public engagement and charity teams. • SLG reporting **Gaps in Control and Actions:**	• Commercial strategy delivery reporting • Your Voice Engagement Group • Social Value strategy oversight	Good	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	FPC	COO	COO	**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 vfm, sustainability and variation of services for patients will not decrease sufficiently	4	2	8	• Engagement in current 'provider collaboratives' e.g. Elective Care Oversight, Home First etc, UECB, DCP • Commitment to be engaged fully in ICS 'Provider Collaborative' South Walks initiative with system partners including Local Authority and community provider **Gaps in Control and Actions:** ICS still in formation phase - can better articulate when ICS constructs better described	• Reporting to Trust Board and FPC • System documentation for Home First, Urgent and Emergency Care Board, Elective Care Oversight Group including Deep Dives and SRO roles, work-stream specific documentation	Good	Good	8	
PA 3.2	FPC	CEO	CMO	**Risk description:** If the Trust does not initially support the appropriate delegation of authority to the Provider Collaborative and then does not adequately acknowledge and accept the delegation then effective functioning of the Provider Collaborative will not be possible and appropriate and measured solutions which improve sustainability and reduce variation will not be implemented	4	2	8	• Engagement of Trust Board in ICS discussions and planning • Trust Board review and approval of any delegation. The Trust has a legal obligation to collaborate outlined in the amended provider licence **Gaps in Control and Actions:**	• Trust Board papers	Good	Good	8	
PA 3.3	QC	CMO	CMO	**Risk description:** If the Trust does not invest and support key services identified as 'centres of excellence' by the clinical strategy then investment into key services integral to the future sustainability of the Trust will not be forthcoming	4	4	16	• The Clinical Strategy will set out the areas for investment and prioritisation. • Investment through business planning will be aligned to clinical strategy to ensure investment in key areas which are integral to the future sustainability if the Trust • Review of investment and impact via divisional performance framework and sub-committee structure. **Gaps in Control and Actions:**	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	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	FPC	CEO	Head of Social Value	**Risk description:** If the Trust does not recognise the impact of it's decisions on the wider economic, social and environmental well-being of our local communities then our impact will not be as positive as it could be and so the health our populations will be affected	3	3	9	• Social Value Programme. • Social Value Impact Assessments against decision • Reporting of social value programme progress and impact against social value plan to SLG and Trust Board. **Gaps in Control and Actions:**	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	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 >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

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

DOMAIN C5: FINANCIAL IMPACT OF RISK OCCURING

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

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

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

Meeting Title:	Board of Directors Part 1
Date of Meeting:	30th March 20222
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	22nd March 2022	

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. All risks have been aligned with the revised Board Assurance Framework.							
Action recommended	The Board is recommended to: • review the current Corporate Risk Register • note the Extreme and High risk areas and actions • consider overall risks to strategic objectives and BAF • request any further assurances							

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	

Audit and Risk Committee
Corporate Risk Register as at 09.03.2022

Executive Summary
The Committee will note that the highest risks are associated with the impact of delayed patient treatment as a result of COVID 19 pandemic control, and the recruitment and retention of staff. There has been some impact on services as a result of staff absence linked to Covid-19.

1. Introduction

1.1 This report provides an update from the report presented to the January 2022 Committee meeting and to highlight any new and emerging risks from within the Trust. It should be noted that this report details the Trust position as at 09.03.2022 unless otherwise stated and is reflective of the operational risks.

1.2 This report is to provide the Committee with assurance of the continued focus on the identification, recording and management of risks across the Trust at all levels. These are managed in line with the Trust's Risk Management Framework. The Corporate Risk Register is an amalgamation of the operational risks that require Trust level oversight. The Corporate Risk Register items are the overarching cumulative risks that cover a number of services and the divisions where individual risk elements are being actively managed.

1.3 Presented to the Committee at Appendix 1 is a heat map of those items currently on the Corporate Risk Register with Appendix 2 providing the detail.

- Heat Map (detailed in Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)
- Risk register items recommended for movement to 'managed'.

2. Updates

2.1 **Financial sustainability (449)**
Risk level remains at Moderate. Details are contained in Appendix 2.

2.2 **709 – Failure to meet constitutional standards (Extreme (20))**
710 - Follow up waiting list backlog (Extreme (20))
These risks were required with the Chief Operating Officer on 23 February 2022. Following NHSIE guidance, these two risks have been closed and reframed as:
1221 – Tackling the backlog of elective care (Extreme (20))
The guidance within the delivery plan for tackling the Covid-19 Delivery plan for tackling backlog of elective care with focus on four areas of delivery published 08.02.2022:

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

2.2.1 The central aim is to maximise NHS capacity, supporting systems to deliver around 30 per cent more elective activity by 2024-25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

2.2.2 The plan will require significant investment in the capacity and skills of our staff while ensuring that our workforce is supported to deliver the task ahead. We know that you have already made strong progress on elective recovery, and this plan tries to reflect the work that you have been doing.

2.2.3 The impact of the COVID-19 pandemic is not limited to elective care, and it can be seen across mental health, primary and community care.

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 remains variable. However, patients admitted with Covid are at a manageable level. Since early January 2022 the Covid cases impacting on staff absences has been at a higher level. The incidence relates to community transmission. 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.)
- FFP3 lead has been appointed and will be supported by the Health, Safety and Security manager (when in post) and staff from the Divisions.

3.2 1221 - Tackling the backlog of elective care (Extreme (20))

3.2.1 The access team are continuing to contact patients on the waiting lists. Patients are being called in clinical priority with consultants having oversight of the lists.

3.2.2 This risk has been scored as ‘Extreme’ due to the potential impact on patient safety and delay in treatment that could potentially lead to harm. (This is being mitigated by reviewing patients based on clinical need and any changes in presentations). There may be financial implications if there is an increase in litigation if patient harm has been caused due to delays caused by Covid 19.

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.

3.3.2 Updates to both of these risks are detailed in Appendix 2

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 UPDATE: No Reason to Reside Patients

4.1 461- 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.

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 patient's well-being and the flow of patients. As at 15 March 2022, the figure stands at 85 patients.

4.1.3 Predominantly, this cohort 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 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.

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

Strategic Estates have a risk register that relates to the new builds and the masterplan, whilst their risk register has not yet identified anything that requires escalation to the Corporate Risk, the Committee may wish to seek assurance on this project as it progresses.

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
- request any further assurances

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 09.03.2022
Appendices
Appendix 1 – Heat map
Appendix 2 - Corporate Risk Register

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** (641)	**20**	**25**
	4 Major	**4**	**8**	**12** (690)	**16** (474, 979)	**20** (472, 840, 919,1221)
	3 Moderate	**3**	**6**	**9**	**12** (449, 450, 464)	**15**
	2 Minor	**2**	**4**	**6**	**8**	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**
	KEY	**(↓number) (↑number)**	Risk score has decreased since previous report Risk score has increased since previous report **Please note that no arrow indicates no change to previous risk score.**			
	Managed/Tolerated risks	463 (High – next review date 28.02.22)Workforce Planning & Capacity for Nursing and Allied Health Professional and Health Sciences staff; and 468 (Extreme –next review date 28.02.22) Recruitment and retention of Medical staff across specialities				
	Closed	469 Temporary Medical Workforce Planning & Capacity (this was reframed as 468) 456 (Low) Patient Transport Provision & Urgent Patient Transfers 973 (Very low) Public Disorder 709 (Extreme) Failure to meet constitutional standards 710 (Extreme) Follow up waiting list backlog				

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 and mitigations)	Extreme (20) Consequence: Catastrophic Likelihood: Likely Reviewed: 24.01.2022
919	Covid- 19	Previous Rating	Extreme (20)
This will impact on all of our strategic objectives.		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** – Incident leading to death, mismanagement of patient care with long term effects **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation **Service/business interruption** - major impact on service Catastrophic impact on all health systems especially acute hospitals being unable to cope with demand, plus mortuary capacity overload. **Finance pressure**: Cost of agency, locum and bank staff. **Likelihood:** Certain		Local Manager	Tony James
Current position Mitigation As at 24.01.22 (data correct as at 24.01.2022)		TARGET RATING 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. • If supplies are provided as an alternative which are not CE marked these items go through a rigorous risk assessment process before being introduced. • Eligible staff have received their Covid 19 vaccination booster to ensure resilience of the workforce. • Fit Mask testing continuing • National guidance being followed		Next review date **All actions identified to date have been completed**	31.03.2022

Movement on Risk Register: 	Risk Statement Community Paediatric Long Waits for ASD Patients **Date added to Corporate Risk Register 09.06.2021** **Opened by Service 10.09.2018 – reviewed monthly** **Escalated to Division 08.06.2021 request to escalate to Corporate**	CURRENT RISK RATING (Following review and current mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 09.02.2022
472	There has been a significant increase in referrals to the ASD (Autism Spectrum Disorder) service, alongside ongoing commissioning issues for the service.	Previous Rating	High (15)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Statutory duty** - multiple breeches in statutory duty, low performance rating **Adverse publicity** - National media coverage <3-day service well below reasonable public expectation **Finance including claims** - Claims between £100k and £1m **Likelihood:** Certain		Local Manager	James Male (service Manager)
Current position/Progress/Mitigation As at 09.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 31.03.2022
Mitigation: • Interviews for specialist grade took place 08.10.21. Post was appointed to start date 01.02.2022. Target date amended to reflect the start date. Staff member appointed and in post • Validation needed for ASD pathway and current waiting list • All Age Autism Review led by CCG underway • Specialist Grade, Community Paediatrics now in post • ASD funding awarded from the CCG to be spent in 21/22, to support patients awaiting ADOS assessment • Meeting to discuss ASD database arranged – 11/2		Next review date **ACTION RE APPOINTMENT COMPLETED** **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	Not noted – on track for completion at the end of the month

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 and current mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 15.02.2022
840	Paediatric Diabetes Service Staffing	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3-day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Certain**		Local Manager	Anna Ekerold
Current position/Progress/Mitigation As at 15.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target Date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 01.12.2022
Mitigation: • Band 7 JD/PD for Paediatric Diabetes Clinical Nurse Specialist and Band 8b Paediatric Diabetes Clinical Psychologist uploaded to TRAC. Email received today (15.02.2022) from recruitment to state that CoE needed to be submitted before both jobs could be advertised. • New Band 6 PDSD now in post - no desk space, laptop or phone for this new member of staff.		Next review date **TARGET DATE EXTENDED DUE TO RECRUITMENT PROCESS.**	15.03.2022

Movement on Risk Register: REVISED RISK REPLACES 709 and 710	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 23.02.2022
1221	Tackling the backlog of elective care	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Likelihood:** Certain		Local Manager	All speciality leads
Current position/Progress/Mitigation As at 23.02.2022 (data correct as at 09.03.2022)		POST MITIGATION RATING (TARGET) Target date	Very Low (8) Consequence: Minor Likelihood: Likely 31.03.2025
• To support elective recovery the government plans to spend more than £8 billion from 2022/23 to 2024/25, supported by a £5.9 billion investment in capital – for new beds, equipment and technology. • This is in addition to the £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund (TIF) already made available to systems this year to help drive up and protect elective activity. • Under the TIF, the NHS is investing in over 870 schemes across more than 180 hospital trusts to increase capacity through expanding wards, installing modular operating theatres, upgrading outpatient spaces, expanding mobile diagnostics for cancer, upgrading MRI and screening technology, all to tackle cancer and elective waiting lists and reduce waiting times. There will also be investment in technology to improve patient experiences of care and help patients manage their conditions. • The funding committed for elective recovery will be spent on delivering additional activity in an innovative way, enabling the NHS to carry out more checks, scans, outpatient appointments, operations and other procedures up to March 2025. • A significant part of this will be invested in staff – both in terms of capacity and skills.		Next review date	31.03.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.09.2018**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed: 08.10.2021
474	Review of Co-Tag system and management of issuing/retrieving tags to staff	Previous Rating	Extreme (20)
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective: Place **How this risk has been scored:** **Consequence: Major** **Patient safety** - major injury leading to long term incapacity/ disability. **Quality/complaints/audit** - multiple complaints, low performance rating, non-compliance with national standards with significant risk to patients if unresolved. **Adverse publicity** - national media coverage with <3 days service below reasonable public expectation (no access for RESUS teams) **Service/business interruption** - major impact on environment **Likelihood:** Certain		Local Manager	Don Taylor
Current position/Progress/Mitigation As at 08.10.2021 (data correct as at 09.03.2022)		TARGET RATING 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**	31.03.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 12.07.2019**	CURRENT RISK RATING (Following review and mitigations)	High (15) Consequence: Moderate Likelihood: Certain Reviewed: 16.02.2022
641	Clinical Coding	Previous Rating	Extreme
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic Objective: Place **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results **Likelihood:** Certain		Local Manager	Sue Eve-Jones
Current position/Progress/Mitigation As at 16.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.12.2022
Almost all the coding is completed up to the 31.08.21 which will be included in the next Dr Foster report. NHS digital pull data from HES which includes incomplete data unlike Dr Foster who use SUS data for reporting therefore take our data in its entirety. While they do not calculate SHIMI they do calculate HSMR, which provides further assurance following the decline in the SHIMI. We do need to decide when we request a HES data refresh. From an executive perspective they are happy to consider appropriate requests for additional staff. It is difficult to get contract coders to come to site so may take on more remote coders who have to code with what is available. Difficult position may need to compromise at some point. Following further discussion, the group agreed that requesting remote coders to do coding on ERF work and contract coders to code the remaining data as already in place was the best course of action at present. We will need to review how we continue as there is not enough scanned records to support what is required. We will have to use the first part of the new financial year to ensure we have cleared up the previous year which may put our income at risk in the first couple of months.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING (Following review and mitigations)	High (16) Consequence: Major Likelihood: Likely Reviewed: 11.11.2021
979	Removal/reduction of education funding from HEE commencing April 21.	Previous Rating	Moderate (12)
Impact on Strategic Objectives		Lead Executive	Dawn Harvey
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **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 09.03.2022)		TARGET RATING 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 Q4 21/22**	31.03.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 26.10.2017**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 01.11.2021
450	Emergency Department Target, Delays to Care & Patient Flow	Previous Rating	High
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How the risk has been scored:** **Consequence: Major** **Impact on patient safety** - major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit** - non-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources** - Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty** - multiple breeches in statutory duty, low performance rating Adverse publicity - National media coverage <3 day service well below reasonable public expectation **Business objectives** - Key objectives not met. **Finance including claims** - Claims between £100k and £1m **Likelihood: Possible**		Local Manager	Samantha Hartley
Current position/Progress/Mitigation As at 01.11.2021(data correct as at 03.11.2021)		TARGET RATING Target date:	Moderate (12) Consequence: Major Likelihood: Possible 31.11.2022
Mitigation: Liaison Service on site. Increase in activity is being managed with IMT ED area increased during pandemic to assist with flow and capacity. Building works commenced to enlarge ED 2021 ED performance continues to be impacted by increased attendances and ambulance conveyances. This is being partially mitigated by increased ambulatory care activity and focused work on super stranded patients and delayed transfers of care. Whilst this standard is not being achieved, the Trust performance remains above the national average. UPDATE: Minor service has relocated to Weymouth UCC 28 June 2021 to assist with patient flow and attendances at ED		Next review date **ACTIONS ONGOING, BUILDING WORK CONTINUES TO ENLARGE FOOTPRINT. ADDRESSING FOOTPRINT VIA MASTERPLAN**	30.09.2022 (annual review)
OTHER RISK REGISTERS LINKED TO RISK 450		**Current rating following local review**	**Target rating following completion of all actions**
1060 ED Footprint not fit for purpose 1061 Workforce requirements for new ED 709 – Failure to achieve constitutional standards (now closed).		Low risk Moderate risk	Very Low risk Very Low risk

Ref: 	Risk Statement	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed:08.03.2022
449	**Financial Sustainability**	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership**		Local Manager	Claire Abraham
Current position/Progress/Mitigation As at 08.03.2022(data correct as at 09.03.2022)		TARGET RATING Target date:	Low (6) Consequence: Moderate Likelihood: Unlikely 31.03.2022
The 2021/22 year end position is on trajectory to deliver a planned breakeven. However the initial analysis of the planning guidance and level of resources available within the Dorset system are indicating that the Trust is likely to be submitting a sizeable deficit plan for 22/23 when the first draft position is submitted in mid March.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	31.03.2022

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Moderate Likelihood: Likely Reviewed:16.02.2022
464	Mortality Indicator	Previous Rating	Low
Impact on Strategic Objectives		Lead Executive	Alastair Hutchison
Strategic objective: Place **How the risk has been scored:** **Consequence: Moderate** **Impact on patient safety -** major injury leading to long term incapacity/ disability, mismanagement of patient care with long term effects **Quality/complaints/audit - non**-compliance with national standards with significant risk to patients if unresolved, multiple complaints, low performance rating **Human resources -** Uncertain delivery of key objectives/ service due to lack of staff, loss of key staff, very low staff morale **Statutory duty -** multiple breeches in statutory duty, low performance rating **Adverse publicity - National** media coverage <3 day service well below reasonable public expectation **Business objectives -** Key objectives not met. Likelihood: Possible		Local Manager	Alastair Hutchison
Current position/Progress/Mitigation As at 16.02.2022 (data correct as at09.03.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2022
After progressive rise in SHIMI over the last 9 months the last month rolling year to July 21 has seen a huge drop down from 1.20 to 1.15. The reason is a jump in expected mortality which relates to coding. The actual number of deaths did not change over that period. Good news is depth of coding which had been increasing then dropped over the last five months has picked up again. This data is dependent on the actual number of deaths which is unchanged which all points to an improvement in coding. The Hospital Mortality group discussed the significant improvement in the SHIMI and various reasons for it. It was agreed that the biggest impact of all is having data uncoded which goes into the data as an unspecified diagnosis and is given the lowest relative risk which results in a huge discrepancy. If we do have to compromise, we want to ensure we get people in the right diagnostic basket for the non-electives.		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641** **LIKELY TARGET DATE WILL NEED TO BE REVISED.**	31.03.2022

Movement on Risk Register: 	Risk Statement **Added to the Risk Register 16.09.2016 reviewed in line with national policy and national risk register annually (unless incident occurs)**	CURRENT RISK RATING (Following review and mitigations)	Moderate (12) Consequence: Major Likelihood: Possible Reviewed: 15.09.2021
690	Malicious attack - Cyber-attack on the NHS / Internal ICT failure	Previous Rating	Moderate
Impact on Strategic Objectives		Lead Executive	Stephen Slough
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met. **Finance including claims** - Non delivery of key objectives loss of >1% of budget, loss of contracts and payment by results		Local Manager	Simon Brown
Current position/Progress/Mitigation As at 15.09.2021 (data correct as at 03.11.2021)		TARGET RATING Target Date:	Moderate (12) Consequence: Major Likelihood: Possible 31.03.2025
PLEASE NOTE: EXTENAL RATING FROM NATIONAL RISK REGISTER OF CIVIL EMERGENCIES is Medium – low risk. 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 **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 and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 09.09.2021
461	High volume of patients with no reason to reside	Previous Rating	High Risk
Impact on Strategic Objectives		Lead Executive	Anita Thomas
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** **How this risk has been scored:** **Consequence: Moderate** **Impact on patient safety** - mismanagement of patient care with long term effects **Quality/Complaints/Audit** - Non-compliance with national standards, critical report. Human resources - loss of key staff, low staff morale. **Statutory duty** - multiple breeches in statutory duty, improvement notices, low performance rating, critical report. **Adverse publicity** - National media coverage (being outliers) **Business objectives** - key objectives not met.			
Current position/Progress/Mitigation As at 08.09.2021 (data correct as at 09.03.2022)		TARGET 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 LIKELY TARGET DATE WILL NEED TO BE REVISED.	31.03.2022

Meeting Title:	**Board of Directors**
Date of Meeting:	**30th March 2022**
Document Title:	**Well Led Review Final Report**
Responsible Director:	**Nick Johnson, Interim Chief Executive**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	Not Confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Trust Board	January 2022	Submit comments on draft report and prepare an action plan in response.
Senior Leadership Group (SLG)	16th March 2022	Consider involvement of non clinical divisions in the action plan Meetings with divisional triumvirate on Divisional and Care Group Governance actions. SLG members to input to the draft action plan Return an update to SLG in 6 week's time

Purpose of the Paper	The Final Report following completion of the Well Led Review undertaken by PriceWaterhouseCoopers at the end of 2021 has been received and is provided for the Board's consideration.						
	Note (✓)		*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The final report following the PriceWaterhouseCoopers review of the Trust's 'Well Led' arrangements has been received and makes nine recommendations on areas for further development by the Trust. A draft Action Plan in response to the nine recommendations will be presented to the Board of Directors at the end of May 2022 following discussion with corporate and divisional service leaders.						
Action recommended	The Board of Directors is asked to: 1. **Note** the Final Well Led Review Report 2. **Note** that the Action Plan in response to the nine report recommendations will be presented to the Board in May 2022 for approval.						

Governance and Compliance Obligations

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

Impacts Social Value ambitions?	Y	Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust's social value ambitions.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Dorset County Hospital NHS Foundation Trust

Independent review of leadership and governance

February 2022

pwc

Dorset County Hospital
NHS Foundation Trust
Williams Ave
Dorchester
DT1 2JY

21 December 2021

Dear Sir / Madam

Independent review of leadership and governance: Dorset County Hospital NHS Foundation Trust

We have been instructed by Dorset County Hospital NHS Foundation Trust ("the Trust") to report on the findings of our independent review of governance and leadership arrangements in accordance with the call-off form dated 1st October 2021.

This draft document has been prepared only for the Trust and solely for the purpose and on the terms agreed with the Trust in our call-off form dated 1st October 2021. We accept no liability (including for negligence) to anyone else in connection with this document, and it may not be provided to anyone else.

In the event that, pursuant to a request which you have received under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004 (as the same may be amended or re-enacted from time to time) or any subordinate legislation made thereunder (collectively, the "Legislation"), you are required to disclose any information contained in this report, you will consult with us prior to disclosing such report. You agree to pay due regard to any representations which we may make in connection with such disclosure and to apply any relevant exemptions which may exist under the Legislation to such report. If, following consultation with us, you disclose this report or any part of it, you shall ensure that any disclaimer which we have included or may subsequently wish to include in the report is reproduced in full in any copies disclosed.

Yours faithfully,

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Introduction

Background

Dorset County Hospital NHS Foundation Trust is the main provider of acute hospital care to the residents of West Dorset, North Dorset, Weymouth and Portland, a population of approx. 250,000. It serves an area with a higher than average elderly population and lower than average proportion of school-aged children. It provides a range of district general services including urgent and emergency care, planned and specialist care, maternity and paediatric services, care for long-term conditions, frailty and end of life care. It also provides some specialist services to the whole of Dorset and beyond.

The main hospital site is based in Dorchester and the Trust delivers community based services in GP practices, patients' homes and community hospitals. The Trust actively supports collaborative initiatives with local partners, including as part of the Integrated Care System (ICS).

The Trust has recently refreshed its five-year strategy through significant engagement with stakeholders across the health and care system. It is in the process of refreshing the underpinning strategies including the Clinical and People strategies.

The Trust is currently facing significant pressures as a result of the Covid-19 pandemic, including a high rate of admissions and workforce issues caused by staff having to isolate. As a result of this, and in line with the other NHS Trusts nationally, DCH is currently experiencing a substantial elective backlog. This has been exacerbated by a high number of patients with no reason to reside. In November 2021, the Trust was put into segment 3 of the Single Oversight Framework reflecting the operational pressures the Trust is facing.

The Trust is running a number of significant programmes at both organisational and system/place level. The Trust was awarded £77.3 million of funding from the Government's New Hospitals Programme to expand services on the Dorchester site, including extending the Emergency Department and Intensive Care Unit, plus creating an Integrated Care Hub. The Trust has also recently set up an outpatients assessment clinic at South Walks House in partnership with NHS Dorset Clinical Commissioning Group (CCG), Dorset Healthcare, LiveWell Dorset and Active Dorset.

Our Scope

Our work commenced in October 2021 and has been conducted in accordance with the call-off form dated 1 October 2021.

We have undertaken a review of governance and leadership at the Trust, based on the Well-Led Framework published by NHS Improvement in 2017.

Introduction

Process

Our review process has involved the following elements:

- Review of the Board's Well-Led self-assessment
- Interviews with Board members, the Lead Governor, and other staff including triumvirate leads
- Observation of key meetings
- Document review

Details of interviews held and meetings observed can be found in Appendix 1.

In addition, we have held regular update calls with the Trust.

We are grateful for the cooperation of all the staff involved, who have been most helpful.

At a Glance

At a glance – our views

The Board is operating at the higher end of NHS trust board effectiveness, based on our experience. The Board is stable, diverse and has a good mix of skills. The strategic refresh has clarified the strategic direction of the Trust. The supporting strategies are in the process of development but once this is complete, it will become important to align enablers.

1 ***The Board is stable, diverse and works effectively as a team. There is a good mix of skills and experience among the NEDs, including significant clinical leadership experience.***

The Board has a good mix of skills and experience, and both Executives and NEDs are clear on their roles and responsibilities. There is a shared understanding of Trust risks and challenges. The Chair leads the Board well with a strong focus on development and self-reflection. The relationship between the Chair and CEO is supportive and appropriately challenging.

A number of NEDs are coming to the end of their tenures, including the Chair. Furthermore, the CEO will shortly be moving on to lead the Integrated Care System (ICS). This presents both a risk and an opportunity to the organisation. There is an opportunity to bring fresh perspectives and skills to the Board, but at the same time there is a risk that Board stability and dynamics may be impacted. It will be critical to ensure there is targeted and comprehensive Board development and NED inductions to ensure leadership remains cohesive and stable.

2 ***The Board leverages governance systems and processes effectively to ensure it is assured and sighted on risks, issues and interventions***

Board and subcommittee meetings function well, effectively leveraging the governance structure to ensure appropriate risks and issues are escalated. The Board uses its subcommittee structures effectively, focusing on pertinent matters by exception and creating sufficient time for strategic matters. Board and subcommittees are well chaired with good scrutiny from NEDs for the most part. However, from our observations of the Board and subcommittees, we did identify a need for stronger challenge over finance and performance in some areas in order to gain more robust assurance and ensure pace is maintained..

3 ***The new strategy clarifies the Trust's ambition and is in the process of being embedded. Work is underway to develop the Clinical and People Strategies which will support the delivery of the overall strategy.***

The Trust has undergone a significant process to refresh its strategy, including substantial stakeholder engagement. In our view, the approach taken has been robust and the strategy clearly articulates the vision for the Trust. Furthermore, the strategy is outward-looking, taking into account both system and place-based plans. As the strategy is further developed into plans, it will be important to work more closely with system partners to deliver joint objectives including around financial sustainability and access.

The strategic refresh is ongoing, and the underpinning Clinical and People strategies are in the process of being developed through a significant bottom-up process. Once the strategies

At a glance – our views

The Trust has an open and inclusive culture with significant focus on continuous improvement and innovation. Staff feel that there are opportunities for training and career progression. The Trust is outward looking and committed to the population of West Dorset. The Board is proactive in engaging with the wider Integrated Care System.

have been finalised, it will be important to ensure that other enablers such as risk registers, recruitment and appraisals are aligned to these.

4 ***DCH is a values-driven organisation, where patient safety and quality are prioritised.***

The Trust has an open and inclusive culture and there is significant focus on continuous improvement and innovation. The Trust has invested in innovation including a dedicated Transformation and Improvement team, which supports staff to make positive changes including a number of innovative QI projects.

Staff feel able to raise concerns, challenge behaviour inconsistent with the values of the Trust, and leadership were described as open, approachable and transparent. There is significant focus on the diversity and inclusion agenda throughout the Trust and this is championed by the Board. Staff also articulated a sense of pride in working at DCH.

5 ***The Board is proactive in engaging with and seeking to influence partner organisations in the Integrated Care System***

The Trust is viewed as transparent and outward looking, albeit with a significant focus on place. The Trust is influential in driving the agenda around population health management and reducing inequalities. The Trust is involved in a number of cross-system programmes and has made exceptional progress in certain areas, for example, the Digital agenda. The Trust recognises its status as an “anchor organisation” in West Dorset and seeks to exploit this for the benefit of its population.

There is scope for DCH to improve engagement with a number of system partners in order to build more open relationships and accelerate the pace of change at system and place level. In particular, the Board should consider how it communicates with external partners to ensure they have a good understanding of DCH’s overall strategy, including areas where system collaboration is necessary to deliver shared objectives.

6 ***While there has been less focus on finances as a result of the Covid-19 pandemic and the NHS’s emergency funding arrangements, as these arrangements come to an end, finance must again be prioritised alongside quality and operational performance.***

The Covid-19 pandemic has, quite rightly, shifted the Trust’s focus towards operational pressures and ensuring patient safety and quality of care. This focus has been supported by alternative funding arrangements, which have provided the Trust the headspace to focus on frontline services. NHS England is planning to end emergency financial arrangements as early as

At a glance – our views

Governance arrangements were temporarily streamlined as a result of the Covid-19 pandemic. The Trust is well invested in business intelligence and data analysis capability, and uses this in a forward-looking way to obtain insight into emerging risks and the development of its services.

April 2022, and so, it is critical that the Trust turns its attention back to ensuring that a culture of financial sustainability is embedded at every level throughout the Trust, and championed by the Board. The Transformation and Improvement teams have plans to integrate productivity and efficiency as part of the wider QI work, which will support this agenda. The Trust must ensure that the 22/23 CIP programme has sufficient governance to identify and deliver the necessary cost improvements.

7 ***The Trust has invested in business intelligence recognising the importance of accessibility of intelligence to support Divisions and Care Groups***

The Trust uses business intelligence in innovative, forward looking ways. There is a central Business Intelligence team which provides support to the Divisions and Care Groups. While it is currently under-resourced, the team ensures accessibility to intelligence.

The quality of performance reporting at Trust-level is good. Key issues with performance are clearly highlighted both in data dashboards and in supporting narrative in Board and subcommittee papers, although the consistency of the level of narrative provided could be strengthened.

8 ***The Divisional structure provides clear lines of accountability, reporting and escalation but more consistency and clarity needed at Care Group level***

The Divisional structure functions well and there is good devolved leadership with well-defined roles. Divisional leadership understood the importance of governance and were keen to ensure this functioned effectively.

There are effective risk management processes in place we observed risk escalation from the Divisions to the Board working well. Divisional leadership also feel that there is opportunity to informally escalate risks and concerns to the Executive team. There is a clear Performance Management Framework in place setting out governance and lines of accountability. Divisional leadership are aware of the inconsistencies at Care Group level and the need to provide more support and guidance.

Key priorities for development

Recommendations

Ref	Recommendation	Time frame	Priority
1	**Leadership** Strengthen oversight and scrutiny by the Board and subcommittees over aspects of finance and performance, in particular, ensuring there is adequate assurance gained over financial plans to deliver sustainability, including the internal accountability processes for delivering plans.	3 months	Medium
2	**Board development** Provide training and support for incoming NEDs, including tailored induction to meet individual needs. Ensure there are Board sessions tailored to support the development of a high-performing and cohesive team to manage transition through period of change.	3 months	Medium
3	**System-working** In order to accelerate progress in the Integrated Care System (ICS) towards clinical and financial sustainability, DCH should consider how it communicates with system partners. This should include: ● Ensuring system partners have a good understanding of DCH's challenges and plans to tackle these ● Ensuring DCH is communicating in a way that is impactful - consider who is giving the message and in what forum. ● A Board-to-Board session with acute partners to build relationships and set out the processes to accelerate progress ● Training to service managers and clinicians on system working, including the leadership skills and capabilities required to deliver successful cross-system projects. ● As the strategy development process comes to an end, consider ways to communicate the outputs with external stakeholders	3-6 months	Medium

Recommendations

Ref	Recommendation	Time frame	Priority
4	**Strategy refresh** As the Clinical and People strategy refresh is completed, the Trust should ensure all other enablers are aligned to the strategy. This should include recruitment, appraisals, performance management, policies and procedures.	3-6 months	Medium
5	**Performance management** The Trust should strengthen accountability at all levels, and in particular, ensure performance management is balanced between quality, operations and finances, while still maintaining its focus on wellbeing and support to staff	3 months	Medium
6	**Care Group governance** The Trust should leverage the Divisional leadership teams to reinforce the expectations of the structure, content, attendance and recording of Care Group governance meetings. Ensure that where division or Care Group leaders are unable to attend meetings, suitable deputies attend in their place and this is recorded in the minutes	3 months	Medium
7	**Leadership visibility** Implement a more structured approach to Board visibility across the organisation for example through periodic Exec briefings	2-4 months	Low
8	**Patient comms** Ensure communications to service users and the public are simple, easy to read and jargon-free.	3 months	Medium
9	**Clinical Audit** Leverage clinical audit to focus on key priorities for the Trust in addition to national standards.	3 months	Medium

Detailed report

Selected information

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Our view

The Board is stable and diverse in its membership, and it functions effectively. There is a good mix of skills and experience with NEDs bringing a range of knowledge and insight from their professional backgrounds. The Chair leads the Board well and the relationship between the Chair and Chief Executive is both supportive and appropriately challenging. NEDs are clear on the role in providing independent oversight and constructive challenge to Executives. Board development has considered the importance of the NED role in relation to board assurance and accountabilities.

A number of NEDs, including the Chair, are now coming to the end of their tenures, and new NEDs will be appointed in the upcoming months. The Board has managed previous change in its membership successfully and recognises the need to manage this transition carefully.

Findings

Board member capacity and capability

Board members have been carefully selected based on the needs of the Trust and the local system, and have complementary skills and experience. They bring a wealth of capabilities, skills and experience including on pertinent matters such as population health management, and the inclusion and diversity agenda. There is a shared understanding of Trust risks and challenges, and Board members are aligned in their understanding of the new strategy. Board members have the capability to ensure the strategy can be delivered and risks to performance are addressed. Not surprisingly, given the pandemic and the shift in priorities nationally, including changes to the financial regime, financial planning and performance have have had lower prominence in terms of Board focus. Going forward there will need to be a concurrent and balanced focus on financial sustainability alongside other aspects of performance.

The capacity and capability of the Executive team is well-balanced and in line with expectations for the Trust, taking into account the strategic agenda. The Executives are supported by the Senior Leadership Group and there is good devolved leadership throughout the Trust to support strong oversight.

Board development

The Board is focused on its own development and reflects on its effectiveness. The Board has regular development sessions every other month. These sessions provide them with the time and space to explore relevant topics and build their own knowledge and develop capabilities.

There is an agreed programme in place, covering topics including emerging ICS challenges, maternity safety and system working on inequalities. External guests, including from NHSE/I, are also invited to support the delivery of these sessions. The topics are relevant and aligned with the Trust's agenda, and

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

the invitation of external speakers supports the acquisition of knowledge. These sessions have also served to support Board cohesiveness and collaboration in applying the learning to the Board's work.

Leadership visibility

The Covid-19 pandemic has resulted in a range of social distancing policies being introduced, including remote working. As such, the regularly scheduled NED walkarounds were cancelled. The Board have been, understandably, less visible, and this has been felt by staff at the Trust. However, the Board, and the NEDs in particular, acknowledge this issue, and have expressed a desire to address this. At the time of our fieldwork, the regular NED walkarounds were in the process of being reinstated. More generally, staff told us that the Board communicated well with the organisation and the Executives were approachable and supportive in their leadership approach.

Succession planning

The Board takes a strategic approach to succession planning with regards to both the Executive Team and NEDs. We identified robust succession planning in place, reducing the risk of Board instability. The Trust is in the process of recruiting a number of new NEDs. We identified a very strategic and thoughtful approach to the recruitment of NEDs, based on skillset and the needs of the Trust and the local system.

Investment in leadership development

We found clear, well-established devolved leadership, decision making and accountability through the organisation. Divisional leadership teams feel supported and empowered by the Board. The Trust has taken a strategic approach to managing talent. The Trust recognises it needs to 'grow its own' leaders given workforce shortages, local and national, for many roles and specialties. As such, the Trust invests heavily in training and coaching for its staff, and continued to do so despite operational pressures related to Covid.

There is a robust leadership development programme in place, focusing on developing leaders across grades. This includes a Leadership Fundamentals programme for Bands 4-6, a Clinical leadership programme and an Advanced Leadership programme for above Bands 6 and above. The Trust can demonstrate having successfully developed its own leaders including the current interim COO.

Recommendations

- Ensure there is concurrent and balanced focus on financial sustainability alongside other aspects of performance
- Consider the training needs of incoming NEDs and ensure the induction programme is tailored to meet these
- Consider ways of improving Board, particularly NED, visibility through walkabouts or digital means

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Our view

The Trust undertook a comprehensive process to refresh its high-level strategy in early 2021. This included substantial staff and stakeholder engagement. In our view, the approach taken has been robust and the strategy clearly articulates the vision for the Trust, helping to provide a clear articulation of priorities, direction and intent.

Work is ongoing to develop underpinning, enabling plans, including Clinical and People strategies, through a service and clinically-led engagement process. These plans are expected to be in place by the end of the current financial year.

Findings

Strategy refresh

A strategy refresh was carried out in April 2021 through a structured process with significant stakeholder engagement, including staff, the Patient and Public Engagement Group, the Council of Governors, and representatives from groups such as Age UK.

The Strategy is clear, relevant and easy to understand focusing on three strategic themes:

- **People** - focusing on making DCH a great place to work
- **Place** - reflecting the shift towards population health management
- **Partnership** - outlining the importance of integration with primary, community and local authority partners to deliver joined up care.

The Strategy is outward looking and articulates the Trust's ambition of working with the Integrated Care System (ICS) and at place-level to ensure integrated care for its population, as well as clinical and financial sustainability in the medium to long terms. While the Strategy has been developed with the needs of system and place in mind, as the ICS develops further, it will be important to adjust the strategy accordingly to ensure continued alignment - this is something that the Board is aware of.

Clinical and People enabling strategies

The overarching strategy has been communicated effectively across the organisation, and the Trust is now in the process of developing the underpinning Clinical and People strategies. This process has been clinically-led with Executive oversight provided by the Chief Medical Officer and the Chief People Officer. This is a significant bottom-up process which aims to develop a sense of ownership of the strategies, and associated plans,among service leadership and staff.

The Board is aware that once these plans have been developed, there will be a need to evaluate and assess the financial aspect of their delivery, as part of further refinement and as they are finalised.

KLOE 2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

It is important that clinical quality and sustainability are approached in a joined-up way as the plans are reviewed and finalised, with expectations around efficiency and productivity improvement being an integrated aspect of the delivery of the plans and their intended outcomes.

Embedding the strategy

Staff we spoke to had a clear and consistent understanding of the Trust's vision, values and strategic goals of the trust. Due to the timing of our review, work was being undertaken to translate the strategy into Clinical and People strategies, and so there was less clarity on how the strategy would be implemented, although this is to be expected. We expect this to be resolved in due course as the clinical and people strategy process comes to a close. Once this work is complete, the strategies should be translated into clear implementation plans, and monitored through key performance indicators.

The Trust has established robust governance to support the delivery of the strategy. A bi-monthly 'Strategy and Transformation' Senior Leadership Group (SLG) has been established to support the delivery of the strategic objectives, including reviewing the delivery plan, dashboard, enabling strategies and progress against wider strategic programmes. It will also provide a forum to bring together all transformational change initiatives that are taking place across the Trust.

Service development

As set out in its strategy, the Trust is considering innovative models of care that will contribute to the health of its local population, and relieve pressures on its own services. As such, DCH has set up an outpatients assessment clinic at South Walks House in partnership with NHS Dorset Clinical Commissioning Group (CCG), Dorset Healthcare, LiveWell Dorset and Active Dorset as part of the efforts to tackle the elective backlog. The venture is managed through DCH's usual governance processes.

Recommendations

- Ensure the financial sustainability is woven into the Clinical and People strategies as part of the initial review and finalisation of these plans
- Communicate the Strategy and underpinning strategies to system partners in an impactful way to facilitate joint working
- Once the underpinning strategies have been signed off, ensure there is a robust delivery plan with objectives, timelines, key performance indicators etc

KLOE 3. Is there a culture of high quality, sustainable care?

Our view

We found DCH to be a values-driven organisation, where patient safety and quality are prioritised. Leaders challenge themselves to be compassionate and inclusive, and the trust has implemented a range of programmes to promote equality and diversity, including staff networks and the Inclusive Leadership Programme.

While staff identified the DCH culture as positive, with a lot of emphasis placed on staff wellbeing, as is necessary during a pandemic, there is a need to find the right balance between support, empowerment and accountability for performance. Furthermore, the Board should continue to reflect on how it embeds a culture of financial sustainability and accountability across the organisation.

Findings

People Strategy

The Trust takes staff development, wellbeing and inclusion seriously and has a structured approach to addressing these. The People agenda is championed at Board-level by the Chief People Officer and a Non-Executive Director. This reflects the the importance the Trust places on its people as set out in its strategy.

The Chief People Officer was appointed in April 2021 and has been working closely with the Chief Medical Officer and the Divisions in the development of the Clinical and People strategies. The People strategy development has been a clinically-led process.

The People and Culture Committee is a dedicated subcommittee of the Board chaired by a Non-Executive Director with significant experience across organisational development, diversity and inclusion. There is an annual People Plan that is scrutinised by the Committee on a monthly basis. The Committee scrutinises wellbeing indicators through a People and Performance dashboard. This looks at metrics including staff sickness absence, harassment rates, grievances by month, bank use, agency spend, pulse survey engagement numbers. The dashboard makes good use of comparative data and presents this in an insightful, visual way.

We observed the People and Culture Committee on 16 November. The meeting was chaired effectively, members were respectful and there was constructive questioning and oversight from NEDs.

Equality and diversity

Equality and diversity are championed from the top of the organisation by the Board. The Board took a strategic decision to appoint a Non-Executive Director in January 2021 with experience in designing and delivering equality and diversity initiatives in the public sector. Leaders spoke knowledgeably

KLOE 3. Is there a culture of high quality, sustainable care?

about equality and diversity, including the work carried out by the trust on this to date.

The Trust is in the process of a cultural change programme, with special focus on equality, diversity and inclusivity. This includes a number of initiatives, aligned to the Strategy and overseen by the People and Culture Committee, including:

- A Transforming People and Practices Programme
- An Inclusive Leadership Programme
- Various staff networks - over 400 active participants

The Board was provided with training focused on increasing self-awareness and awareness of the racial equity issues in the Trust and community. The Board has put together a number of options for how this training can be turned into action.
The Trust is also planning on running a development programme for BAME staff to help address the impact of systemic racial inequity on themselves and on the systems that they work in.

As part of the Transforming People and Practices Programme, there is a “Just Culture” workstream focusing on taking a different approach to disciplinary action.

Staff perception of culture

We observed that all Board members promoted compassionate and inclusive leadership, and showed a genuine interest in the welfare of trust staff. Staff feel they can raise concerns and issues and leadership are perceived to be approachable and open.

Moreover staff feel a sense of pride to work at DCH.

Training

The staff we spoke to confirmed that the organisation invests in staff development through training programmes and further study. This is strategically important for the trust given workforce issues and the need to ‘grow’ its own leaders. Furthermore, there is a strong focus on quality improvement and QI training is provided across the system to support staff to make changes to improve patient care.

Performance management

There is a performance framework in place aligned to the Single Oversight Framework to support continuous improvement. This includes a framework for appraising ward, department, Care Group and divisional performance. We have discussed the Performance Management Framework in greater detail in KLOE 5.

Due to the pressures on staff as a result of the Covid-19 pandemic, there has rightly been a focus on staff wellbeing, with perhaps less of a focus on strengthening staff accountability and performance management throughout the organisation. While the focus on wellbeing is important, the Trust should ensure that going forward attention on performance management is not lost, in particular when it comes to performance and finance.

KLOE 3. Is there a culture of high quality, sustainable care?

Recommendations

- Consider how the Trust can turn its attention to performance management while ensuring focus on staff wellbeing
- The Trust should consider how to develop greater awareness of financial sustainability among staff including understanding of the underlying deficit and the system-wide strategy to resolve this

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Our view

In general governance functions well, there are good levels of delegated authority and accountability is strong. The Trust has a clear structure in place with appropriately defined roles and responsibilities to ensure good clinically led governance and management. Below the senior management team, the two divisions are well-embedded with appropriate delegated powers from the Board. Care Group governance was found to be a little weaker.

Findings

Board

The Trust Board currently comprises 14 directors, as follows: Non-Executive Chair and six other Non-Executive directors, CEO, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships, Chief Medical Officer, Chief Financial Officer, Chief Nursing Officer, Chief People Officer, Chief Information Officer and Chief Operating Officer. The Board holds public and private meetings every other month and holds development sessions in the months in between. Papers appear generally well organised with timed and assigned agendas, numbered minutes and action lists.

We observed a public and private board meeting on 24 November 2021. The Board's agenda was appropriately balanced across strategy and current performance, And also struck a good balance across quality, performance and finance, risk and workforce. One of the early agenda items in the Public Board covered the Performance Scorecard and the Escalation reports from subcommittees. We found the escalation process to be particularly strong and noted that the same conversations were not held at multiple meetings.

We found the Trust to be very transparent with its stakeholders with the majority of the Board session being public. The private Board session ended with a review of the meeting in line with good practice.

While for the most part NEDs provided appropriate levels of support versus challenge, there were some instances where the issue could have benefitted from them seeking greater assurance, especially regarding finance and performance. The SHMI figure has been elevated since the 2017 Well-Led Review and it was observed at the Board that there still needs to be a more robust plan in place to ensure the figures do not creep up again.

Board subcommittees

As detailed in KLOE 1, the Board leverages the sub-committee effectively in order to focus on exception reporting and strategy.

We observed a monthly meeting of the Finance and Performance Committee on 16 November 2021 which was well

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

attended and with good contributions from Non-Executive Directors.

We also observed a monthly meeting of the Quality Committee on 16 November 2021. There was robust discussion of issues including questions from all the Non-Executive Directors and the Governor attendee. The subcommittee meetings we observed were well-attended and chaired well.

Divisional leadership

There are two Divisions, Division A (Urgent and Integrated Care) and Division B (Family Services & Surgical Division) which sit between the Board and eight Care Groups (4 for each Division). The division leadership works as a triumvirate comprising a Divisional Director, Divisional Manager and Divisional Head of Nursing and Quality. Supporting them is also a Quality Manager. The structure is flat rather than hierarchical. Divisional leadership we met were clear on their own roles and how the leadership team worked. There was also an understanding of governance and an appetite to improve this.

Appropriate information is flowing from the Divisions to support decision-making and the timely resolution of risks. We found delegated authority to be working very well and staff understood when and how to escalate issues and risks.

The leadership structure in the Care Groups mirrors the Divisional roles, with a flat structure, with Care Groups being led by a triumvirate comprising a Clinical Director, Service Manager and Matron so that each has a counterpart at divisional level. Each department sitting under a Care Group has its own governance meetings with performance and quality issues feeding into Care Group meetings.

We identified inconsistencies at Care Group level in the use of performance reporting, agendas, production of minutes and adherence to the template terms of reference provided. The impact of this is that the Divisions and ultimately the Board are not fully assured over all aspects of governance.

Staff accountabilities

Staff accountabilities are set out in the Performance and Accountability Framework and supported by the objective-setting and appraisal process.

Staff members were clear on the trust's overarching strategy and in the process of developing the clinical strategies. The bottom-up process supports ownership and accountability among staff. We identified a need for staff to have greater ownership and understanding of the trust's financial challenges. Finance and use of resources must be considered at the same time as quality and safety, not as an afterthought.

The Trust is aware of the need to support staff to better understand and contribute to the efficiency agenda. As such, the

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Transformation and Improvement team are planning to integrate sustainability into their QI methods to support staff to incorporate value for money more effectively in their QI projects, helping them to identify and deliver Cost Improvement Programmes in the medium to long term.

Recommendations

- The Trust should leverage the Divisional leadership teams to reinforce the expectations of the structure, content, attendance and recording of Care Group governance meetings. Ensure that where division or Care Group leaders are unable to attend meetings, suitable deputies attend in their place and this is recorded in the minutes.

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Our view

The Trust has implemented appropriate risk management processes within Care Groups and Divisions. Risks are discussed on standard format risks registers at governance meetings and escalated upwards to the Board sub-committees. In line with good practice, exception reporting is used to escalate issues and risks, and we witnessed this working well at the Board and subcommittee meetings we witnessed. All Board and sub-committee papers set out risks clearly as part of the cover sheets.

The Trust is undergoing a piece of work to update its Board Assurance Framework (BAF) and associated Risk Registers in line with the new strategy. An early version of the BAF was submitted to the Board in November.

Findings

The Trust is working to embed a strong culture of risk management across the organisation. There is a Risk Management Framework in place dated May 2018. The policy was due to be reviewed in March 2021 but this has been extended to October 2022. The aim of the policy is to make the effective management of risk an integral part of everyday management and clinical practice throughout the organisation.

A focus of the Risk and Audit Committee has been to improve the way it provides oversight of Risk.

Board Assurance Framework

The Trust has recently undertaken a piece of work to align the BAF with the new strategy. A first draft was presented at the Risk and Audit Committee on 17 November, and taken to the Board on 24 March. It was acknowledged that further work was needed to ensure that strategic risks and mitigations were adequately captured. Although we recognise this is an early version of the BAF, as it develops further, it may be helpful to note:

- More work is needed to ensure the risks are articulated as risks rather than reverse controls
- The mitigations need to be effective enough to offset the risk
- Where there are risks or mitigations that involve system working, it is important to effectively communicate this with system partners.

Once the BAF is finalised, the Corporate and associated risk register will be refreshed to align with this.

Performance management

The updated Performance Management and Accountability Framework was approved at the Finance and Performance Committee on 20 July 2021. The framework provides an integrated approach to manage performance and ensures there is clear visibility and lines of accountability from Board to ward.

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Performance is reviewed in line with the six themes set out in the NHS System Oversight Framework -

- Quality of care, access and outcomes
- Finance and use of resources
- Preventing ill-health and reducing inequalities
- Local strategic priorities
- Leadership capability
- People

Divisional performance is assessed and managed through formal monthly performance reviews. These are chaired by the Chief Operating Officer with attendance of the rest of the Executive Team including the Chief Executive. Standardised agendas and performance packs are used for the reviews.

The Performance Management and Accountability Framework explicitly outlines committee and individual responsibilities and reiterates that overall accountability for performance lies with the Board. There is a clear process in place for supporting Divisions where performance is below expected level, including through mandated support and intervention where there is significant underperformance. In addition, 'earned autonomy' is granted to Divisions where good/outstanding performance is achieved across all themes.

Accountability for performance rests with the Trust Board, who are supported in this role by the Executive Management Team and the Finance and Performance Committee. Divisional performance reviews chaired by the Chief Operating Officer with attendance of the rest of the Executive Team including the Chief Executive, and so there is a clear escalation process to the Board and subcommittees.

Clinical and Internal Audit

There is a programme of clinical and internal audit in place. An update on the internal audit plan 2021/22 was presented to the Risk and Audit Committee on 17 November 2021. The Trust is currently on track in implementing recommendations from internal audits.

The Trust is aware that clinical audit needs to be strengthened and better aligned with priorities identified from risk intelligence and gaps in other assurance, so it can be effectively utilised by the business as a form of assurance. Divisions and Care Groups are in the process of refreshing their governance arrangements to facilitate this.

Recommendations

- Leverage clinical audit to focus on key priorities for the Trust in addition to national standards.

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Our view

The Trust has invested in business intelligence, recognising the importance of accessibility of intelligence to support Divisions and Care Groups. There is a dedicated Business Intelligence team providing support to Divisions and Care Groups.

The quality of performance reporting at Trust-level is good. Key issues with performance are clearly highlighted both in data dashboards and in supporting narrative, although the consistency of the level of narrative provided could be strengthened.

Findings

Board and subcommittee reporting

The quality of meeting papers for Board and committees was good, with timed and assigned agendas, numbered and well-written minutes, actions, good labelling of papers. The papers themselves were generally clear and contained sufficient and relevant information. Papers are introduced with cover sheets stating the purpose of the paper and usually highlighting the key points from the paper. We did observe some inconsistency in the narratives provided which could be strengthened in some cases. Cover sheets should provide a concise summary of the paper including next steps and actions required from the Board.

We noted that not all Board and subcommittee papers were sent out in good time. Operational pressures were cited as a reason for this. However, our interviews with the Board confirmed that there have been instances of late papers making it difficult for Board members to be fully prepared at Board meetings. We recognise that operational pressures make it difficult for papers to always be submitted in a timely manner; however, it is important that this does not become the norm.

We observed good coverage of quality issues at the committees and the Board, with appropriate scrutiny from the NEDs. While NEDs are experienced with regards to finance and performance, and there is good coverage of these issues at the Board and relevant subcommittees, we identified a need for more robust challenge with regards to some performance and financial issues. We recognise that there are contextual reasons for this including altered funding arrangements due to the pandemic, as well as some fatigue around dipping performance standards. As Covid-19 funding arrangements come to an end next year and there is a need to identify recurrent CIPs, it is crucial that focus on financial sustainability is ramped up.

The quality of performance reporting at Trust-level is good. The Trust has invested in its business insight capabilities and exception reporting is used at Board, Committee, Division and Care Group level in line with good practice.

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Data quality

We consistently heard that the Trust has invested in data and there has been significant improvement in the quality of data. We were told that there regular information governance audits The Board feel assured that the data they are receiving is of good quality.

However, the Trust is aware of poor data quality with regards to the Summary Hospital-level Mortality Indicator (SHMI). At the time of the 2017 Well-Led Review, the trust was investigating the raised SHMI figures. As a result of the recent investigation by the Chief Medical Officer, the figures were attributed to coding delays. To mitigate the risks of being unable to use SHMI as an indicator of quality, Structured Judgement Reviews are being used to examine the care of a sample of people who died, and to learn from any lapses in care that are identified. The DCH Medical Examiners review every death and highlight any obvious causes for concern.

The SHMI figures have been elevated since at least 2017, and at this point it is critical that the Trust agrees a process for resolving and learning from this issue to ensure this is not repeated.

There is a dedicated Clinical Systems Manager in place. The Trust has invested in its clinical systems over the last few years, and are in the process of a digital transformation. The Trust is using digital to monitor and improve the quality of care but there are some legacy issues, for example the SHMI, that need to be resolved.

Recommendations

- Ensure that there is a robust plan in place to resolve the elevated SHMI issue and safeguard against recurrence

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Our view

We found the Trust to be a very outward looking organisation, proactive in engaging its stakeholder in the shaping of its services. The Trust is also very proactive in seeking to influence its system partners, and is a strong advocate in the system for reducing health inequalities, particularly for the population of West Dorset. The Trust has positive relations with many of its system partners, led by the CEO and Chair.

The staff survey indicates that the Trust compares relatively well overall to other Trusts in relation to staff engagement. However, the Trust's overall score for a number of themes including morale; team working; and equality, diversity and inclusion have fallen from 2019. Significant steps have been taken to increase staff engagement, including appointing a new Freedom to Speak Up Guardian and establishing a number of staff networks.

There was extensive engagement with patients and staff in the development of the strategy, and the Clinical and People Strategy development has been clinically-led by staff.

Findings

Staff engagement

The response rate for the staff survey at 46% was slightly above the national average. DCH scored above or the same as the national average for all ten key themes in the 2020 results – equality, diversity and inclusion; health and wellbeing; immediate managers; morale; quality of care; safe environment; violence; safety culture; staff engagement and team working. The Trust's overall score for a number of themes has fallen since 2019, including the theme of equality, diversity and inclusion. As such, this is the focus of a major programme for the Trust. The Trust has launched an Inclusive Leadership Programme for middle managers aimed at supporting them to integrate a 'pro-equity' approach into the teams they lead, manage & supervise.

The Board usually uses patient stories as a way to engage directly with patients and their experiences of using services. The Board meeting we observed chose to present a staff story instead. Board members engaged positively with the staff member, asking relevant questions around his experience of working as an HCA at the Trust, and setting out next steps for issues that were raised.

Overall, the staff we spoke to felt that they could speak up and would be heard by leaders.

Strategy development

The Trust has ensured that staff are engaged throughout the strategy development process. The Clinical and People strategy development is a bottom-up, clinically led process, which captures the voices of staff to shape the future of their services. We have covered this in more detail in KLOE 2.

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Due to covid restrictions, the trust was unable to hold patient open days during the development of the strategy as planned but captured the patient voice through its membership.

Patient engagement

The trust engages well with patient groups, the local Healthwatch team and its governors. Governors are invited to subcommittee meetings as observers, and asked to pose questions at the end. Governor meetings are attended by the Chair and NEDS, and NEDs will periodically present at the meetings.

The Trust runs a Patient Advice and Liaison Service that has been described by stakeholders as being very effective. The Trust regularly carries out joint projects with the local Healthwatch. At the time of this review, the Trust and Healthwatch were undertaking a project on patient experiences of A&E.

The latest inpatient survey revealed that 86% of patients rated their experience as 7/10 or more, 99% of patients felt they were treated with respect and dignity, and 98% of patients had confidence and trust in the staff. There were a number of scores that were below the national average including Q.38 - *Given written/printed information about what they should or should not do after leaving the hospital.* These results were discussed at the Quality Committee on 17 August 2021, with a number of recommendations including, developing an action plan.

Our review noted that communications to patients could be more tailored. Patients often found communications from the Trust to be overly complicated, resulting in difficulties navigating A&E for example.

External engagement

The Trust engages with external partners through many different fora. Several system stakeholders remarked that teams in DCH were easy to work with and responsive.

Several Executives, as well as the Chair, engage with system partners across the system to deliver projects in a joined up way. For example, the Chief Nursing Officer has agreed with the ICS to invest in Registered Nurse degree apprenticeships as a priority. DCH is leading work on the place-based partnerships. The CIO also works heavily across the system and has recently agreed a high-level ICS Digital Strategy. This has been discussed in more detail in KLOE 8.

The Trust also engages the public through its Public Board sessions. We observed transparent and frank discussions at the public part of the Board session.

There is still work to do (collectively as a system) to help build a shared understanding of each organisation's financial, quality

KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

and operational pressures, in order to build trust and accelerate progress in terms of system collaboration. While DCH acts very transparently with relevant information, how it shares information is as important as what it shares.

Recommendations

In order to accelerate progress in the Integrated Care System (ICS) towards clinical and financial sustainability, DCH should consider how it communicates with system partners. This should include:

- Ensuring system partners have a good understanding of DCH's challenges and plans to tackle these
- Ensuring DCH is communicating in a way that is impactful - consider who is giving the message and in what forum.
- A Board-to-Board session with acute partners to build relationships and set out the processes to accelerate progress
- Training to service managers and clinicians on system working, including the leadership skills and capabilities required to deliver successful cross-system projects.
- As the strategy development process comes to an end, consider ways to communicate the outputs with external stakeholders

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

Our view

The Trust has a strong culture of continuous improvement and innovation which is supported by a dedicated Transformation and Improvement Team. There is a QI strategy in place and programmes are already underway to upskill staff at DCH and across the system in QI methodologies. The trust demonstrated high levels of awareness of QI methodologies.

The trust has a strong focus on digital, and is using technology in innovative ways to solve challenging problems. The trust is considered a trailblazer both within the ICS and nationally for the way it uses digital.

The Trust has carried out a number of innovative projects including the development of the Patient Action Tracker App which the Trust recently submitted as an HSJ award nomination.

The Trust Board is focused on self-review and seeking independent views in order to support improvement. We observed robust Board conversations around development.

Findings

QI Strategy

The Trust has a dedicated Transformation and Improvement team that supports QI initiatives across the trust. There is a QI strategy in place, approved by the Board in October 2020. Central to the strategy is creating a culture where everyone in the Trust is empowered to improve things. The strategy was updated due to the impact of Covid-19 as resource from the Transformation and Improvement team were diverted to support the Covid-19 vaccination programme, which uses many QI methodology principles.

The Trust's approach to innovation is clinically-led and digitally *enabled* rather than digitally-led. Clinical leadership is critical to the delivery of successful QI projects. There have been several examples of successful QI projects in the last year alone. For example, the Transformation and Improvement team have supported the development of the Patient Action Tracker (PAT) app. This is a digital, user-friendly patient tracker, used by ward staff to capture/highlight discharge constraints and delays. DCH have submitted this as an HSJ award nomination.

ICS Digital Strategy

The Trust shares its Chief Information Officer (CIO) with the CCG. This is a Board-level position, reflecting the importance the Trust places on technology as an enabler in tackling organisational and system challenges.

The CIO was integral in production of the system Digital Strategy. This enshrines the intention of the system to work together to improve service quality and sustainability. The strategy is high-level reflecting where the ICS is in their journey, and over the next few months, further work is needed to ensure

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

further alignment of partners and a more granular work plan.

The system is already performing well on some aspects of digital integration. The Dorset Intelligence and Insight Service (DiiS) brings together millions of data records across a wide number of different data sets from many care settings including primary care, mental health, social care and even non-care data, to provide insights and support population health management, population needs assessment and system resilience. This system is used across the whole of Dorset and the team itself is hosted by DCH, who provide the necessary training and support to analysts. The DiiS has received much national attention and the team is now hosting a national peer learning network in collaboration with NHSI/E.

QI training

There is a plan in place to develop the QI skills and capabilities of the workforce both at DCH and across the system. An ICS project group was formed to create and roll out basic level QI Lite training for all staff in the system. Links were established with University Hospitals Dorset to commence a central resource for training staff virtually using QSIR trainers from both Trusts.

Overall, we found that staff spoke knowledgeably about improvement methods and understood the value of using these to improve the quality and safety of patient care.

Trust digital governance

The Trust has appointed a Digital Transformation Lead focusing on benefits realisation of digital programmes. Risks are managed through the Digital Portfolio Group which feeds into the Risk & Audit Committee. There is a Clinical Systems Programme Group which is the delivery arm of the Digital Portfolio Group. This is chaired by the Chief Medical Officer and has a clear roadmap.

Acting on feedback

We found the Trust to be self-aware and open to taking and acting on feedback. As well as feedback from staff and patients, the trust makes effective use of external and internal reviews, as well as external benchmarking data to inform its improvement trajectory.

The Trust commissioned an external Well-Led review in 2017. The Trust made effective use of the review, implementing many of the recommendations. The trust is actively working on a number of recommendations from the previous report including strengthening clinical audit and how the business uses this for assurance.

Despite operational pressures, staff were provided with protected time for their away-day sessions to support the development of the clinical strategies. Staff indicated that this time was useful in terms of taking a step back, evaluating performance and planning for the future. However, it was also suggested that.

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

these sessions could have benefitted from a little more structure .

Recommendations

- Revisit the recommendations of the 2017 Well-Led review and ensure these are implemented, including:
  - Ensuring that clinical audit can be appropriately leveraged by the business to ensure adequate assurance.
  - Leveraging the Divisional leadership teams to reinforce the expectations of the structure, content, attendance and recording of Care Group governance meetings.

Appendices

Appendices

Supplementary information

Interviews conducted

We conducted 35 interviews in total with Board members, staff, lead Governor and external partners. Our interviews aimed to assess how governance arrangements are working in practice and to understand the decision making and risk assessment process relating to major strategic decisions.

Name	Role
Mark Addison	Chair
Patricia Miller	Chief Executive Officer
Anita Thomas	Interim Chief Operating Officer
Paul Goddard	Chief Finance Officer
Judy Gillow	Chair of Quality Committee (Non Exec)
Nick Johnson	Deputy Chief Executive; and Director of Strategy, Transformation and Partnerships
Nicky Lucey	Chief Nursing Officer
Stephen Tilton	Chair of Finance & Performance Committee (Non Exec)
Alastair Hutchison	Chief Medical Director
Ian Metcalfe	Chair of Audit Committee (Non Exec)
Sue Atkinson	Non Exec
Dave Underwood	Non Exec
Margaret Blankson	Chair of People and Culture Committee (Non Exec)
Dawn Harvey	Chief People Officer
Stephen Slough	Chief Information Officer
David Cove	Lead Governor
Don Taylor	Head of Estates and Facilities
Terry May	Deputy Head of Estates and Facilities
Paul Lewis	Head of Transformation and Improvement
Adam Savin	Associate Director of Performance
Ruth Gardiner	Deputy CIO/Clinical Systems Manager
Emma Hoyle	Deputy Chief Nurse
Emma Hallett	Deputy Chief People Officer
Claire Abraham	Deputy Director of Finance
Andrew Prowse	Chief Pharmacist
Trevor Hughes	Head of Corporate Governance

Supplementary information

Interviews conducted (continued)

Name	Role
Division A Leaders	Andy Miller, Sonia Gamblen, James Metcalfe
Division B Leaders	Stuart Coalwood, Fiona Richie, Richard Sim
Forbes Watson	Dorset CCG Chair
Tim Goodson	Dorset CCG CEO
Louise Bate	Healthwatch
Debbie Fleming	Chief Executive Officer, University Hospitals Dorset
Eugine Yafele	Chief Executive Officer, Dorset Healthcare
Andy Willis	Chair, Dorset Healthcare
Jenni Douglas-Todd	ICS Chair Designate
Matt Prosser	CEO Dorset Council

Supplementary information

Meetings observed

We undertook six observations of meetings in order to see governance arrangements working in practice.

Date	Meeting
15 November 2021	People & Culture Committee
16 November 2021	Risk & Audit Committee
16 November 2021	Quality Committee
16 November 2021	Finance & Performance Committee
24 November 2021	Public Board
24 November 2021	Private Board

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Meeting Title:	DCHFT Board
Date of Meeting:	30th March 2022
Document Title:	**DCH Charity Strategy Business Plan 22/23**
Responsible Director:	Paul Lewis, Deputy Director, Strategy, Transformation & Partnership
Author:	Simon Pearson, Head of Charity & Social Value

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH Charity Strategy Group DCH Charitable Funds Committee	25.1.22 28.2.22	DCHC Business Plan 22/23 review CFC supports DCHC Business Plan 2022/23

Purpose of the Paper	DCH Charity Business Plan 2022/23 outlining key fundraising objectives; activities and budgets.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The key elements of the DCH Charity Business Plan 22/23 (including Arts in Hospital Plan) include: • Strategic overview • DCH Charity objectives • Primary Fundraising activities • Fundraising timeline • DCHC Budget 2022/23 • DCHC 5Yr Budget (indicative) • Fundraising roadmaps • Arts in Hospital Plan 22/23							
Action recommended	The DCHFT Board is recommended to: 1. **APPROVE** DCH Charity Business Plan 2022/23.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Charities Act (2011)
Financial	Y	DCH Charitable Fund (SFIs)
Impacts Strategic Objectives?	N	
Risk?	Y	DCH Charity Risk Register
Decision to be made?	Y	To Approve
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	DCH Charity contributes to the delivery of DCH social value commitments as per DCHFT Social Value Pledge.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DORSET COUNTY HOSPITAL CHARITY
STRATEGIC BUSINESS PLAN 2022-25

Thepower
ofgiving

Strategic Development

2022-25

DCH Charity Strategy 2022-25

Dorset County Hospital Charity's overarching aim is to raise significant funds to help enhance patient care and staff welfare at Dorset County Hospital and become recognised as a leading charity across our community and Dorset ICS. To achieve this goal we will need to continue to invest time and resource to build the level and sustainability of our income. The impact of the Covid-19 pandemic during 2021-22 will continue to present significant risk for UK Charities' income through 2022/23. A major positive outcome has been increased support for the NHS nationally, though focused primarily on its role in response to coronavirus. Our aim will be to build on this and promote the value of charitable support across all areas of DCH patient care. Our Business Plan 2022/23 reflects this situation and plans for financial sustainability, whilst maintaining our ambition to grow our income during the strategic period to 2025.

DCH Charity: Vision & Mission

Our Vision and Mission statements for DCH Charity convey our purpose to deliver significant fundraising in support of outstanding patient care at Dorset County Hospital.

Vision statement:

Dorset County Hospital Charity's vision is to become a leading charity in the heart of our community.

Mission statement:

Dorset County Hospital Charity raises significant funds to support DCH to deliver outstanding care for people in ways which matter to them.

Strategic proposition: *'Managing Financial Sustainability-Planning Future Growth'*

DCH Charity's statement of strategic intent is: *'To help make DCH even better; delivering outstanding fundraising to enhance the Trust's outstanding patient care.'*

This strategy presents plans, accounting for the Covid pandemic's impact, for sustaining and building our income during the period 2022/23-25/26. The pandemic has negatively impacted our planned annual fundraising programme and overall income, with reduced fundraising activity including cancellation of the majority of Community and Events fundraising. This was counter-acted by significant levels of Covid-related income secured through the DCHC Covid Appeal and NHS Charities Together Covid Appeal grants. We continue to plan to secure our charity's finances, build financial sustainability and plan for future growth. National and local economic conditions will determine how fast and far we are able to grow our income as the UK economy works to recover over the next five years. We have presented our budget forecasts for 2022/23 and through to 2025/26 accordingly. Please see budget table section.

Managing Financial Sustainability: The success of our major Appeals has generated an increased donor base including individuals and organisations, providing the foundations upon which we plan to build future support. To enable the Charity to build its financial sustainability during this period of economic challenge we aim to focus on the value of our current donor base, whilst planning to recruit new supporters, through new fundraising appeals and campaigns.

Unrestricted reserves: The level of the charity's unrestricted reserves will be a key indicator of our ability to sustain our fundraising operation over the period. Our target unrestricted reserves level is approved in our DCHC Reserves Policy as £200K. In addition to our planned fundraising activities, work is in progress with the Charitable Funds Committee to review the structure of our charitable funds (unrestricted/restricted funds) to determine an approach to re-structure our funds through rationalising the number of restricted funds and converting these funds to unrestricted income.

Our objective will be to build and manage the sustainability of our income including unrestricted income and generate new income with a focus on the Power of Giving fundraising brand statement, particularly our Greatest Need (General) Fund and the major Capital Appeal. This approach aims to reduce the risk of low reserve levels, build our income base and continue to make a significant contribution to enhance patient care at DCH.

The key elements of DCH Charity's strategic development through to 2025/26 will include:

- Manage financial sustainability, build reserves
- Promote charitable giving across DCH specialist care areas/Greatest Need (General Fund)
- Major capital appeal (ICU/ED(Trauma) – implementation
- Achieve income forecasts including growth through to 2025/26

The table below presents an overview of DCHC budget forecasts for the five-year strategic period 2021/22-2025/26 (See Appendices 1.1/1.2):

Budget	Total Income	Total Expend	As % of Income	Income ratio	£Patient contribution
DCHC 2021-25 budget forecast	**£4655K**	**£992K**	**21%**	**5:1**	**£3663K**

DCH Charity will plan to continue to achieve significant charitable funding towards major developments, staff welfare and patient care at DCH.

DCH Charity Strategic Concept

Purpose:
The purpose of Dorset County Hospital Charity's 'strategic concept' is to establish the strategic framework, key themes and approach which underpins the development of DCH Charity's fundraising strategy 2021/22-25/26.

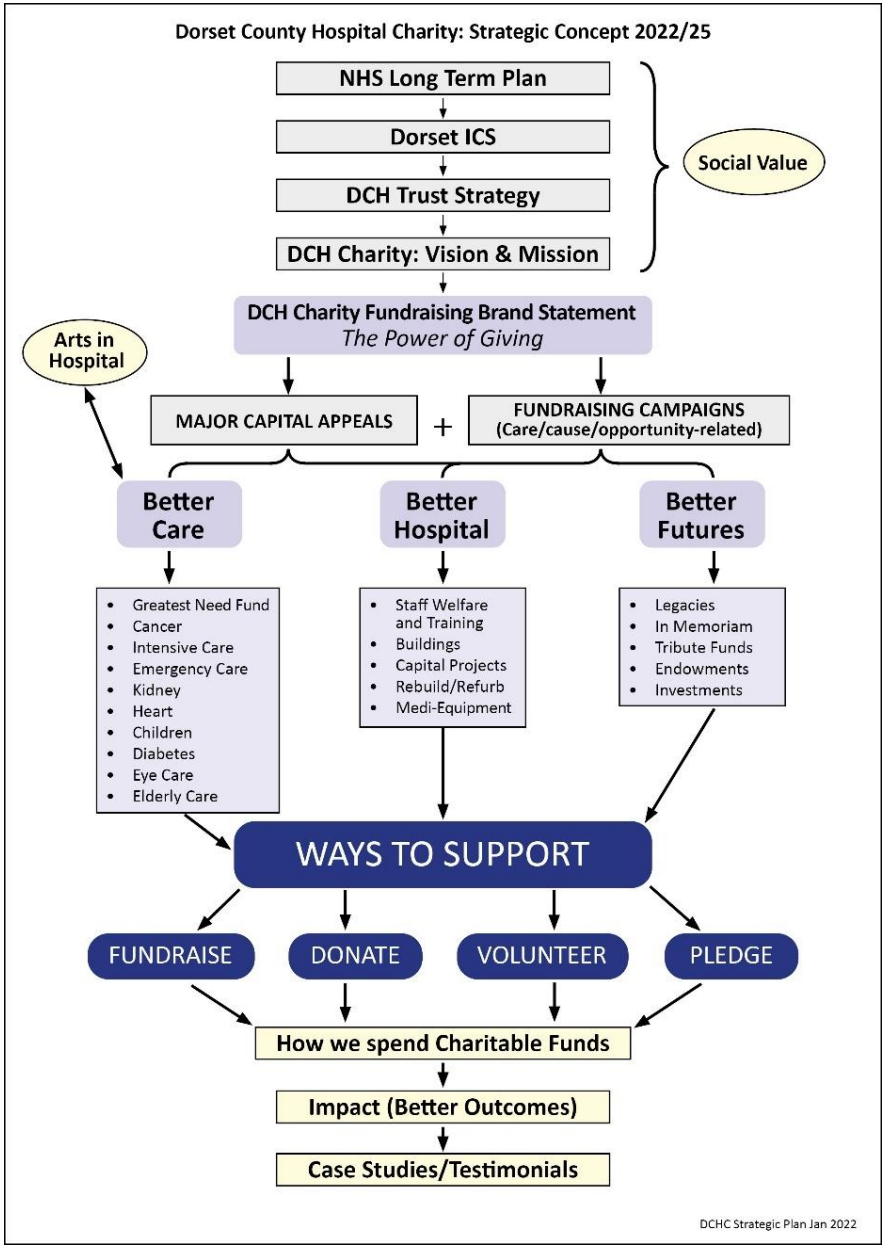
Strategic context:
Development of DCH Charity's fundraising strategy needs to align with DCHFT's organisational strategy (within the context of the Dorset ICS and NHS Long Term Plan).

Strategic aim:
Our strategic aim is to focus on major appeals, whilst developing a wider portfolio of opportunities for generating charitable income through DCH Care Funds and the Greatest Need Fund, across the work of the Trust and aligned to its strategic and operational priorities.

Social Value:
Through their mission to provide outstanding care for people in ways which matter to them Dorset County Hospital, as an anchor institution, seeks to maximise the positive impact they have on the local community, contributing to the improvement of the economic, social and environmental well-being of the community it serves.

Dorset County Hospital Charity will work to maximise the social value it delivers through its charitable activities, contributing to the Trust's social value commitments to address health inequalities. The Head of Charity & Social Value is leading on the development and coordination of DCHFT's social value programme.

The schematic overpage presents our current Strategic Concept framework.


Dorset County Hospital Charity: Strategic Concept 2022/25
NHS Long Term Plan
Dorset ICS
DCH Trust Strategy
DCH Charity: Vision & Mission
Social Value
DCH Charity Fundraising Brand Statement
The Power of Giving
Arts in Hospital
MAJOR CAPITAL APPEALS
+
FUNDRAISING CAMPAIGNS (Care/cause/opportunity-related)
Better Care
Better Hospital
Better Futures
Greatest Need Fund
Cancer
Intensive Care
Emergency Care
Kidney
Heart
Children
Diabetes
Eye Care
Elderly Care
Staff Welfare and Training
Buildings
Capital Projects
Rebuild/Refurb
Medi-Equipment
Legacies
In Memoriam
Tribute Funds
Endowments
Investments
WAYS TO SUPPORT
FUNDRAISE
DONATE
VOLUNTEER
PLEDGE
How we spend Charitable Funds
Impact (Better Outcomes)
Case Studies/Testimonials
DCHC Strategic Plan Jan 2022

DCH Charity Strategy 2022-25: Strategic development

Strategic Themes

Our Charity Strategy promotes opportunities to give to major appeals, specialist care funds and our General Fund to support our strategic themes including:

'*Better Care*' – Fundraising to support patient care and staff welfare focused on our specialist care areas, which also relate to leading charitable causes (ie. Cancer Care, Children, Kidney, Critical Care, Elderly Care et al). Promotion of the DCHC Greatest Need Fund (General Fund).

'*Better Hospital*' - Specific capital appeals for major capital projects (including medical equipment). Our next major Capital Appeal will contribute towards enhancements for the new ED/ICU build.

'*Better Futures*' – We will proactively promote legacy giving as a key income stream for supporting DCH's future developments.

'How we spend Charitable Funds: Measuring Impact'

Donors need to understand the impact their giving will deliver in achieving outcomes for enhancing patient care to deliver '*outstanding care for people in ways which matter to them'*. Working with Trust managers and staff we will monitor outcomes for significant projects supported by charitable funds. We will collate case studies and testimonials in support of the benefits delivered through charitable funds. We will aim to publish an Annual Review, alongside our Annual Accounts.

Key strategic development activities

DCH Charity Strategy 2022-25 will focus on key development activities:

- Identifying the key funding opportunities across DCHFT to successfully build the fundraising development programme, financial sustainability and growth in the Charity's income.

- Forecasting annual fundraising income and expenditure budgets, due to uncertainty in the economy and charity sector due Covid pandemic impact, in line with agreed funding priorities, in order to achieve agreed return on investment levels, commensurate with the key stages in the Charity's income development. (See Appendices 1.1/1.2)

- Implement our major Capital Appeal Plan (ICU/ED project-focused) and continue to promote our Power of Giving fundraising brand statement (care/cause-related). These will be underpinned by DCH Charity's statement of strategic intent: *'To help make DCH even better'*. Delivering outstanding fundraising to enhance the Trust's outstanding care.

- Continue to review the structure, skills and investment required in the Charity's fundraising team, needed to deliver the fundraising programme during the period 2022/23-25/26.

- Develop our fundraising appeals 'Case for Support' - this needs to convey our key messages, underpinned by our brand statement *'The Power of Giving'*. A project-specific case for support will be produced for the new Capital Appeal. We need to communicate the 'evidenced' need for funding over and above NHS budgets, how much we need and the impact this funding will deliver to enhance patient care and the environment in which this is provided.

- Build the profile of DCH Charity utilising our brand statement *'The Power of Giving'* and public phase of the new Capital Appeal, whilst managing the impact of the Covid-19 pandemic, through effective media, publicity, social media, digital and other marketing activity.

- Promote the Charity's website which reflects our 'strategic concept' and brand statement which provides the functionality to drive supporter engagement, digital fundraising and income development year on year.

- Implement a major Capital Appeal, aligned to the Trust's plans to build new ICU and ED facilities.

- Carry out new prospect research to identify high net worth individuals and trusts/foundations, both regionally and nationally, who may be pre-disposed to support DCH; in particular the new Capital Appeal.

- Engage fundraising leadership through establishment of the DCHC Appeal Board with a key objective to develop a major donor fundraising programme.

- DCH Charity data insight and income analysis to identify areas of income growth potential (ie. Individual giving, major donors, digital fundraising) in order to focus our fundraising resources effectively.

- Implement our review of the structure of our charitable funds (unrestricted/restricted funds) by re-structuring our funds through rationalising the number of restricted funds and setting up unrestricted 'mirror' funds; to improve the effectiveness and impact of our charitable funding and the charity's financial sustainability.

- Plan for the organisational development of DCH Arts in Hospital overseen by DCH Charity.

- NHS Charity regional comparator analysis to develop our strategy in the context of sector performance benchmarks. (*See Appendix 2)*

- To develop a leadership role in promoting the role of NHS Charities (as part of the VCSE Alliance) within Dorset ICS. To collaborate with our partner NHS Charities across Dorset and surrounding region to maximise the impact of our collective potential to enhance patient care.

- Dorset County Hospital Charity will work to maximise the social value it delivers through its charitable activities, contributing to the Trust's social value commitments to address health inequalities.

- Economic awareness across our catchment area, with reference to the economic impact of the pandemic and potential of the market in which we will be fundraising.

- Develop annual operational plans for our fundraising development programme, based on the strategic concept, funding priorities and objectives; underpinned by agreed key performance indicators to achieve sustainable annual income growth. See DCHC Roadmap Appendices.

Our DCH Charity Strategy 2022-25 is developed working with our Charity Strategy Group, engagement with Trust Board and Executive Team, Charitable Funds Committee, Finance team, Governors and Staff.

Section 2

Business Plan
2022/23

DCH Charity Business Plan 2022/23

Our priority will be the implementation of our fundraising business plan for 2022/23.

The negative impact of the Covid-19 pandemic during 2021-22 will continue to present significant risk for our income through 2022/23. Our Business Plan 2022/23 reflects this situation and plans for financial sustainability, whilst maintaining our ambition to grow our income during the strategic period to 2025. We will aim to build on the increased support for the NHS, promoting the value of charitable support across all areas of DCH patient care utilising our Power of Giving fundraising brand and in line with our plans to commence a new Capital Appeal.

Our primary aim during 2022/23 will be to improve our financial sustainability through budget management and building our unrestricted reserves. We will focus on maximising income from our current supporter base, whilst implementing new plans to engage new supporters. Our 2022/23 budget reflects the ongoing economic impact of the pandemic on forecast annual income; together with the opportunity to focus on securing initial grants/pledges for the planned Capital Appeal.

DCH Charity Objectives 2022/23

Our objectives (as outlined in table below) have been developed to reflect the current economic situation and its impact on charity fundraising; whilst reflecting DCHFT's new strategic themes: People/Partnership/Place.

Primary Focus Areas

Our objectives for 2022/23 will be focused on delivery of our primary focus areas including:

- **'Power of Giving':** We will continue to promote our overall fundraising brand statement *'The Power of Giving'*. The brand proposition '*be part of the Power of Giving'* will focus on the value of supporter engagement in enhancing patient care. We will promote giving for Specialist Care Areas across the hospital, as well as the *Greatest Need Fund* (General Fund) *supporting 'wherever the need is greatest'.* This approach will also contribute to building our general (unrestricted) charitable funds and in so doing help to build our unrestricted reserves, contributing to a more sustainable financial position for the Charity. We have developed our Power of Giving Communications Roadmap *(See Appendix 3).*

  Greatest Need Appeal: will raise funds to provide support where it is needed most across our hospital, funding equipment and projects that make a real difference to our patients which would otherwise not be funded. Funds will be received by our General Fund, which will enable a proportion of these funds to be used for the operational requirements of the charity, primarily fundraising costs. This will be in line with budgeted cost to income ratios as detailed in the DCHC Budget 2022/23.

Care Area/Ward Funds: we will utilise the Power of Giving fundraising brand to promote support for DCH specialist care areas/wards. We will also capitalise on publicity generated through national health awareness campaigns ie. Breast Cancer Awareness Month, Heart, Kidney, Stroke et al. These areas relate to some of the major charitable causes supported across the UK. Our specialist care funds will be promoted on the Charity's website as well as in wider fundraising/marketing campaigns, media and social media communications.

DCH 'Wish List' project: We will continue to promote and support fundraising on behalf of DCH Wards, care areas and specific projects; working with staff, patients and other supporters. Our aim is to develop a DCH 'Wish List' of fundable opportunities to provide a wider portfolio of items and projects for us to promote to our current and prospective supporter base to increase levels of giving year on year.

Patient Awareness & Engagement: DCH Charity will promote its work to cohorts of DCH patients (potentially warm supporters) by integrating a link to the charity website in the DCH Patient Feedback (Friends & Family) text survey. The survey concentrates on four clinical areas - ED, Inpatient/Day Cases, Outpatients and Maternity, providing a valuable opportunity to raise awareness and potential support for DCH Charity. In addition, we will increase charity branding visibility and publicity across the hospital site including the use of the digital screens in patient areas.

DCHFT Staff Welfare: Supporting DCH staff welfare will remain a priority for DCHC during 2022/23 building on the funds raised through the DCHC Covid Appeal and NHS Charities Together grants; as DCH moves through the post-pandemic 'recovery' phase and beyond.

DCH Staff Engagement*:* DCH staff are committed and valued supporters of DCH Charity. We will continue to work with staff to support their fundraising. We aim to promote the benefits of employee fundraising more proactively – for the individual, their care area of choice and DCH overall. We will consider the best ways of promoting the role of the charity and engaging with staff, appreciating current workload pressures.

- **Major Capital Appeal:** DCH Charity will commence its major c.£2.3M Capital Appeal to contribute to enhancements for the ICU and ED new build. The **DCHC Capital Appeal Plan** presented with this business plan details the case for support including the funding focus areas, key appeal phases, funding sources, fundraising resources, leadership and targeted financials required to deliver the major capital appeal.

Prospect research: We will carry out new prospect research including High Net Worth Individuals (based in/or with a connection to Dorset) and Trusts/Foundations to identify key sources of prospective funding and opportunities to engage major donors.

Appeal Board: establishment of the DCHC Appeal Board, focused on the new Capital Appeal, with a key objective to develop a major donor fundraising programme.

Please see Appendices 4 & 5 Capital Appeal and Appeal Board 'roadmaps'.

- **Individual Giving:** Individual Giving presents a significant opportunity for income development for DCH Charity. We will take a planned approach to supporter acquisition, donor development and stewardship to maximise the value of our donor base over the lifetime of our supporters.

  We will utilise our 'Power of Giving' fundraising brand statement to promote Individual Giving generating new income, including unrestricted income (to build the General Fund), to grow our income base, increase reserve levels and contribute to the sustainability of the Charity's operation. This income will be achieved from a range of existing and new sources and will include the following specialist fundraising activities:

  - ✓ Digital fundraising including DCHC website, online fundraising platforms and contactless donation points. (*See Appendix 7. Digital Fundraising Roadmap*)
  - ✓ DCH Care Funds promotion to grow Individual Giving to our specialist care areas and wards (*See Appendix 3. Power of Giving Communications Roadmap*)
  - ✓ Legacies/In Memoriam/Tribute Funds (*See Appendix 9. Legacy Marketing Roadmap*)
  - ✓ Major donor fundraising programme*, with a particular focus on the Capital Appeal (*See Appendix 6. Major Donor Roadmap*)
  - ✓ Payroll giving (Give As You Earn) promote employee giving to DCHC through the DCHFT payroll giving scheme.
  - ✓ Patient engagement, through promotion via DCH Friends & Family text service with a link to DCHC website and DCHC information on the DCH Patient App. *(See Appendix 10. Patient Engagement Roadmap)*
  - ✓ Donor stewardship to build loyalty and ongoing support from our donor base. *(See Appendix 11. Donor Stewardship Roadmap)*

  ***Major donor programme:** (*See Appendix 6. Major Donor Roadmap*) – linked initially to the Capital Appeal we will develop a focused approach to identifying and engaging support from major donors (Individual donors £1K+), as well as mid-level donors (£500-£1K). Development of the DCHC Major Donor programme will form the basis for future growth in this key income stream, focused on funding for new DCH projects and major equipment. DCH Arts in Hospital programme will also provide an unique opportunity to engage with new networks of influence/affluence to enlist high value supporters with a strong interest in Arts & Health related projects and initiatives.

- **Community and Events fundraising:** (*See Appendix 8. Community/Events Roadmap*)the pandemic had a significant impact on fundraising from our community due to the restrictions. During late 2021/22 there were signs that community events, local organisations and individual fundraisers are starting to re-commence fundraising activity. Dependent on the prevailing pandemic situation, we expect to see a steady growth of Community and Events fundraising income as we move through 2022/23. Our team have been re-engaging with previous community supporters to inspire further support as this important source of income re-builds. We will also aim to secure charity selection from high value events, which have previously generated valuable income for our charity.

Virtual fundraising/events: as the pandemic continues to impact community fundraising we will build on our growing experience and use of digital fundraising. Virtual/online fundraising will remain part of our mix of fundraising activities and initiatives as a safe and effective way to enable individual and community fundraisers to raise funds for the charity**.**

NHS 75th Anniversary 2023: We will start considering fundraising plans to capitalise on the NHS 75th Anniversary celebrations in 2023. These will be primarily implemented during financial year 2023/24; with a focus on the 5th July anniversary date. NHSCT will also be developing fundraising initiatives and campaigns in which DCH Charity will participate as appropriate.

DCHC Volunteers: DCH Charity will aim to recruit new charity volunteers, where the need is identified. DCHC will also work with DCH Volunteer Manager to identify/recruit new charity volunteers. DCHC has a new Volunteer recruitment and management procedure based on DCH Volunteering procedures. We will engage with DCH Governors and work with Governors who have offered to help promote and support the work of the charity.

- **Grants:** this is a significant income stream for DCH Charity. The Capital Appeal will provide a key opportunity to secure major grants from current and new grant-making supporters. In addition to the Capital Appeal, we will identify new grant-making organisations interested in supporting specific care areas and projects at the hospital, as opportunities and needs are identified. We will continue to receive NHSCT grant funding from current and future grant programmes.

Capital Appeal grants: please see the DCHC Capital Appeal Plan presented with this business plan and DCHC budgets 2021/22-25/26 for forecast grant income.

NHS Charities Together grants: We expect to receive the balance of grant funding during 22/23 from NHSCT Covid Appeal Stage 2 Community Partnership & Stage 3 Recovery grants schemes; as well as new NHSCT grant programmes as these are announced.

Other Grants: we will continue to monitor charity sector grant funding information to identify new opportunities to apply for funding for specific projects related to care areas/projects. Local grant-making organisations such as Fortuneswell Cancer Trust also support DCH Charity on an 'as and when' basis dependent on their funding focus and available funding.

DCHFT Pharmacy Sub-co: have agreed to gift a proportion of its annual profits to DCHC's General Fund. These funds will make an important contribution to increasing the financial sustainability of the charity and provide wider support through the General Fund. This arrangement will be reviewed on an annual basis with the Pharmacy Sub-co Board.

- **Corporate support:** Our team have re-commenced attending Corporate networking events to re-build and establish new corporate relationships. DCHC is a member of Dorchester Chamber for Business, DORVIL, HK Solicitors Breakfast Club and Weymouth & Portland Chamber. We aim to secure charity selection for corporate fundraising, events and promotional opportunities with local businesses. There will also be opportunities to secure 'Gifts in Kind' for the benefit of the hospital. These gifts are now accounted for and their value reported in DCHC Annual Accounts report.

- **DCHC Personnel:** We will continue to review the structure, skills and investment required in the Charity's fundraising team, needed to deliver the fundraising programme during the period 2022/23-25/26.

  Fundraising/Finance administration and support: The current Fundraising/Finance Administrator post has been vacant since 2020 when the previous postholder was redeployed in DCH. Since 2020/21 the charity has had temporary, part-time bank administration support, primarily to administer donations and the donor database. With plans to rebuild income as we move on from the pandemic and with plans for a major Capital Appeal the charity team needs more substantial administrative and fundraising support to increase fundraising capacity and effectiveness.
  To provide this support during 2022/23 we propose utilising the forthcoming NHSCT Development Grant (Grant £30K) to fund a Band 3, part-time (0.8 WTE), fixed-term contract (12mth) Fundraising/Finance Support post (budget c£20K). This would not represent a recurrent commitment and continuation of the post beyond the FTC period would be reviewed during 2022/23, dependent on DCHC's financial position.

- **GDPR:** we will continue to monitor GDPR regulatory updates which apply to charitable fundraising/activity. We will continue to implement, review and report on our DCH Charity GDPR Action Plan, working within the wider DCHFT Information Governance structure.

- **Charity Governance:** We will work with the Corporate Trustee, Charitable Funds Committee and the Trust Head of Governance to monitor and review the governance of DCH Charity. The Charity Commission's *Charity Governance Code* (updated Dec 2020) represents a standard of good governance practice to which all charities should aspire. The new Charities Bill 2022 is currently progressing through Parliament. DCH Charity is registered as a member of the Fundraising Regulator. A DCHC Governance Review commenced in 2021 and agreed outcomes and actions will be implemented during 2022/23.

- **Arts in Hospital 2022/23** *(Please see Appendix 12. AiH Plan 22/23)*
  Our priorities include developing the AiH Steering Group membership/role; curating the forthcoming exhibitions programme; DCH AiH 35th Anniversary project/s; re-instate AiH Assistant post; developing new Arts projects; planning AiH organisational development and building-up the AiH charitable fund. The AiH 2022/23 budget (funded by DCHFT) is presented in Appendix 12.2 for information.

DCHC Fundraising timeline 2022/23

Table A. DCH Charity: Key fundraising activity 2022/23													
Fundraising activity	**Lead**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
Power of Giving (Fundraising comms)	RC	PoG comms											
Greatest Need Appeal (General Fund)	RC	Launch	General appeal	General appeal			Care area appeal	Care area appeal	Care area appeal		Care area appeal	Care area appeal	Care area appeal
Capital Appeal ICU/ED (Private phase)	SP	Commence											
Capital Appeal (Prospect research)	SP	HNWI/ Trusts	HNWI/ Trusts										
Capital Appeal (Appeal Board)	SP	Plan	Engagement	Engagement	1st meet	Prospecting	Prospecting	2nd meet	Prospecting	Prospecting	3rd meet	Prospecting	Prospecting
Capital Appeal (Grants/Major donors)	SP	Proposals - ongoing											
Individual Giving (Patients)	JH	Launch	Promotion										
Individual Giving (Contactless)	JH	Plan	Implement	Launch									
Individual Giving (Legacy marketing)	JH	Legacy comms						Free Will promotion	Free Will promotion			Free Will promotion	Free Will promotion
Individual Giving (Payroll giving)	JH	Plan	Plan	Launch	Promotion								
Community & Events (incl. Virtual events)	KC	Events - ongoing											
Grants (NHSCT)	SP	S2/Dev grant	Stage 2 grant	Stage 3 grant	Future grants tbc								
Corporate (Networking; corporate support)	KC												
Charity Governance (GDPR; Regulation)	SP												

Key:
High-level activity
On-going/lower-level activity
SP: Simon Pearson, Head of Charity & Social Value
RC: Fundraising & Communications Manager
JH: Individual Giving Manager
KC: Fundraising Officer

Business Plan Review & Monitoring

Our fundraising plans aim to improve the charity's financial sustainability impacted by the Covid pandemic. We will regularly review and monitor our financial position. Key performance indicators for managing the charity's financial position include annual income and the level of unrestricted reserves. Income will be reviewed in line with approved budgets (see Appendices 1.1/1.2). Our 2022/23 target unrestricted reserves level required to maintain our charitable operation equates to £200K. In line with charity sector standards we should maintain our reserves level at or above 6 months operating costs.

Key review points will be as follows:

- **Monthly:** Head of Charity and DCH Deputy Financial Controller review monthly income/reserves level
- **Bi-monthly:** Charitable Funds Committee review Finance reports incl. DCHC Risk Register (Corporate Trustee receives Charitable Funds Committee Escalation Report)
- **Financial Review (Quarterly):** DCHC Strategy Group full financial review including DCHC Risk Register. The Group will provide a progress report to the Corporate Trustee and Charitable Funds Committee.
- Matters requiring decision by the Corporate Trustee will be escalated accordingly.

DCH Charity Objectives 2022/23

DCH Strategic Themes	Vision/Mission	DCHC Strategic Objectives	Key Focus Areas	Measures
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. **Partnership:** Working together to ensure outstanding services, accessible to our patients and population.	**Vision:** *Dorset County Hospital Charity's vision is to become a leading charity in the heart of our community.* **Mission:** *Dorset County Hospital Charity raises significant funds to support DCH to deliver outstanding care for people in ways which matter to them.*	Delivery of outstanding fundraising activities, support and standards	• Increase profile/awareness of DCH Charity • Improve financial sustainability • Power of Giving promotion • Secure income for Specialist Care Areas • Implement Capital Appeal (ICU/ED)	• Income targets achieved • Increase unrestricted reserves • Maximise value donor base • Maintain regulatory requirements
		Our Fundraising plans and priorities will be aligned to DCH Strategy	• Reflect Trust's Vision/Mission and Strategic Themes (PPP) • Integrate Trust/Charity key messages in FR appeals 'Case for Support' development • Build on board/senior management/clinician engagement in fundraising programme	• Strong, emotive integrated Case for Support • New Major Appeal developed • Increased SLG involvement in fundraising • Establish DCHC Appeal Board
		Fundraising in collaboration with our Charity partners, staff and supporters	• Proactive donor acquisition programme • Develop fundraising leadership • Support and advise staff fundraisers • Provide excellent support to community fundraisers • Build relationships with major funding organisations • Support Friends of DCH & other Charity partners	• Grow value of DCHC donor base • Support Community/Events (incl. online) • Sustained major funding • Increase digitally raised income • Engage major funders (New Appeal) • Staff engagement levels
		Engaging with staff, partners and other supporters to enable successful fundraising in support of the Trust	• Engage appropriately and effectively with our patients and donors and fundraisers • Build support for donors and fundraisers in the community we serve • Planned donor development/stewardship • Grow digital fundraising activity	• Increased income from patient supporters • Rebuild community fundraising • Increase digital fundraised income • Support fundraisers (incl. online)
		Ensuring we are productive, effective and efficient to deliver long term sustainable income growth	• DCH Charity Fundraising Strategy 2022-25 • Power of Giving brand statement • Communications/marketing plan • Charity website • Utilise digital fundraising technologies/social media • Continual monitoring and review of fundraising performance	• Charity Strategy 2022-25 implemented • Major Appeal commences • Secure new major donors/funders • Increased awareness driving income growth • Digitally fundraised income growth • SMART income targets achieved

DCH Charity: Budget (2021/22-25/26)

Prior to the Covid-19 pandemic our five-year aim was to achieve over £5 million income during the period 2019/20-24/25; delivering in excess of £1 million average annual income and over £4 million income contribution to patient care during the period. As a result of the impact of the pandemic on UK charity income we have needed to review our five-year forecasts accordingly. Financial year 2021/22 now represents our baseline year. Our revised income forecast position during the period 2021/22-25/26 now aims to achieve £4655K, delivering an average annual income of £930K and £3663K income contribution to patient care and staff welfare during the period.

To achieve our potential over the five-year period we will need to focus on improving the charity's financial sustainability through income generation to increase our unrestricted reserves; promoting increased giving across DCH specialist care areas, building our General Fund and developing and implementing a new major capital appeal (ICU/ED). Our overall aim will be to maximise our return on investment and the contribution the charity makes to patient care and staff welfare. We will continue to review the investment required in our fundraising capacity and resources to achieve return on investment targets to grow our income and contribution to patient care and facilities. Forecast five-year budgets are presented in Table 1 below and Appendices 1.1/1.2 incorporating income and expenditure budgets.

Table 1 DCH Charity 21/22-25/26 budget forecast

Budget	Total Income	Total Expend	As % of Income	Income ratio	£Patient contribution
DCHC 2021-25 budget forecast	**£4655K**	**£992K**	**21%**	**5:1**	**£3663K**

We will monitor our forecast income on a monthly/quarterly/annual basis and budget forecasts may need to be reviewed through the year as there remains significant economic uncertainty and constraints on traditional fundraising activities. The new budget 2021/22-25/26 includes an indicative £2.3M target (including fundraising appeal costs) for the Capital Appeal (ICU/ED). This figure will need to be refined as we further develop the Capital Appeal plan. Due to the current economic uncertainty all budgets from 2023/24 onwards are indicative and will be reforecast more accurately on an annual basis to reflect the prevailing economic conditions and DCHC income performance. Our DCHC Business Plan budget 2022/23 is presented in Appendix 1.2.
DCHC budgets are based on our primary fundraising activities during 2022/23-25/26 as follows:

- Power of Giving fundraising for Specialist Care Areas/Wards/Greatest Need Fund
- Major Capital Appeal (ICU/ED). Full financial details are presented in the separate DCHC Capital Appeal Plan (enclosed).

Appendix 1.1 DCHC Annual Budget 2022/23

Dorset County Hospital Charity - Budget 2021/22-2022/23 (COVID)

Activity	Original Budget (Covid impact) 2021/22			Budget (Yr end reforecast) 2021/22			Budget (forecast) 2022/23		
	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total
Income (£k)									
Legacies	75	0	75	125	0	125	75	0	75
Donations	75	25	100	175	0	175	75	100	175
Community/Events	50	0	50	60	0	60	60	15	75
Corporate	5	0	5	5	0	5	5	0	5
Grants	185	260	445	425	0	425	345	200	545
Total Income (excl investments)	390	285	675	790	0	790	560	315	875
Total Net Income (net NHSCT Stg 2 distribution)				585	0	585	470	315	785
Costs (£k)									
Staff									
Head of Charity	10	40	50	45	6.5	51.5	12	40	52
Fundraising&Comms Manager	21	21	42	31	5	36	18	18	36
Fundraising/Finance Administrator	0	0	0	0	0	0	14	4	18
Fundraising Officer	20	8	28	17.5	2	19.5	12	8	20
Individual Giving Manager	40	0	40	40	1	41	11	30	41
Fundraising/Finance Administrator (Bank)	5	0	5	5	0	5	0	0	0
Support costs (provided by DCH, funded by Charity)	9		9	6	0	6	6	0	6
Total Staff Costs (£k)	105	69	174	144.5	14.5	159	73	100	173
Non-Staff Costs									
Design & Printing costs (leaflets, banners etc)	4	1	5	4	1	5	4	1	5
Stationery	0.5	0	0.5	0.5	0	0.5	0.5	0	0.5
Training	0	0	0	0	0	0	0	0	0
Insurance costs	1	0	1	1	0	1	1	0	1
Database costs	4	0	4	4	0	4	2.5	0	2.5
Website	2	0	2	2	0	2	2	0	2
Prospect Research	0	10	10	0	5	5	0	5	5
Marketing/Fundraising Consultancy	0	2	2	0	2	2	2	0	2
Equipment (Contactless point/s etc)	1	0	1	2	0	2	1	0	1
Subscriptions (NHSCT, Trustfunding)	4	0	4	4	0	4	2	2	4
Donor recognition	1	0	1	0	0	0	1.5	0	1.5
Travel	0	0	0	0	0	0	0	0	0
Hospitality (networking events, donor meetings, etc)	0	0	0	0	0	0	0	1	1
Total Non-Staff Costs (£k)	17	13	30	17.5	8	25.5	16.5	9	25.5
Total Budget (£k)	122	82	204	162	22.5	184.5	89.5	109	198.5
As % income	30%	28%	29%	28	0	32	20	35	26
Contribution to Patient Care (£k)	268	203	471	423	-22.5	400	380.5	206	586.5
Jan-22									

Appendix 1.2. DCH Charity Budget 2021/22-25/26 (5Yr indicative)

DCH Charity 5Yr Budget 2021-26 (Covid)

Activity	Budget 2021/22 (Reforecast Covid)			Budget 2022/23 (Forecast)			Budget 2023/24 (indicative only)			Budget 2024/25 (indicative only)			Budget 2025/26 (indicative only)			Av pa (5yr)	Totals (5yr)
	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total	DCH Charity/ PoG Appeal	ED/ICU Appeal	Total		
Income (£k)																	
Legacies	125	0	125	75	0	75	100	0	100	125	0	125	125	0	125		
Donations	75	0	75	75	100	175	100	150	250	100	150	250	175	50	225		
Community/Events	60	0	60	60	15	75	50	75	125	50	150	200	75	100	175		
Corporate	5	0	5	5	0	5	10	15	25	10	15	25	10	0	10		
Grants	525	0	525	345	200	545	125	500	625	125	650	775	150	100	250		
Total Income	790	0	790	560	315	875	385	740	1125	410	965	1375	535	250	785		
Total Net Income (net NHSCT Stg 2 distribution)	**585**	**0**	**585**	**470**	**315**	**785**	**385**	**740**	**1125**	**410**	**965**	**1375**	**535**	**250**	**785**	**930**	**4655**
Costs (£k)																	
Staff (£k)																	
Head of Charity	45	6.5	51.5	12	40	52	12	40	52	12	40	52	12	40	52		
Fundraising&Comms Manager	31	5	36	18	18	36	18	18	36	18	18	36	18	18	36		
Fundraising/Finance Administrator	0	0	0	14	4	18	14	4	18	14	4	18	14	4	18		
Fundraising Officer	17.5	2	19.5	12	8	20	12	8	20	12	8	20	12	8	20		
Individual Giving Manager	40	1	41	11	30	41	11	30	41	11	30	41	11	30	41		
Fundraising/Finance Administrator (Bank)	5	0	5	0	0	0	0	0	0	0	0	0	0	0	0		
Support costs (Provided by DCH, funded by DCHC)	6	0	6	6	0	6	6	0	6	6	0	6	6	0	6		
Total Staff Costs (£k)	**144.5**	**14.5**	**159**	73	100	173	73	100	173	73	100	173	73	100	173		
Total Non-Staff Costs (£k)	**17**	**8**	**25**	16	9	25	16	14	30	16	14	30	16	14	30		
Total Budget (£k)	**162**	**23**	**185**	89	109	198	89	114	203	89	114	203	89	114	203	198	992
As % income	**28**	**0**	**32**	20	35	26	24	15	18	23	11	15	17	44	25	21	21
Contribution to Patient Care (£k)	423	-23	400	381	206	587	296	626	922	321	851	1172	446	136	582	732	3663

(NB. Due to the prevailing uncertainty resulting from Covid pandemic - All budgets from 2023/24 onwards will be reforecast more accurately on an annual basis to reflect covid impact, economic conditions and DCHC income performance)

(Feb 22)

Appendix 2. NHS Charities: Comparator Analysis (Regional) 2020/21

Table 1 provides a summary of comparator performance information from regional NHS Charities' 2020/21 Annual Accounts.

Table 1

NHS Charities 2020/21	DCH	UHD (formerly Poole & Bournemouth charities)	Salisbury	Southampton	Taunton	Yeovil	Exeter
Population	250,000	1,050,000	250,000	1,300,000	340,000	185,000	450,000
Income £000's	£500K	£1300K	£1470K	£3590K	£913K (c.£600K legacies)	£773K	£861K
Fundraising/Gov/Investment expenditure	£190K	£410K	£394K	£273K	£255K	£120K	c.£100K (HoF employed by NDHFT)
Cost:Income ratio	2.6:1	3.2:1	3.7:1	13:1	3.6:1	6.4:1	8.6:1
FR expend as % of income	38%	32%	27%	8%	28%	15%	12%
£/popln	£2.00	£1.24	£5.88	£2.76	£2.68	£4.18	£1.91

(NB. DCH Charity budget 2022-25 (Appendix 1.2) would target £785K annual income by 2025/26 which would achieve £/popln = £3.15)

Appendix 3. Power of Giving (Communications) Roadmap

Appendix 4. Capital Appeal Roadmap

CAPITAL APPEAL (ICU/ED) ROADMAP 2022/23

Objective

- Implement a major Capital Appeal
- To achieve appeal target (c.£2M tbc) over c.3 year period
- To establish an influential DCHC Appeal Board
- To build Major Donor income focussed on the major appeal

Main focus:

- Current/new major donors/funders ('private phase')
- Local community including fundraising groups and corporate sector ('public phase')
- DCH patients and families

Activities Quarter 1

Private Phase

- Implement ED/ICU Capital Appeal Plan (linked to SOC/OBC)
- Develop Capital Appeal case for support
- Initial prospect research (HNWI's/Trusts and Foundations)
- Early approaches to 'warm' major funders.

Activities Quarter 2

Private Phase

- Case for support development
- HNWI prospect research (working with a specialist agency)
- DCHC Appeal Board development plan (see Roadmap)
- Early approaches to 'warm' major funders

Activities Quarter 3

Private Phase

- DCHC Appeal Board core group meeting
- HNWI research review/prospecting phase development
- DCHC Appeal Board – engage with potential external members
- Initial bids to 'warm' major funders

Activities Quarter 4

Private Phase

- DCHC Appeal Board initial business meeting
- Prospective major donors (HNWI) – initial engagement meetings
- Prospecting group meetings (to review prospect research/pipeline)
- initial bids to 'warm' major funders

Appendix 5. DCHC Appeal Board Roadmap

DCHC APPEAL BOARD ROADMAP 2022/23

Objective

- Establish an influential Appeal Board to drive Capital Appeal
- HNWI prospect research to identify potential external members
- Engage ED/ICU Clinical leads to join Appeal Board
- Plan initial Appeal Board meetings

Main focus:

- DCHFT Board
- ED/ICU Clinical leads
- Influential/affluent external membership
- Corporate sector

Activities Quarter 1

- Capital Appeal Plan – DCHC Appeal Board core element
- Agree Appeal Board ToR and objectives
- Initiate HNWI prospect research
- DCHFT Board/CFC Major Appeal session (external facilitator + DCHC HoC)

Activities Quarter 2

- Appeal Board development plan
- Ongoing HNWI research to identify external members
- Engage ED/ICU Clinical leads

Activities Quarter 3

- Initial Appeal Board core group meeting
- Identify potential external members (from prospect research)
- Plan engagement with prospective external members

Activities Quarter 4

- Initial DCHC Appeal Board business meeting
- Major donor prospecting – review HNWI research/hold prospecting groups/arrange engagement meetings

Appendix 6. Major Donors Roadmap

MAJOR DONORS ROADMAP 2022/23

Objective

- To connect with and engage support from major donors (£1k+)
- Prospect research (HNWI) using specialist agency, taking into account GDPR and ethical considerations
- Establish DCHC Appeal Board; enlist influential/affluent external members
- Develop donor solicitation plan, prioritise prospects and engage prospective major donors to develop their interest in supporting DCH
- Secure major donor support for specific appeals/projects and care areas
- Implement major donor stewardship plans to maintain/grow income

Main focus:

- Current major donor supporters
- HNWI prospect research
- DCH patients

Activities Quarter 1

- Prospect research (HNWI); desk-based research; network mapping
- Prioritise current/warm prospect pipeline; develop prospect engagement plan
- Integrate with Capital Appeal Plan development

Activities Quarter 2

- Ongoing prospect research (HNWI)
- Review prospect research; prioritise new prospects; develop engagement plans
- Focus on Capital Appeal 'case for support' opportunities
- Integrate with Appeal Board development plan

Activities Quarter 3

- Develop ICU/ED (and other Care Area) project' case studies' for funding
- Review HNWI research; further DCHC donor insight/mapping
- Feed into Appeal Board core group meeting
- Develop prospecting groups; engagement plans

Activities Quarter 4

- Major donor engagement plans
- Feed into Appeal Board initial business meeting
- Prioritise/develop initial major donor solicitation plans

Appendix 7. Digital Fundraising Roadmap

DIGITAL FUNDRAISING ROADMAP 2022/23

Objective

Use the RACE framework which breaks the journey into 4 main stages:

- Reach: Build and maintain strong online brand awareness.
- Act: Encourage digital interactions with supporters and followers.
- Convert: Increase conversion rates through a multichannel approach to convert followers into supporters.
- Engage: Improve supporter loyalty and advocacy using digital supporter communications.

Main focus:

- DCH Charity supporters
- Local community
- DCH volunteers
- DCH Staff
- DCH patients and their families

Activities Quarter 1

Mapping our current position

Acquire new and retain current supporters and facilitate long-term engagement in order to help us raise funds digitally.

We are aware that Facebook and Instagram are our most effective channels and response rate to different post types. This knowledge will allow us to be more focused.

Just Giving remains our fundraiser's preferred platform. Although we continue to ensure we are registered with other platforms.

Our main focus/plan is to increase traffic to our website donation page and conversion (donation) rate through social media.

Activities Quarter 2

Donor metrics

Responding to audience behaviour across all digital platforms to aid retention and adapt accordingly.

Social Media Engagement:
How many people share, like, or comment on our posts?

Landing Page Conversion Rate:
How many of our donation page visitors actually complete the donation process?

Activities Quarter 3

Fundraising metrics

Adapt our digital fundraising and giving opportunities to audience needs and touchpoints

Retention Rate:
What percentage of our donors have given more than once through digital means and through which channels; social media platforms or direct website visitors?

Average Donation Amount:
What is the average donation through our website from social media vs traditional and independent website visitors?

Activities Quarter 4

Measure performance

Measure our current performance to establish our 2023/24 plan .

Supporter growth:

- How much has our supporter base grown?
- How much has our click-through rates vs conversion (donation) rate grown?

Supporter data:

- Where are our supporters located?
- Who are our demographic from each digital platform?

Appendix 8. Community & Events Roadmap

COMMUNITY & EVENTS ROADMAP 2022/23

Objective

- Promote Dorset County Hospital Charity to our community for their consideration to support the hospital through local and national events and fundraising activities
- Promote using traditional, digital and social media and other marketing activities with the aim to raise funds for our DCH Appeals, specialist care areas and staff wellbeing
- Assist fundraisers and donors with their events and activities with dedicated and personal support
- Encourage and support fundraising for Greatest Need Appeal and future major capital appeals

Main focus:

- DCH Charity donors, supporters and fundraisers
- DCH patients and their families and friends
- Local community including fundraising groups and corporate sector
- Wider Dorset community
- DCH staff

Activities Quarter 1

- Connect with potential fundraising events and reconnect with any local events that have been previously postponed or cancelled.
- Investigate national and global awareness days/weeks/months as part of online fundraising promotion
- Continued promotion of current Greatest Need Appeal and focus areas within the Appeal
- Develop 'Wish Lists' for fundraisers to focus donations towards, working with DCH staff on ensuring the Wish List items are a priority for the ward/department
- Continue to support and thank fundraisers including via social media

Activities Quarter 2

- Support community events and fundraisers with fundraising collateral, such as, collection buckets/tins, bunting, leaflets and information, raffle prize letters and raffle tickets etc
- Attending wider community events, where appropriate, supporting DCH
- Focus on staff and patient engagement
- Continue to support and thank fundraisers including via social media
- Continue to support and promote virtual fundraising

Activities Quarter 3

- Continue thanking supporters using cheque presentations, social media, PR to local media, Thank you letters and cards.
- Research opportunities for Christmas fundraising opportunities and ideas
- Review small grant opportunities, such as supermarket token schemes
- Continue with regular engagements at business networking groups, providing corporate fundraising opportunities.
- Continue to support and thank fundraisers including via social media

Activities Quarter 4

- Review annual and seasonal fundraising and support to the hospital
- Build on relationships developed through fundraising to encourage future support
- Continue to promote current appeals and prepare for upcoming appeals
- Continue to support and thank fundraisers including via social media

Appendix 9. Legacy Marketing Roadmap

LEGACY ROADMAP 2022/23

Objective

- Increase the number of pledges received.
- Generate a minimum of 12 new legacy leads each year.
- Targeted communications.
- Integrate a multichannel 'drip-drip' approach across a variety of media - including targeted direct mail, social media posts and advertising, email, press releases and PR.

Main focus:

- DCH Charity supporters
- DCH patients and their families

Activities Quarter 1

Focus on warm donors

- Promote Free Will scheme working with local solicitors throughout 2022
- Screen charity supporter database against wealth intelligence database to identify prospective legators
- Wider public awareness-raising through fundraising communications

Activities Quarter 2

Targeted approach

- We will use inspirational stories to get our message across – helping our supporters to see the difference their gift will make. These stories will be used across all marketing materials and media. To achieve this, we must first draw up a list of suitable case studies of people that have pledged or with families permission previous legacies received.
- Focus on loyal and warm supporters.
- Wider public awareness-raising through fundraising communications

Activities Quarter 3

Increased awareness

- With an aim to create a short video to visualise this approach and promoting gifts in Wills on our website. The video aims to showcase how their gift could have a real and lasting impact
- Wider public awareness-raising through fundraising communications

Activities Quarter 4

Measure

We aim to measure types of legacy activity by:

Legacy fundraising is inherently difficult to measure. We aim to measure the types of communications relating to...

- ·the number of legacies pledges
- ·the number of notifications received.

Appendix 10. Patient Engagement Roadmap

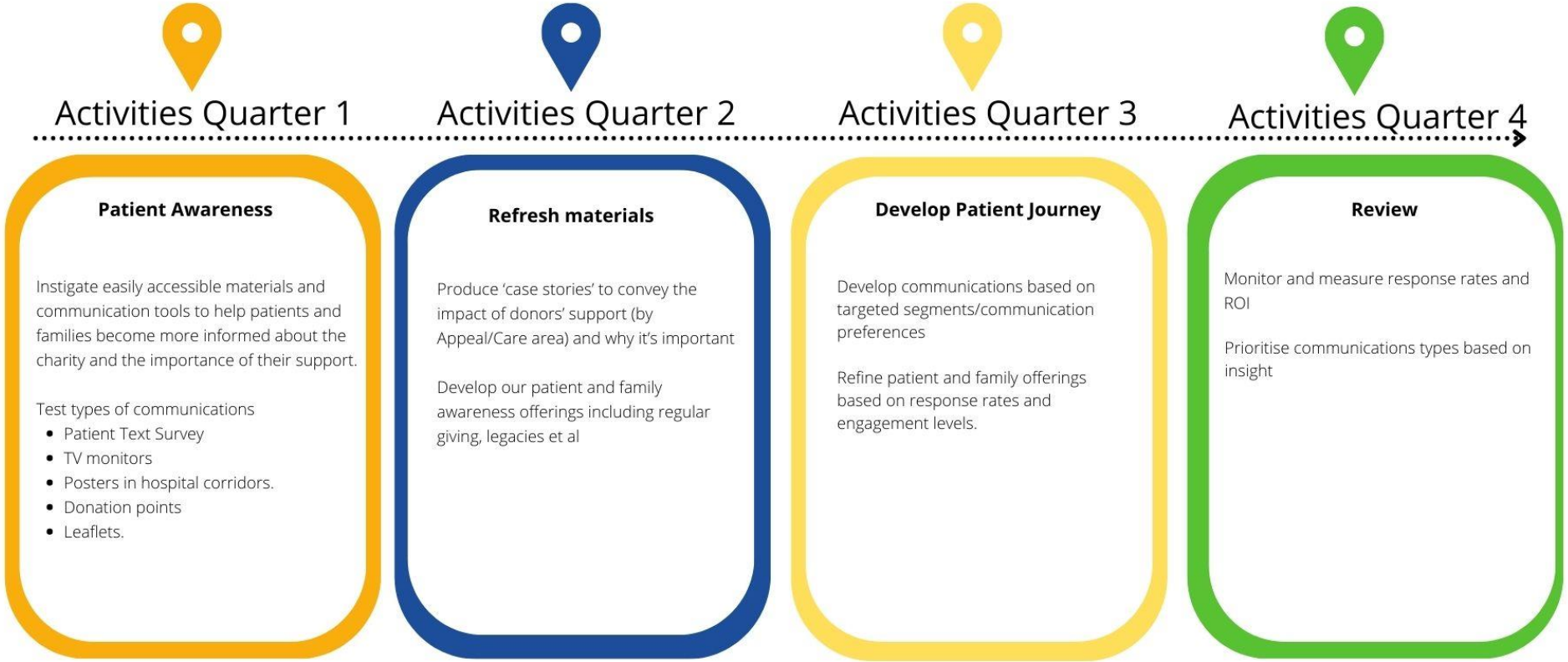
PATIENT AWARENESS AND ENGAGEMENT ROADMAP 2022/23

Objective

- Increase charity's visible presence in the hospital
- Raise awareness of the charity to patients and families
- Encourage them to take an active role in supporting the hospital.
- To connect with and engage support from donors
- Develop key patient stewardship communications/activities
- Secure ongoing/regular support to maintain/grow income

Main focus:

- DCH patients and their families



Appendix 11. Donor Stewardship Roadmap

DONOR STEWARDSHIP ROADMAP 2022/23

Objective

- To connect with and engage support from donors
- Donor insight-led
- Develop key Donor Stewardship communications/activities
- Understand our supporters' journey to encourage donor retention
- Secure ongoing/regular support to maintain/grow income

Main focus:

- DCH Charity supporters
- DCH volunteers
- DCH staff
- DCH patients and their families

Activities Quarter 1

Understanding

- Understand our supporter motivations, interests, and preferred communication channels to date using Donorfy CRM and prospect research
- Develop Donor Stewardship communication plans based on donor CRM and prospect research insight

Activities Quarter 2

Develeop Supporter Journey

- Use Donorfy CRM and prospect research to segment donors/map donor journey to date
- Develop Donor Stewardship communications based on targeted segments/communication preferences
- Produce 'case stories' to convey impact of donors' support (by Appeal/Care area)

Activities Quarter 3

Implement

- Test Donor Stewardship communications by donor segment
- New Donor Stewardship communications implemented

Activities Quarter 4

Review

- Monitor and measure response rates and ROI
- Prioritise Donor Stewardship communications based on insight
- Develop our supporter journey offerings including regular giving, legacies et al

Appendix 12. DCH Arts in Hospital Plan 22/23

DCH is committed and supportive of the continued development of its Arts in Hospital programme which delivers staff and patient benefit. This is even more important as DCH staff and our community recover from the pandemic. Arts in Hospital also makes a significant contribution to DCH's Social Value commitments to improve the social, economic and environmental well-being of our wider community.

The DCH Arts in Hospital Plan 2022/23 details the key activities and developments which will be delivered. We will build on our successful programme delivered during 2021/22, which included the new AIH website providing a greater online presence, which has been vital in the last 2 years. One of DCH AIH's key developments are the planned project/s for celebrating the 35th anniversary of DCH AIH. Also, working with the DCH Charity team we plan to raise significant funding for AIH elements for the new ED/ICU build as part of DCH Charity's Capital Appeal which commences in 2022/23.

The key activities for the year ahead are outlined below.

- Celebrating 35 years of DCHFT's Art collection. This will include designing DCH Art Map (with QR codes linking to the AIH website) and an accompanying booklet.
- Deliver 2022/23 Temporary Exhibitions programme.
- Involvement in arts provision for New Hospital Project (ED/ICU build) as part of DCH Charity's Capital Appeal. The Appeal aims to raise c.£120K for AIH related elements of the project. AIH will also work with DCH Charity to engage major donor prospects with interests in supporting Arts and Health causes, generating additional income for the overall Capital Appeal; in addition to funding for arts elements.
- Reinstate an AIH Assistant role to support key projects including the AIH elements for the new ED/ICU build; as well as focus on patient engagement as we move out of covid restrictions.
- Continue to upload the DCH art collection to AIH website to increase accessibility to this cultural asset.
- Deliver arts elements in ED15 development.

- Liaise on 'NHS Unmasked' publication and plan launch.
- Expand Arts in Hospital 'on-screen' initiative.
- Be part of a working group focussing on the hospital's green spaces.
- Work with DCH Volunteer Co-ordinator to bring artists onto wards and train DCH volunteers to participate in arts and crafts activities with patients.
- Photographing and cataloguing important pieces of the DCH collection.
- Reorganise the Art store and rationalise our collection.
- Consider opportunities to collaborate with other NHS Trusts in Dorset and surrounding region to promote and grow Arts in Hospital programmes.

Appendix 1 DCH AIH Activity Timetable 2022-23

Activity	***Month***	***Notes***
Frink Dog returned	*January*	*Now re-installed*
Artwork into ED15	*January - May*	*Ongoing throughout the early part of this year*
DCH Art Map + booklet	*February-April*	*Print for a Spring/Summer launch*
DCH Charity Capital Appeal for ED/ICU	*From Apr 2022*	Plans for fundraising for AIH elements – target c.£135K
Exhibition change over	*April 26 + 27*	*Kathryn Thomas – Dorchester Camera Club*
NHS Unmasked publication and launch	*April/May*	*Funding already obtained £5K from CCG spend prior March 2022*
Continue to add collection to AIH website	*April onwards*	*We have had some slides converted so have additional quality images to add to website*
Online auction of Judy Tate art	*Spring*	*Work with DCH Charity to auction donated prints*
Input to DCH volunteer programme	*Spring*	Work with Hannah Robinson re artists onto wards + train volunteers in arts and crafts activities
Exhibition change over	*July 13 + 14*	*Dorchester Camera Club – Rose Hatcher*
Programme 2023 Temporary Exhibitions	*In place by September*	*Programme tbc*
Improve AIH on-Screen	*Ready for the winter months*	*To have an AIH YouTube channel + content and better publicised*
NHS Unmasked exhibition at Dorset Museum	*September-December*	*With promotional event to promote NHS Unmasked publication* *In addition, DCHC Capital Appeal engagement event for major donor prospects planned*
Exhibition change over	*October 12 + 13*	*Rose Hatcher – Paul Cledon*
Add AIH donation records to DCHC donor database		*To ensure there are more thorough records and that we can use the information in future*

Appendix 2 DCH Arts in Hospital Budget 2022-23

DCH Arts in Hospital programme budget will ensure we continue to deliver inspiring and engaging artistic and cultural initiatives, enhancing the hospital's care and working environment, to benefit our patients and their families, as well as the well-being and resilience of DCH staff.

During 22/23 we aim to reinstate the AIH Assistant role (B2). The role will enable us to increase the AIH service, our activity, funding and the profile of our work. We have not done this since the previous post-holder left due to the lack of certainty around Covid-19. This capacity will contribute to the delivery of our ambitious and highly regarded arts programme including new projects.

In addition to our standing budget lines, we have proposed some project funding for 22/23 to enable us to deliver the AIH core service such as Exhibitions throughout the year; as well as new projects to celebrate the 35th Anniversary of DCH AIH, agreed with the AIH Steering Group, including a DCH ArtMap. We also need to do work to safeguard the collection we have in terms of its maintenance and storage.

Covid-19 has been a challenging time for AIH, it makes our work ever more important, however we have had limited opportunities to secure external funding. Significant public funding has gone towards safeguarding collections and jobs in museums and public galleries. We are neither a public gallery or a museum, our collections are not under threat as we sit within the NHS, so we are considered by external funders as secure during this time. We do however plan to raise significant funding for AIH elements for the new ED/ICU build as part of DCH Charity's Capital Appeal which commences in 2022/23. AIH will also assist in engaging affluent donors with an interest in Health and Arts causes to secure additional funding to the overall Capital Appeal target.

The AIH budget for 2022-23 will enable AiH to deliver even more benefit for DCH staff, patients and their families.

Please see DCH AIH budget 2022/23 in table 1 below.

Table 1. DCH AiH budget 22/23

Account			Annual	Annual	Notes
Account	Description	WTE	Annual 21/22 Budget £	Annual 22/23 Budget £ (proposed)	
20406	Agenda For Change Band 6	0.60	27,106	27,106	DCH Arts in Hospital Manager
20410	Agenda For Change Band 2	0.19	4,202	4,202	DCH Arts in Hospital Assistant
	Pay Codes	**0.79**	**31,308**	**31,308**	
33000	Printing (Exhibition boards et al)		0	750	Required to install DCH Exhibitions
31138	Medical Equipment Maintenance (Pencils)		2,800	2,800	Annual budget requirement
33018	Staff Travel and Subsistence		104	250	Travel to visit artists
34021	Insurance Premises		4,312	4,500	Annual budget requirement
36500	AiH Website Costs		232	350	Website development/maintenance
37103	Membership Subscriptions		0	400	Arts & Health South West Network
36500	AiH Projects		0	2,500	DCH AiH 35th Anniversary projects
	Nonpay Codes	**-**	**7,448**	**11,550**	
	Report Total	**0.79**	**38,757**	**42,858**	

Appendix 13. Professional Memberships

Organisation	Membership Type	Professional Qualifications/Nominals
Fundraising Regulator	**Registered Charity**	
Chartered Institute of Fundraising	**Individual (Simon Pearson)**	**MCIOF**
Chartered Institute of Marketing	**Individual (Rachel Cole)**	**MCIM**
Chamber for Business (Dorchester)	**Organisation**	
Social Value UK	**Organisation (DCHFT)**	

Meeting Title:	DCHFT Board
Date of Meeting:	30th March 2022
Document Title:	**DCH Charity Capital Appeal Plan (ICU/ED)**
Responsible Director:	Paul Lewis, Deputy Director, Strategy, Transformation & Partnership
Author:	Simon Pearson, Head of Charity & Social Value

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH Charity Strategy Group DCH Charitable Funds Committee	25.1.22 28.2.22	DCHC Capital Appeal Plan review CFC supports DCHC Capital Appeal Plan

Purpose of the Paper	DCH Charity Capital Appeal Plan outlines plans for major capital fundraising appeal in support of the planned ED/ICU build.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The DCHC Capital Appeal Plan is currently in working draft form. The plan will be developed further, working with the DCH NHP team, to refine funding area costings and the final Appeal target. The key elements of the DCH Charity Capital Appeal Plan include: • Appeal planning • Appeal timeline 2022-25 (key phases) • Proposed funding areas/costings (ICU/ED) • Appeal case for support overview • Funding prospect research (HNWI) • Appeal Board development • Capital Appeal budget							
Action recommended	The DCHFT Board is recommended to: 1. **APPROVE** DCH Charity Capital Appeal Plan (ICU/ED).							

Governance and Compliance Obligations

Legal / Regulatory	Y	Charities Act (2011)
Financial	Y	DCH Charitable Fund (SFIs)
Impacts Strategic Objectives?	N	
Risk?	Y	DCH Charity Risk Register
Decision to be made?	Y	To Approve
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	DCH Charity contributes to the delivery of DCH social value commitments as per DCHFT Social Value Pledge.
Equality Impact	N	

Assessment?		
Quality Impact Assessment?	N	

Dorset County Hospital Charity – Capital Appeal Plan (ICU/ED-Trauma) (*DRAFT summary)*

Capital Appeal

This plan outlines Dorset County Hospital Charity's approach to the development of its major capital fundraising appeal to contribute to the planned ED/ICU new build for Dorset County Hospital. Charitable support will fund important enhancements to this major project which will improve patient care and transform the experience of Emergency and Intensive Care patients and their families. Importantly, the charitable funding will be separate and additional to the NHS NHP capital funding budget for the ED/ICU new build. The DCH ED/ICU project business case will not be conditional on securing charitable funding; DCHC's contribution will contribute to enhancements in the new build, over and above NHS funding.

1. Appeal planning

DCH Charity has held a series of appeal planning meetings with the project team including Strategic Estates, ED/ICU Consultants and Finance. Meetings have focused on aligning the appeal planning with the project development plans and identifying the key funding focus areas and associated costings. Meetings focussed on identifying the charitable funding elements and costs to enable DCHC to quantify the appeal target and produce a comprehensive Capital Appeal Plan.

Appeal planning process: the following provides an outline of the key steps in the development of the DCHC Capital Appeal Plan:

Appeal Planning activity	Timeline
Appeal planning meetings with project team	During 2021-Jan 22
DCH NHP Board: update on Appeal planning	2.11.21
CFC: Appeal planning and proposed approach	3.11.21
Prospect research (HNWIs/Trusts) assess funding feasibility in relation to potential Appeal target	Mar-May 22
Appeal Case for Support drafting – key appeal messages, funding focus areas, case stories	Nov 21-Mar 22
Appeal Plan drafting (DCHC Business Plan 22/23)	Nov 21-Mar 22
CFC: Appeal development progress report	15.12.21
CFC: draft Appeal Plan for review	28.2.22
DCH NHP Board: draft plan (for information)	8.3.22
DCHFT Board: Capital Appeal Plan for approval	30.3.22

2. Appeal planning - assumptions

As represented by the estimated funding targets in section 4 and in DCHC Case for Support – Capital Appeal diagram (section 5), the ICU and Trauma (ED) elements represent two distinct areas in fundraising terms; albeit part of the same integrated project. The Capital Appeal Plan has been developed based on the Charity's previous capital appeal target levels achieved (c£2M for Cancer Appeal); fundraising team capacity; level and feasibility of securing capital funding targets and with regard to the continuing impact of the pandemic on charity fundraising, together with the prevailing, challenging economic situation. We need to plan prudently and realistically in order to maximise our chances of securing significant capital funding in support of the overall project.

Key planning considerations:

- Ongoing impact of the pandemic on economy and charity fundraising, through 22/23 and beyond. However, good will for the NHS has been heightened due to the pandemic; and there has been increased profile of the role of NHS Charities. Strong reputation of DCH in local community.
- Previous Appeals successful track record – Cancer Appeal, Chemo Appeal, Covid Appeal. Significant major grants from trusts and other charitable organisations have previously been achieved.
- The Charity's fundraising team provides skills and experience, though requires capacity in fundraising support and administration function to help maximise fundraising efficiency and performance.
- Evaluation of funding research to determine the feasibility of achieving the proposed appeal target. Appeal target needs to be realistic and deliverable.
- Taking an integrated approach, focused primarily on Critical Care (ICU) with Trauma Care (ED) areas, will enable DCHC to work on identifying and engaging with prospective major funders in parallel.
- We will develop a focused and emotive 'case for support' which can be clearly communicated to potential donors. Points to be considered:
  - From public/donors' perspective the role of Critical Care/ICUs during the pandemic remains 'front and centre'. The ICU elements provide a strong 'story' focussed on patient, relatives and staff welfare; together with enhancing the care environment.
  - ED plays an essential role in this integrated pathway, though may be considered less appealing in fundraising terms with public expectations that Govt/NHS should provide this funding. Re-positioning our 'ask' for Trauma Care is considered more emotive and integrates with the 'story' of Critical Care provision.
- Critical Care Support Fund and ED/Trauma Care Support Fund: the major appeal provides the opportunity to build up the current DCHC Critical Care and ED Funds. This would provide for future enhancements to the new ICU and ED facilities, over and above NHS budgets.
- Dorset County Hospital's leadership at Board and Executive team strong commitment/engagement with the appeal.
- Clinical staff engagement is strong including Critical Care and ED Consultants and DCHC will work closely with key staff to engage major donors (ie. Donor, meetings, site tours), as well as in promoting the public fundraising phase of the appeals.
- Influential Appeal Board will be established, to drive major donor, grants, high-value events and corporate support.
- Digital fundraising through new DCHC website, fundraising platforms, contactless donations and social media promotion.

- DCHC will need to continue to monitor competitor/comparator appeals within Dorset; including other NHS charities and local/national charities, which could have an impact on our appeal fundraising.
- The development and success of our appeal will be dependent on the ED/ICU Project business case (SOC/OBC) approvals, construction timeline and any matters which may impact the project's delivery. We are working closely with the NHP Strategic Estates team to ensure our Capital Appeal Plan aligns to the project's development plans accordingly.

3. Appeal timeline

DCHC's major Capital Appeal needs to align with the NHP ED/ICU project timeline outlined below:

DCH ED/ICU project timeline

Project Plan Milestone	Date
Strategic outline case	January 2021
Outline business case (ED/ICU)	May 2022
Full business case (ED/ICU)	January 2023
Construction commences (ED/ICU)	October 2023
Completion of new build (ED/ICU)	December 2024
Completion of refurbishment (ED/ICU)	July 2025

DCHC Capital Appeal phases

The ED/ICU project build timeline provides a three-year period from 2022-25 for delivery of the DCHC Capital Appeal. As with all major capital appeals, activity will be delivered through two key fundraising phases – 'private' phase which is major gifts led to secure majority of funding, then 'public' phase with a media launch and focus on community events, corporate and individual giving. The table below provides a high-level timeline for the DCHC Capital Appeal phases:

DCHC Appeal Activity	Fundraising activity	Timeline
Appeal planning phase	Appeal Plan development/approvals	Oct 21 – Mar 22
	Initial funding research (HNWIs/Trusts)	Mar 22 – May 22
Private Phase	Private phase (Further funding research; Appeal Board set up; Major donor engagement; Major gifts fundraising)	Apr 22 - Dec 23
Public Phase	Public phase (PR launch; Community/Events fundraising led; final Major donor gifts)	Jan 24 – Dec 24
Appeal close/thank PR	Media comms/major donor recognition	Mar 2025

4. Proposed funding areas/costings

DCH NHP Strategic Estates team obtained estimated costings in October 2021 from MMC Project Consulting for most areas proposed for charitable funding. In discussions with the project team, DCHC has identified potential key project areas as strong, emotive elements for the capital appeal. The table below outlines the current proposed areas with estimated costings (rounded up for fundraising purposes). These areas and costings will need to be further refined, updated and agreed with the NHP project team as our appeal planning progresses in order to quantify the final appeal target.

Project Area	**MMC cost estimate**	**DCHC target (*cost rounded up*)**
1. Critical Care (ICU)		
Relatives' overnight accommodation (x2)	£233K	£250K
Staff rest/overnight accommodation (x2)	£309K	£325K
Staff quiet room	tbc	£100K est
Paediatric CC bed/equipment	tbc	£100K est
Enhanced ICU reception (with AiH design elements)	£135K	£150K
ICU patient garden	£149K	£150K
CCU specialist medical equipment	N/A	£100K
AiH elements (not incl. above)	(£30K incl in figs above)	£75K
Sub-total	**£0.8M**	**c. £1.25M tbc**
*Critical Care Support Fund	N/A	£250K
Sub-total	**£0.8M**	**c. £1.5M**
DCHC fundraising costs (20%)		c.£300K
Critical Care total (est/tbc)		**£1.8M (est)**
2. Trauma Care (ED)		
Relatives Room	*tbc*	*£100K est*
ED staff facilities	*tbc*	*£100K est*
AiH elements		£25K
Sub-total	**£K tbc**	**£225K tbc**
* ED/Trauma Care Fund	N/A	£250K
Sub-total	**£K tbc**	**c. £475K tbc**
DCHC fundraising costs (20%)		c. £95K
Trauma Care total (est/tbc)		**c. £570K (est)**
Overall Appeal total (est/tbc)		**c. £2.4M (est)**

(NB. Strategic Estates team have advised the proposed Helipad will be separately funded including support from HELP Appeal, so not in the DCHC Appeal.)

5. Capital Appeal – Case for Support (summary)

Draft Case for Support: DCH Capital Appeal (Supporting new ED/ICU)

Overview
- National situation
- Dorset population growing/ageing
- Increased demand
- Other NHS services being reduced
- Current facility outdated

Current ICU
- Lack of beds
- Lack of space
- Poor layout
- Staff shortages
- Pressure on other departments
- Lack of relatives' facilities
- Lack of staff facilities
- Operations cancelled
- No dedicated paediatric area
- Doesn't meet needs of Trust
- No capacity for increased future need

New ICU
- Sufficient beds for 20 years
- Increased space around beds
- Optimum layout for efficiency
- Increased staff efficiency
- Pressure relieved on other departments
- Layout works for ED/ICU integration
- Improved infection control

DCHC funding focus areas:
- Paediatric Critical Care Bed (incl. eqpt.)
- 2 x Relative Overnight Accommodation Rooms with ensuite*
- 2 x Staff Overnight Accommodation Rooms with ensuite*
- Staff rest/refreshment area*
- Staff quiet room*
- Specialist medical equipment
- Patient garden
- ICU Reception enhancement
- AiH design elements
- Critical Care Support Fund

Current ED
- Built for 22k attendances: 2019/20 figure 49k
- Insufficient capacity for current/ future demand
- Concerns due to overcrowding/queuing
- Ambulance handover delays
- No dedicated mental health or paediatric facilities
- Insufficient resuscitation bays

New ED
DCHC funding focus areas:
- Improved staff facilities
- Relatives' room
- AiH design elements
- Emergency Care Support Fund

Helipad
Not in DCH Appeal. To be funded by HELP Appeal and other sources

Documents referenced:
Build once Build Well paper and Demand Capacity (Video)
Build once Build Well (CCU 2nd floor proposal).pdf
Financial Environmental Benefits of a new Build Critical Care Unit - Dec 2020.pdf
DCH SOC Annexe V22.28th January SUBMITTED.pdf

* Would be provided for in vacated ICU space

updated 9.3.22

6. Appeal target

The current Appeal target will need to be further refined as the scope of ICU/ED project elements are confirmed and we quantify final costs for the project's charitable funded focus areas. The final Appeal target will also be developed further as we quantify the Prospect Research including HNWI and Charitable Trusts research.

Based on the appeal planning meetings with members of the NHP project team including Strategic Estates, Finance and ICU/ED Consultants, the project funding areas/costs identified and agreed to date equate to an overall Capital Appeal target (including fundraising costs) estimated in region of c£2.4M over 3 years.

Capital Appeal by income stream (indicative)

The following information provides indicative targets for key Appeal income streams, based on the indicative forecasts in the DCHC 2022-25 Strategic Business Plan budgets (to be approved). Initial income stream forecasts will be reviewed following the HNWI and Trusts/Foundations funding research, and on an annual basis in line with DCHC Business Plan development and Capital Appeal income stream performance as the appeal progresses.

Table 1.

Income Stream	Target	Source
Grants	£1,450K	Major national/local trusts; local charities
Donations	£450K	Major donors (HNWI), other individual donations
Events & Community	£440K	Community organisations; Events (incl Major/High Value events); Virtual fundraising; DCH Staff fundraising
Corporate	£30K	Local corporate supporters, business networks
Total	**£2,370K**	

7. Prospect Research

We propose working with specialist wealth intelligence research agency Prospecting for Gold (PFG). Established in 1999, Prospecting for Gold is a leading prospect research agency to the not-for-profit sector offering a full range of fundraising and prospect research services.

Prospect Research work programme

High Net Worth Individuals research

Data Protection/GDPR: PFG will advise on GDPR requirements in relation to HNWI research and charity database screening. Data security and data sharing contracts will be agreed, with reference to DCH IG Manager.

Phase 1 research – March/April 2022

1. **Wealth screening** of DCHC donor database to identify any current supporters with the capacity to give at major gift levels. Cost includes initial screening and up to 52 Snapshot reports. Estimated cost £650 plus VAT. Additional reports are available at £12.50 plus VAT each.

2. **New HNWI names research:** to identify 50 HNW individuals not yet connected to the charity, based on research brief, to identify good prospects for the capital campaign. PFG have around 4,500 millionaires on their research database across Dorset. In this first phase of research they suggest we focus on people within the county, while those with current/past connections to the County are included in second phase research.
   Cost: £3750 plus VAT

3. **Presentation to CFC (Apr)** by Andrew Thomas and/or Kerry Rock to CFC to discuss PFG research services, first phase research findings and major donor development for Capital Appeal.

Phase 1: Total cost £4,400 + VAT

Phase 2 additional research (*tbc, if required*) – May/June 2022

To further expand the HNWI prospect pool for the Capital Appeal, if required. Depending on DCHC's requirements this may include some of the following research elements:

1. **Additional HNWI new names** – building on the work in phase 1. This research would focus on HNWI prospects both within Dorset and/or with connections to Dorset. Cost would be £3,750 + VAT for an additional 50 names.

2. **HNWI Prospect briefings** – reports on individual prospects which include:
    - **Biographical** information & career history
    - **Wealthband**
    - **Spouse** information
    - **Business** and philanthropic links
    - **Membership** of clubs and other associations
    - **Interests** and motivations
    - **Other** points of interest

   These cost £195 plus VAT per report. Estimate need initial 10 Prospect briefings £1950+VAT

3. **DCH Historic donors research:** as recorded on the historic donor boards displayed in the hospital, the former hospital was supported by influential donors and families in/and with connections to Dorset. These names would be screened against PFG's wealth intelligence database and other research sources to identify any current family members and/or connections to these donors. Our aim thereafter would be to engage the people identified to ascertain their interest in continuing the philanthropic legacy of their forebears. Cost: Initial 2 days desk research £1300+VAT

4. **Network mapping** initially on 1 key HNWI prospect to identify useful connections/networks to work with in the early stages of the campaign. This will show the scope available from this approach. Further network mapping for key HNWI prospects if required. Cost: £845 plus VAT

Phase 2: Max. spend £3,900 + VAT (specific research elements tbc)

Trusts and Foundations research

Grant making charitable trusts will include local Trusts/Foundations and other charities which have previously supported DCH Charity; as well as new prospects. DCH Charity will carry out desk research using online grant research platforms to identify new Trusts with capital grant-giving criteria related to Health/Medical causes. This will include local Dorset based Trusts, as well as larger national Trusts with an interest in the related project, Health/Medical and/or Dorset based charitable causes. DCH Charity team will also work with members of the DCHC Appeal Board to identify known connections to grant-giving organisations and utilise these to introduce, advocate and apply for support for the capital appeal accordingly.

Capital Appeal - Table of Gifts

DCHC will assess the prospect research findings for the appeal and develop a Table of Gifts; this a key tool for planning and managing a major Appeal. It presents the number of donations at specific donation levels required to achieve the target most effectively. The Table of Gifts will be presented in the full DCHC Capital Appeal Plan once the prospect research has been completed.

8. Appeal Leadership: DCHC Appeal Board

DCHC APPEAL BOARD ROADMAP 2022/23

Objective

- Establish an influential Appeal Board to drive Capital Appeal
- HNWI prospect research to identify potential external members
- Engage ED/ICU Clinical leads to join Appeal Board
- Plan initial Appeal Board meetings

Main focus:

- DCHFT Board
- ED/ICU Clinical leads
- Influential/affluent external membership
- Corporate sector

Appendix 1. DCHC Capital Appeal Budget *(Draft indicative 2022/23-25/26)*

Income Stream	**Target** (Indicative)	**Actual t/d** (Inc/Pledge td)	**Source**
Grants	£1,450K	**£125K***	Major/local trusts; local charities *(*DCH Friends pledge from legacy received)*
Donations	£450K	**£**	Individual donations, major donors, in memoriam, legacies
Events & Community	£440K	**£**	Community; High Value Events; Staff fundraising
Corporate	£30K	**£**	Local corporate supporters
Total	**£2,370K**	**£125K**	**Balance to be achieved: £2,245K**

Budget (£K)	**2022/23** (forecast)	**2023/24** *(indicative)*	**2024/25** *(indicative)*	**2025/26** *(indicative)*	**Totals**
Capital funds target (£K):	**£315K**	**£740K**	**£965K**	**£350K**	**£2370K**
Staff costs related to Appeal					
Head of Fundraising (0.8)	£40K	*£40K*	*£40K*	*£40K*	**£160K**
Fundraising & Comms Manager (0.8)	£18K	*£18K*	*£18K*	*£18K*	**£72K**
Individual Giving Manager (1.0)	£30K	*£30K*	*£30K*	*£30K*	**£120K**
Fundraising Officer (0.8)	£8K	*£8K*	*£8K*	*£8K*	**£32K**
Fundraising Support Assistant (0.4) ftc	£4K	*£4K*	*£4K*	*£4K*	**£16K**
Total Staff Costs (£K)	**£100K**	***£100K***	***£100K***	***£100K***	**£400K**
Non-Staff Costs related to Appeal					
Marketing, Design & Printing	£1K	*£10K*	*£10K*	*£10K*	**£31K**
Prospect Research /Research subs	£10K	*£2K*	*£2K*	*£2K*	**£16K**
Engagement events	£1K	*£2K*	*£2K*	*£2K*	**£7K**
Total Non-Staff Costs (£K)	**£12K**	***£14K***	***£14K***	***£14K***	**£54K**
Total Appeal Costs (£K)	**£112K**	***£114K***	***£114K***	***£114K***	**£454K (*c.20% cost:income*)**

Meeting Title:	DCHFT Board
Date of Meeting:	30th March 2022
Document Title:	**DCH Charity Funds Restructure**
Responsible Director:	Paul Lewis, Deputy Director, Strategy, Transformation & Partnership
Author:	Simon Pearson, Head of Charity & Social Value

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH Charitable Funds Committee	28.2.22	CFC supported the proposed approach and preferred option.
Risk & Audit Committee	22.3.22	Proposals noted by RAC.

Purpose of the Paper	Proposed restructure of DCH Charity charitable funds.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The enclosed report presents DCH Charity's proposals and recommendations for restructuring its charitable funds. The proposed recommendations are as follows: • **DCHC to establish Unrestricted 'mirror' funds for current Restricted funds, where appropriate, to commence from Apr 2022.** • **DCHC to align all charitable funds with the DCH Divisional care area structure, to commence from Apr 2022.**							
Action recommended	The DCHFT Board is recommended to: 1. **APPROVE** DCH Charity's recommendations for restructuring its charitable funds.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Charities Act (2011)
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	Y	DCH Charity contributes to the delivery of DCH social value commitments as per DCHFT Social Value Pledge.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DCH Charity: Charitable Funds restructure proposal

Introduction
DCH Charity commenced a Governance Review in April 2021. A key element was the review of the composition of the Charity's charitable funds in relation to restricted and unrestricted funds. The review's objective was to ensure DCH Charity utilises all funds donated for the benefit of Dorset County Hospital as effectively as possible to maximise their beneficial impact on enhancing patient care and staff welfare.

Context
All NHS Charities will have a variety of different charitable funds. Managing and accounting for these funds can be a complex process. The Association of NHS Charities (now NHS Charities Together) published a briefing paper on the **'Management of restricted and unrestricted funds'** outlining how NHS Charities should work to rationalise their funds, to ensure the effective administration of their charitable funds. Their briefing note set out the different types of charity funds, the legal restrictions which apply and what steps can be taken to de-restrict and rationalise funds. DCH Charity Governance Working Group were tasked by the Charitable Funds Committee to review the composition of the DCH Charity's charitable funds accordingly.

Classes of charitable funds
There are three principal categories of funds, within which there are further distinctions as to how funds are held.

Unrestricted Funds
Unrestricted funds are spent or applied at the discretion of the trustees to further any of the charity's purposes. Generally speaking, funds received by a charity should be assumed to be unrestricted unless the donor places an unequivocal restriction on them, for example by saying that they 'must be used' or 'can only be used' for a specified purpose or by giving to a specific appeal which makes clear that the use of the donated funds is restricted.

Designated Funds
Trustees may decide to set aside a part of the unrestricted funds to be used for a particular project. If the trustees earmark funds in this way, those funds would become 'designated' funds, but would still remain part of the unrestricted fund of the charity. This is because the designation may be cancelled by the trustees if they later decide that the charity should not proceed or continue with the use or project for which the funds were designated; a specific trust has not been imposed in relation to these funds.

Restricted Funds
Restricted funds are funds held on specific trusts under charity law. These specific trusts can be for special purposes (within the scope of, but narrower than, the NHS charity's objects)

or can contain a bar on the expenditure of capital (known as 'permanent endowment'), or both. NHS Charities restricted funds may consist of linked charities or special trusts.

Current DCHC Funds structure
DCH Charity's charitable funds are split between restricted and unrestricted funds. The current structure comprises 16 Restricted funds, currently representing c.85% of the value of all funds; and 44 Unrestricted funds currently representing c.15% of the value of all funds.

The current funds structure creates specific constraints and consequences including:

- Restricted funds are not necessarily providing maximum benefit, where they could otherwise be applied to a wider care area if the restriction could be removed; or a mirror fund set up.
- A number of Unrestricted funds are small and therefore relatively ineffective and would benefit from rationalisation.
- A high proportion of DCHC funds are in Restricted funds, which has the potential to affect the operational sustainability of the charity, where operational charges need to be primarily charged on the value of Unrestricted funds. Unrestricted funds attract a larger proportion of charges for DCHC Governance and Fundraising costs.
- The current funds structure is not reflective of DCH's Divisional care areas structure and could benefit from alignment in order to consolidate funds by care area; as well as align to care area focused fundraising campaigns.

1. DCHC Funds restructure review – options

The following options were considered by the DCHC Governance Working Group:

1. 'Do nothing': maintain current DCHC charitable funds structure.

2. Convert all Restricted funds to Unrestricted funds, where appropriate. As part of this process, Restricted funds set up for a specific project linked to an Appeal (ie. Cancer Appeal) could be reclassified as 'Unrestricted - Designated Fund', enabling any funds in excess of the Appeal target to be utilised for related purposes or care areas (ie. Cancer Services).

3. **Preferred option:** Set up Unrestricted 'mirror' funds for current Restricted funds, where appropriate. New 'mirror' funds would be set up to commence from new financial year (Apr 2022). All future donations would be paid in to new Unrestricted 'mirror' funds (and existing Restricted funds would be spent down).

Regulatory considerations
The DCHC Governance Working Group has reviewed all Restricted funds and determined which should have 'mirror' funds established. This process has considered any formal restrictions and historic/current donor requirements in relation to specific restricted funds. The Charity Commission advises that amendments to the composition of DCHC's charitable funds do not need to be reported to them. However, changes to the Charity's funds structure must be reported in DCH Charity's Annual Report and Accounts. Once these proposals have been approved, DCHC will communicate these beneficial changes to Fund representatives and key staff.

2. DCHC Funds reorganisation
The DCHC Governance Working Group also proposes reorganising all DCHC charitable funds to align with the DCH Divisional care area structure. This would enable more effective analysis of levels of donations across wider care areas; enable consolidation of smaller funds by care area; improve reporting and align with the DCH Charity's Power of Giving campaign focused on fundraising for specialist care areas and the DCHC General Fund.

Please see Table 1. Proposed DCHC Funds reorganisation diagram (attached) developed in consultation with DCH Divisional management.

Governance
DCHC Charitable Funds Committee has been advised of the funds restructure review process since April 2022. **At its Charitable Funds Committee meeting on 28.2.22 the committee supported the proposed approach and 'preferred option'.**

Recommendations:

1. **DCHC to establish Unrestricted 'mirror' funds for current Restricted funds, where appropriate, to commence from Apr 2022.**

2. **DCHC to align all charitable funds with the DCH Divisional care area structure, to commence from Apr 2022.**

- **DCHFT Risk & Audit Committee to note the above recommendations (22.3.22)**

- **DCHFT Board (Corporate Trustee) to approval the above recommendations (30.3.22)**

Simon Pearson MCIOF
Head of Charity & Social Value
(March 2022)

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	30th March 2022
Document Title:	**Maternity Safety Report March 2022 (February information)**
Responsible Director:	Nicky Lucey, CNO
Author:	Jo Hartley, Associate Director of Midwifery & Neonatal Services

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	22/03/2022	

Purpose of the Paper								
	Note (✓)		*Discuss*	✓	*Recommend*		*Approve (✓)*	✓
Summary of Key Issues	This report sets out to the Trust Quality Committee the quality and safety activity covering the month of February and where relevant, quarter three. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board. • Initial data available for third quarter – may be subject to revision as data is cleansed • Maternity staffing remains challenging although workload has been reduced on some shifts. • SCBU staffing remains extremely challenging • Two informal complaints in February • No HSIB cases • No intrauterine deaths or stillbirths • Examples of best practice shared at the CQC quarterly engagement visit • Benchmarking against the Kirkup Response provided assurance • Evidence for Ockenden actions almost complete • Midwifery recruitment agreed for third year students – available to start work in Sept 2022							
Action recommended	The Trust Board is recommended to: 1. **DISCUSS** the report 2. **APPROVE** the contents							

Governance and Compliance Obligations

Legal / Regulatory	Y	Safety and quality in maternity services remains very high on the national agenda. The second Ockenden report will be published in March. Bill Kirkup is also completing a review on maternity care in East Kent

Financial	Y	The refund of 10% of the CNST Incentive Scheme has been confirmed and has been confirmed and national expectation is that it is ring-fenced for maternity
Impacts Strategic Objectives?	Y/N	
Risk?	Y	There are risks around safe staffing levels and mandatory training.
Decision to be made?	N	
Impacts CQC Standards?	Y	As above
Impacts Social Value ambitions?	Y/N	
Equality Impact Assessment?	Y/N	
Quality Impact Assessment?	Y/N	

Dorset County Hospital
NHS Foundation Trust

Maternity Quality and Safety report

March 2022 (data from February)

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 February and where relevant, quarter three. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Initial data available for third quarter – may be subject to revision as data is cleansed
- Maternity staffing remains challenging although workload has been reduced on some shifts.
- SCBU staffing remains extremely challenging
- Two informal complaints in February
- No HSIB cases
- No intrauterine deaths or stillbirths
- Examples of best practice shared at the CQC quarterly engagement visit
- Benchmarking against the Kirkup Response provided assurance
- Evidence for Ockenden actions almost complete
- Midwifery recruitment agreed for third year students – available to start work in Sept 2022

Section 1: Activity and incidents reported.

Activity as of the end of the third quarter

Total number of births	394	
Number of homebirths	33	8.4%
Number of caesareans (emergency & elective)	163	41%
Number of instrumental births	30	7.6%
Number of inductions of labour	141	35.7%
3rd & 4th degree tears	4	1%
Postpartum hemorrhage over 1litre	53	13%
Babies born below 37 weeks	18	4.5%
Number of shoulder dystocia	3	<1%
Commenced breastfeeding		85%

DCH reported incidences

Dorset County Hospital reported Maternity Patient Safety incidents from January to December 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:

Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
72	50	52	50	60	60	65	98	91	87	64	43

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	6 of which 3 were SCBU related. **Business case being finalised to optimise recruitment through banding uplift for nurses and HCAs**
RF2	Missed medication	1
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. Working with Informatics to capture this data
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	0
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	0
RF10	Delay of time critical activity	0

RF1 less datix relating to staffing/delays in care. This reflects a quiter month with a more manageable workload

Incidents in the last 6 months requiring RCAs

Severity	Sept	Oct	Nov	Dec	Jan	Feb
Incidents requiring RCAs	0	0	1	1	0	0

Incidents of interest without RCA required (updated and new)

reference	detail	ongoing action	Update
DCH71279	Category 2 GA caesaean with an admission to ICU **Immediate action taken** Hb falling throughout day prior to Cat 2 – estimated blood loss in theatre 500ml 2 units of X matched blood transfused in theatre due to low and likely falling Hb Baby to scbu, raised temp at birth, affected by GA Placenta swabbed, and sent for		Woman discharged home 2 days after her caesarean.

	histology Failed attempt to extubate, anaesthetist unhappy and reintubated. ABG performed. Plan made with ICU consultant to transfer for scans and admit to ICU		
DCH71240	Shoulder dystocia with gestational diabetic- spontaneous labour **Immediate action taken** P1 36+5 gestational diabetic Coordinator in room anticipated shoulder dystocia, emergency bell called, bed head lowered by coordinator. MacRoberts attempted by coordinator and RM CBE but delivery unsuccessful, coordinator therefore then took over and removed left posterior arm. Normal birth – baby skin-to-skin	Patient's record checked to identify whether the risks associated with a vaginal birth/diabetes had been discussed. Seen in antenatal clinic following a scan showing a large baby. Implications of diabetes explained and second appointment arrangeed but baby born before that date. It would not be expected that labour would start spontaneously before 37 weeks.	Mum and baby well and the care was appropriate with correct folllow up of baby, including observations completed

RCAs round-up and update

reference	detail	Ongoing action
DCH66382	IUD at 34 weeks requiring delivery with IR (interventional radiology) available	Intra-uterine death with delivery by LSCS at UHS (tertiary unit) due to interventional radiology requirements, (nearly completed not yet presented) learning will be around smoking pathway and referral being robust. Guideline needs to be updated. Aspirin guidance to be updated to incorporate previously small babies. IR pathway for women with complicated placental implantation to be agreed ideally Pan-Dorset **Learning from Incident Panel (LIP) 29th March 2022**
DCH68908	Transfer to ITU then to tertiary unit for IR	Transfer to ITU then RBJ for IR small bleeding vessel,(RCA nearly completed not yet presented) learning recognition and management of the deteriorating patient. IR pathway for women with on-going intra-abdominal bleeding (as above). Case reviewed by Practice Educators with plans to incorporate into learning. **Following LIP** No changes required. Follow-up meeting with a consultant in May. Lack of interventional radiology pathway across the ICS to be discussed with UHD

DCH66427	36 week IUD. Focus on the impact of a persistent cough on accurately monitoring the baby	36 week IUD no learning identified at PMRT however there has been some discussion about CTG's in women who are coughing +++ as in this case making a CTG very difficult. She had a CTG which did not meet DR criteria but it was impossible to monitor her adequately because of her coughing. **Following LIP** Further review. CTG did not meet Dawes Redman criteria - mother advised to stay in hospital for continuing observation but could not do so/declined to do so. Had contact with the Day Assessment Unit over the weekend by phone and reported fetal movements good. Issue around documentation explored as limited on Badgernet regarding safety netting advice and risk assessment. Seeing consultant for follow up 22/3/22
DCH66488	Significant shoulder dystocia	IOL at 36+6 weeks normal birth significant shoulder dystocia. Baby received therapeutic cooling, diagnosed with HIE and Erbs Palsy.. Learning around counselling women who have a large for gestational age baby (LGA) and their preferred mode of birth in particular with babies whose mothers are diabetic as they have an increased risk of shoulder dystocia. Also when monitoring babies think is the baby fit for labour when CTG do not meet DR criteria. Possible introduction of another ANC for women with diabetes. **For next M&M** Has been heard at M and M. Parents have requested report.
DCH66585	Intra-uterine death at 24 weeks. No learning identified	IUD 24 +4 weeks at gestation. No learning identified at PMRT however in line with other hospitals in the region we have changed our guidance to recommend aspirin as opposed to advise with low Papp-a results. **Following LIP** Has had f/u with a consultant. Currently pregnant
DCH66603	Baby collapsed on SCBU. Resuscitated successfully	Baby collapsed due to prematurity and was well managed. Learning identified around good communication with parents, including those parents who wish to be very involved in their baby's care (doing observations etc.) and also around information for parents about their expectations of being on SCBU with their baby. Also learning about real-time documentation and ensuring observations are completed by an appropriate healthcare professional and senior review happens regularly. **LIP 30th March**

Medication incidents

Medication Incidents:

Category	Sep	Oct	Nov	Dec	Jan	Feb
Administration: Duplication						
Administration: Missed or delayed medication	1	2	2	1	2 (for same incident)	
Administration: Wrong dose		1	2			1
Prescribing: drug choice inappropriate						
Prescribing: Missed or Delayed						
Storage/Security: Medicine left unattended			1			

	4	3	3	3	2	

Risk Register

ID	Title	Risk Statement	Open	Review	Risk	Risk Level
1227	Provision of the smoking cessation service to pregnant women	**New risk** all pregnant to be tested for their CO levels at booking, at 36 weeks and ideally at any opportunity. Referral is then made to the smoking cessation service. Currently, there is a shortage of the cardboard tubes that are required for the test. Furthermore, although the recent audit of CO testing was positive, there is evidence that women are not always screened - sometimes due to lack of access to the monitor. The smoking cessation lead midwife is on LTS and the service is being managed (very well) by a band 4 MSW. However, this is not a sustainable model and is required for SBLCB and therefore for Ockenden and MIS. **Initial action** Consideration of a significant increase in monitors and MSWs being trained to do the test so women are screened whenever they are admitted. Funding identified for a public health lead midwife as well.	17/03/2022		moderate	Care group
858	Staffing on SCBU is often critical with vacant shifts unfilled with QIS nurses.	**Update March 2022.** Situation remains unchanged. LTS returned to work but staffing still affected by covid-related absence. Business case almost completed with a proposal to increase banding to better attract new staff – both HCAs and nurses	18/12/2019	17/03/2022	extreme	Division
871	Levels of Entonox Exposure on the maternity unit	**Update March 2022**: Jane Hall The fans and covers have been removed and cleaned, the two rooms where the on/off switches are still present will have a blank facia attached so that the fans cannot be turned off. Once this work has been completed we will re audit the levels to make sure that all the rooms are below the recommended level. **Mar 2022** Audits of Entonox levels almost complete – one more required then will be submitted to Cairns for analysis	24/12/2019	03/05//2022	High	Care Group
1127	Maternity Staffing	**Update February 2022** staffing continues to be extremely challenging Escalation to divert happens regularly across the region and staff are redeployed from community	20/07/2021	17/03/2022	high	division

		and from non-clinical roles to fill gaps. Ockenden funding awarded has been fully allocated to increase our Midwifery establishment budget. We are currently in the process of recruiting more newly qualified midwives and experienced midwives and have some in offer already. We are currently reviewing our rosters and skills mix to ensure that our service delivery is structured in the best way possible to deliver safe services and to progress to full delivery of the Ockenden recommendations, **Mar 2022** despite recruitment, covid related sickness absence continues to affect staffing numbers with few shifts fully staffed. Staffing was the number one concern raised by staff through the Safety Suggestions system				

Complaints

Month	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Formal	0	1	0	3	2	4	1	0	0	0	0	0
Informal	0	0	0	0	1	3	4	1	0	2	0	2
Total	0	1	0	3	3	7	5	1	0	2	0	2

Learning/actions from complaints and PALS

Patient described not feeling not listened to properly with a brusque response and left feeling unsafe	I spoke to the patient on the phone immediately to apologise and provide reassurance. Have discussed with the midwife she spoke to – very apologetic. The workload at this clinic has increased significantly with >20 phone calls sometimes during clinic, with only one midwife who is seeing patients and trying to respond to phone calls as well. **Plan:** discussion around extra staff for the clinic – will require sign off at business planning but temporary solution is extra on certain days on an adhoc basis
Patient attended in early pregnancy with abdominal pain. Concerned about her care	I spoke to the patient and have asked a consultant to review her notes. Response to follow

Mortality, Morbidity, Serious Investigations, External Reporting & Learning

Mortality MBRACE (Mothers and Babies Reducing Risk through Audit & Confidential Enquiries) reportable cases

February 2022	
No losses in February 2022	

Neonatal Deaths for quarter three Oct-Dec 2021

Ref	Description
	No neonatal deaths reported

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	

Morbidity including M&M meetings

No incidents reported in January 2022 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 February 2022

Learning and actions

- **Did working from paper notes and Badgernet impact upon reviewing care?**
- Ask "Is the baby fit for labour" (Dawes Redman not met prior to IOL)
- Robust discussion should occur regarding IOL/mode of delivery. Pros and cons of both. Including detailed documentation of the discussion and parents preference.
- ANC capacity is currently every other week-suggestion should be weekly. This would allow for more time for each family and decision making.
- Neonatal staff commended upon immediate care of baby. Good practice to call 2nd Consultant in to assist. Prompt referral to SONET.

Further maternity learning

Maternal, Newborn and Infant Clinical Outcome Review Programme
MBRRACE 2018-2019

Our figures compare favourably with maternity services of a similar size (5% higher or lower than similar size trusts).

Stabilised and risk adjusted extended perinatal morality rate excluding fetal abnormality (per 1000 births)

DCH figure of 3.49 – National aggregate 3.58

New Recommendations to Improve care for Health Professionals	Actions/follow up for DCH
Do not delay consultant appointments and evidence-based effective preventive interventions such as aspirin pending the results of investigations such as prenatal diagnosis	Shared at Clinical Governance meeting. No evidence that interventions or appts delayed
Recognise that 'post-pregnancy' counselling is as important as pre-pregnancy counselling for future pregnancies and for joining up obstetric and medical care to optimise a woman's long-term health	Well established consultant-led postnatal clinic. However, pre-conception services not commissioned currently and rests with GP. There is some capacity for adhoc pre-pregnancy appointments
Consider previous history, pattern of symptom development and ongoing stressors when assessing immediate risk and management of women with mental health symptoms. Plans should address immediate, short term and long-term risk	Care planning managed effectively by multi-professional maternity mental health team at DCH
If psychotropic medication has been discontinued in advance of, or during, pregnancy, ensure women have an early postnatal review to determine whether they should recommence medication	Care planning managed effectively by the multi-professional mental health team at DCH
Where a woman with severe postnatal illness has previously responded well to treatment then there should be an expectation of a good recovery from subsequent postpartum episodes. Ensure that it is recognized that discharge from inpatient care before recovery is achieved is likely to be associated with continued risk	This learning will be shared with the wider Perinatal mental Health Team pan Dorset
While relatives provide invaluable support to the woman, complementing the care provided by universal and specialist services, they should not be given responsibilities beyond their capabilities or be expected to act as a substitute for an effective mental health response	This will be shared with the mental health team and included in the mandatory updates they provide
Women with substance misuse are often more vulnerable and at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Ensure they are reviewed for re-engagement in the early postpartum period where they have been involved with addictions services in the immediate preconception period or during pregnancy	This is not an action for DCH but for support services such as REACH

Ensure symptoms of possible cancer are followed up postnatally	**Recent example of an obstetrician fast-tracking a patient to colposcopy. Consultants reminded – suggested could be discussed in a teaching session for trainees**
Ensure that assessment of adherence to administration forms part of the antenatal or postnatal assessment of women prescribed low molecular weight heparin [ACTION: All Health Professionals].	**Postnatal lead midwife to action this as LMWH provided by midwives on discharge.**

HSIB quarterly review meeting

- No new cases

:Reports and national guidance

Safety suggestions from staff

STAFF SUGGESTIONS	RESPONSES AS PUBLISHED IN THE NEWSLETTER
Copied of the newsletter available in a folder	We will print out 6 months of newsletters, laminate them and put them in a folder in the staff room
Relocate the weighing scales for swabs, in the rooms, as can be difficult to access	unfortunately, its not easily changed as the scales must plug in and be on a level surface. However, the Labour ward lead will review this
Maternal pulse needed on the monitor of the baby's heartbeat recording in the coordinator's office	Digital Lead midwife raised this with BadgerNet – not something we can resolve independently unfortunately
More datascopes/dinamaps with sats probes	Currently being sourced
Explore ways to improve staff's awareness of a more urinalysis sticks available	Currently being sourced
Checking the pink rostering spreadsheet regularly or band 7 midwives having access to the forms as it is not always accurate	I absolutely understand coordinators' frustration about this but I'm reluctant to give many people access to the pink spreadsheets as there is no audit trail so if there are errors, it's impossible to trace it back to the point where the staffing was correct. We are discussing checking the sheets regularly against healthroster but this is not always possible as it changes so often that even if it was checked in the morning, it might have changed again by the night shift. The other issue is that it is essential that the most up to date pink spreadsheet is accessed. The computer screens in the coordinator's office must be up-dated regularly as sometimes we are looking at an old roster.

Not enough staff, shifts rarely fully staffed, unable to take breaks	unsurprisingly, this came up a lot. Currently sickness levels for MWs and MWSs is around 9%, this doesn't include those who can't work because of household members with covid. This sickness level is nearly 3 times our normal level which has a significant impact on staffing. Over the past few months, we have had 8 new midwives join us, but we have of course had midwives retire or leave as well. We have also just offered jobs to all our third year students – a total of 8 whole time equivalents but they won't join us until the Autumn. We have received new money for recruitment but there aren't lots of midwives looking for work so recruitment isn't always successful. Staffing is something that Jane. Lindsey and I talk about countless times every day. I am very happy to discuss this more at the next staff meeting (or whenever anyone would like to)

Safety Champions action plan

Action Plan

Safety walk about 3rd December	CNO Nicky Lucey	Staff discussed the challenges with BadgerNet and the ongoing staffing levels. Staff agreed that a digital system was required and they were gradually becoming more confident but that training had been inadequate and ongoing support from super-users less than required – due to staffing pressures. Ongoing vacant shifts was causing stress and anxiety about coming into work but there was acknowledgement that everything that could be done,was being done by manageemnt, including the senior team working clinically when required

Service User Feedback

debrief feedback and F&F

Birth debrief: Post caesarean section analgesia not adequate. The woman described feeling she had to justify her need for more pain relief	Shared with the postnatal lead midwife. Reminder to staff in the newsletter. Midwife joining the postnatal team so that there will be a dedicated postnatal midwife most days to lead on this, amongst other issues.

There were 32 positive comments in the F&F. Negative and mixed comments numbered five and were concerned with lack of restaurant facilities for partners, the noise at night and the lack of a single room when first admitted for induction of labour (women are admitted to a 3 or 4 bedded ward before transferring to their single room for labour and birth). One comment described a consultation as being rushed, but then praised the next doctor for addressing their concerns.

Unfortunately with F&F, it's not possible to reply to concerns. This comment, *"I was pushed from pillar to post, no real communication and just left me confused and stressed: I would happily talk through my experience with someone on the phone. Maybe someone can explain. My midwife is confused about the whole thing too"* merits a response but the anonymity makes that impossible

Karen is great and approachable. Always feel there is enough time to discuss what we

need to and takes my concerns seriously. Great care, thank you!
Yes, Sarah sorry I can't remember her surname shes was with me on Friday afternoon and all day Saturday (including birth) she was amazing!
We were so impressed with the friendly staff we met and the hospital was just great. Everyone we met was lovely. A few to mention - Charlie, Lauren and the Katrina (who delivered our baby) plus Tom the anaesthetist were all amazing and we will never forget them! Everyone else we met were great too but we can't remember all the names. Overall we couldn't have wished for a better birth for our baby girl Madeleine - thank you Dorset County Hospital.
Staff very attentive and supportive. Excellent patient and baby care 24/7. I don't think anything needs to be improved. All midwife's were excellent especially Liz Norman, Alison and Rachel. First class and thank you to you all
absolutely excellent! Couldn't of asked for more : Every midwife that tended to us postnatal deserves a mention, we felt so looked after, Comfortable and confident when we were discharged only due to the care we got after a traumatic cat 1 section. But particularly student midwife Rosie Clarke who case loaded me, so cover not only my postnatal but my entire journey and labour. She will make the most amazing midwife
All the midwives were caring, informative, reassuring and kind. No job or question was too small and they made us feel nurtured and safe.
Fantastic postnatal ward!!: All the midwives were amazing! All very helpful with breastfeeding & just lovely welcoming people. Love Maria, Sally, Hannah, Katrina! THANK YOU!!
I had a fast labour and the midwife was so reassuring and experienced, made me feel completely at ease. I felt I was in very safe hands. The student midwife I had with me in my labour was fantastic. So friendly and supportive. I can't remember her name but it was Monday 24th I had a little boy . And I would like her to know we want to say thank you to her and let her know how great she did

Training

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	87%
	Obstetric Consultants	100%
	Doctors (Reg/SHO)	66.6% (new starters)
	Midwives	82% (rostered to attend)
BLS	**Obstetric Anaesthetists**	83%
	Obstetric Consultants	75% (emailed)
	Doctors (Reg/SHO)	66.6% (new starters)
	Midwives	86%
	MSW	72.5%
NLS (4 yearly accredited course)	**Senior Midwives/Homebirth Midwives**	91%

NLS (yearly update)	**Midwives**	85%
K2 Fetal Monitoring	**Doctors (All grades)** **Midwives**	86% 83%

Maternity and medical staffing

Maternity Staffing

Staffing continues to be extremely challenging but sickness rates gradually improving

Sickness absence	January 2022
midwives	7.43

Sickness absence	January 2022
MSW	9.01

This doesn't include those members of staff self-isolating due to a family member being positive

Maternity incentive scheme Year 3

Current position

Re: Maternity Incentive Scheme (MIS) year 3: Dorset County Hospital NHS Foundation Trust

This is the confirmation from NHS Resolutions of the full 10% refund. As agreed by the CEO in January 2021, following the Ockenden Report, this must be ring-fenced for maternity spend.

Thank you for your response to our request dated 22 December 2021 in relation to the Baby Lifeline FOI, reconfirming MIS compliance declared in July 2021. Your trust reconfirmed that the declared MIS compliance submitted to NHS Resolution in July 2021 was correct. The trust's response have been reviewed and approved by the scheme's Collaborative Advisory Group and Approval Committee. I am writing to congratulate your organisation on meeting all ten safety actions for year three of MIS. We will issue you with your 10% contribution into the fund in week commencing 14 February 2022.

ATAIN (avoiding term admissions into the neonatal service)

definition

The definition used for the term admissions is:

- Gestation >= 37+0 weeks
- 1st Episode only
- Where NNU is selected on any day of their stay

Most likely reason for admission is respiratory problems. ATAIN reports into Clinical Governance and all term admissions are reviewed by the Advanced Neonatal Nurse Practitioner, the Postnatal Lead Midwife and as requied, an obstetric consultant. Learning is shared at the Clinical Governance Meeting and often with eye-catching posters

Dorset County Hospital NHS Foundation Trust	Live births	Term Admissions	
		N	% live births
Q1 - Apr-June	389	24	6.2%
Q2 - July-Sept	387	15	3.9%
Q3 - Oct-Dec	400	19	4.8%
Year to Date	**1176**	**58**	**4.9%**

Safety and Quality Initiatives

Initiatives shared with the CQC at the quarterly engagement meeting

Essential skills - ALL use local learning based scenarios from real cases (highly contextualised) to enhance the learning experience. These are garnered from Datix & governance forums, case reviews etc.

Caseloading for rainbow families after bereavement

Pathway to Excellence scheme

Aromatherapy for labour and soon to be exploring non-medical support for post dates pregnancy

In development to plug gap of health visiting – postnatal sessions with partners too – encourage UNICEF agenda of close and loving relationships, baby massage, baby first aid, feeding, safe sleeping, skin to skin etc

Seeking solutions for women who can't afford the data for digital access
Provision of "baby wearing" advice to vulnerable parents

LGBTQ+ engagement (within the Trust and maternity service)

SCBU book corner with the laminated books for parents to share with babies

Gifts for mums and babies at Christmas, Easter, Halloween, Mother's Day

Dad packs we made up during covid as canteen shut and only allowed minimal movement around unit and encouraged not to go home ideally

Quality improvement lead midwife established a vaccination service and is now engaged with covid vaccination

Birth dancing sessions with a midwife

Many examples of careful, responsive birth planning for women who wish to give birth off-guideline

Tailoring care to the individual woman (a walk on a beach)

Well established multi-professional Perinatal Mental Health pathway including CoC, yoga and access to a psychotherapist – benchmarked against recent MBBRACE recommendations

Ockenden actions

Please see accompanying spreadsheet for updates

		DCH	UHD	Narrative
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Partial	Partial	Delays extracting data for the LMNS dashboard - LMNS metrics have been agreed but moving to the new maternity I.T system (Badgernet) has caused data quality issues at DCH but a plan in place to improve this. UHD go live with the new system in Feb 2022. Plan in place to deliver the LMNS dashboard.
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Compliant	Compliant	
2) Listening to Women and their Families	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Compliant	Compliant	
	Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	Compliant	Compliant	
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	Compliant	Compliant	
	The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	Compliant	Compliant	
	Confirmation that funding allocated for maternity staff training is ringfenced	Compliant	Compliant	
4) Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Compliant	Partial	UHD have a named consultant and have a plan in place with audit lead commencing in April 2022 (this is a new post)
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Compliant	
5) Risk Assessment throughout pregnancy	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Partial	Partial	Ability to audit compliance for UHD & DCH has been due to delays associated with COVID, in addition DCH plan to embed but there are issues with recording following implementation of new maternity system at DCH. Plan is in place to audit for assurance.
6) Monitoring Fetal Wellbeing	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Compliant	Compliant	
7) Informed Consent	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Partial	Partial	Improvements in progress and more are planned to the Maternity Matters website

Completion Guidance:

1.Overview tab – please complete in full
2.Ockenden return tab
3.Kirkup return tab – please note some recommendations have been greyed out – these do not require completion as they are superseded by information in the Ockenden recommendations. (There is a 4th tab which details the Kirkup recommendations as a helpful reminder – this doesn't require any completion)

Internal trust governance

	Confirmation of / or planned Public Trust Board update on progress against the Ockenden action plan	Date of Public Board update	Executive sign off of this return		
	Yes/No	please insert date	Date	Name	Role
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					
Insert Trust Name					

LMNS sign off of the combined trust returns

LMNS Name	Executive sign off		
	Date	Name	Role
Name of LMNS			

SW Regional Ockenden /Kirkup Assurance Spring 2022
DCH
TRUST NAME: NHS FT

some actions outstanding but nearing completion

compliant at the first assessment

compliant now but not at the first assessment

IEA	Question	Action	Evidence Required	
IEA1	Q1	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	
			Submission of minutes and organogram, that shows how this takes place.	
		Maternity Dashboard to LMS every 3 months Total		
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	
			Policy or SOP which is in place for involving external clinical specialists in reviews.	
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for	
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	
			Submit SOP	
		Maternity SI's to Trust Board & LMS every 3 months Total		
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	
		Submitting data to the Maternity Services Dataset to the required standard Total		

	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		
IEA1 Total				
	Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	
			Evidence of link in to MVP; any other mechanisms	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	
			Name of NED and date of appointment	
			NED JD	
		Non-executive director who has oversight of maternity services Total		
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		
IEA2	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	
			Log of attendees and core membership.	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	

		Trust safety champions meeting bimonthly with Board level champions Total		
	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	
			Name of ED and date of appointment	
			Role descriptors	
		Non-executive director support the Board maternity safety champion Total		
IEA2 Total				
	Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	annual report detailed plans to meet TNA. Submitted to Quality Committee and to The Board
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	annual report submitted to the LMNS and discussed at the LMNS Safety meeting
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	recrods of attendence kept by the Practice Educator Lead and the Education Centre.
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	TNA included within the Education (training) report submitted in January 2022
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	rostering of staff who are eout of date prioritised for attendence at training. New starters rostered as soon as they can attend.
		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	
			SOP created for consultant led ward rounds.	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		

IEA3	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	awaiting confirmation
			Evidence from Budget statements.	awaiting confirmation
			Evidence of funding received and spent.	as above
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	as above
			MTP spend reports to LMS	training report submitted to LMNS and to Board
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	annual report detailed plans to meet TNA. Submitted to Quality Committee and to The Board
			Attendance records - summarised	available for inspection
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	annual report submitted to the LMNS and discussed at the LMNS Safety meeting
		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	repeat of the above
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	repeat of the above
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		
IEA3 Total				

IEA4	Q24	Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre	Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians	
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		
	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	
		Women with complex pregnancies must have a named consultant lead Total		
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	
		Complex pregnancies have early specialist involvement and management plans agreed Total		
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	
			Guidelines with evidence for each pathway	
			SOP's	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	
			Submission of an audit plan to regularly audit compliance	
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		

	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	
			Criteria for referrals to MMC	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		although more evidence requied for this - ther eis no futher evidence we can submit as an organisation as discussions about funding are held at LMNS/ICS level, not individual trusts. Funding has recently been agreed by the LMNS for the Maternal Medicine Specialist service
IEA4 Total				
IEA5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	yes - it is included within the digital maternity system, BadgerNet for midwives. They are referred to consultant care
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	audit completed and demonstrates compliance
			Review and discussed and documented intended place of birth at every visit.	compliant - however a reminder sent to all medical staff as there isn't an obvious place to document this in badgerNet (there is for midwifery antenatal care)
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	compliant
			What is being risk assessed.	
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	compliant
			Out with guidance pathway.	awaiting completion
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	audit completed - compliant
			SOP that includes review of intended place of birth.	linked to off guidance pathway above
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	
			How this is achieved in the organisation	
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	1% or 5% - not clear in relation to Q31

	Q33		Review and discussed and documented intended place of birth at every visit.	
			SOP to describe risk assessment being undertaken at every contact.	linked to off guidance pathway above
			What is being risk assessed.	
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		
IEA5 Total				
IEA6	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	
			Incident investigations and reviews	
			Name of dedicated Lead Midwife and Lead Obstetrician	
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	
			Improving the practice & raising the profile of fetal wellbeing monitoring	
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	
			Keeping abreast of developments in the field	
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2.2	Audits for each element	audits completed
			Guidelines with evidence for each pathway	compliant

	Q36	version 2?	SOP's	SoP or guideline compliant
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		
	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	as above
			Attendance records - summarised	as above
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	as above
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		
IEA6 Total				
	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	
			CQC survey and associated action plans	
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	
		Women must be enabled to participate equally in all decision-making processes Total		
		Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	

IEA7	**Q42**		SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	
		Women's choices following a shared and informed decision-making process must be respected Total		
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	
			Information on maternal choice including choice for caesarean delivery.	all women ar esupported to request a caesarean and after discussion, they ar esupported in that choice
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	MVP is involved with reviewing information provided to women
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		
IEA7 Total				
	Q45	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	compliant
			Most recent BR+ report and board minutes agreeing to fund.	BR plus does not address clinical workforce, it reviews midwifery workforce
		Demonstrate an effective system of clinical workforce planning to the required standard Total		

		Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	
	Q46	**Demonstrate an effective system of midwifery workforce planning to the required standard? Total**		
		Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	
	Q47	**Director/Head of Midwifery is responsible and accountable to an executive director Total**		
WF		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	currently reviewing HoM JD and banding
	Q48		Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	compliant - Consultant midwife not required. All other specialist roles in place. Developmental opportunities available for band 7 roles.
		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	
			Evidence of risk assessment where guidance is not implemented.	
	Q49		SOP in place for all guidelines with a demonstrable process for ongoing review.	
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		
WF Total				

Kirkup report recommendations
SW Regional Update Spring 2022

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.
1	R1, R13, R24	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's) Women and their families are kept informed of the progress of the investigation Women and their families are invited to contribute to the investigation process Offering an apology Ensure that all nurses and midwives are aware of their responsibilities in relation to the duty of Candour and their
2	R1, R13	Review the current processes for obtaining feedback from the public to increase the information received	Offering women and their families the opportunity to make suggestions e.g., "You said… we did…." Ensuring that national/ local awareness opportunities are utilised effectively e.g. international day of the midwife/ Continue to support the LSA in the feedback mechanism to staff from service users regarding our service Share patient stories
3	R2	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working
5	R2	Review the current preceptorship programme	named preceptorship lead midwife with protected time. She meets with all preceptors when they start and then has regular meetings with them during their preceptorship programme. Detailed feedback is provided and concerns raised appropriately. She works closely with the PMAs and the Practice Educator Team as well. there is a detailed preceptorship pack that all staff complete which links closely with the Trust preceptorship programme. New midwives attend classes with general staff where appropriate - this is protected rostered time. This pack is reviewed by the preceptorship lead and signed off by her and the Head of Midwifery. Once completed, there is automatic promotion to band 6. new band 5 midwives also spend time with specialist midwives - this is rostered and protected time all new midwives receive a goody bag as a welcome and an introductory pack for new staff (currently being updated) if the midwife trained at DCH and there has been no delay in employment, shifts are semi-supernumerary with a reduced workload and regularl support from the maternity coordinator. If the midwife trained elsewhere, s/he is entirely supernumerary for a number of shifts, including community for a period of time - this is usually for 4 weeks. However as their confidence grows, they become less supernumerary.
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	recent preceptees fed back that some of the mandatory teaching sessions were more suited to the general side than to midwifery. The programme was reviewed with the Education Department and some adjustments made to the content. The regular 1:1 meetings refered to above, provide a good opprtunity for midwives to feed back any concerns or suggestions
7	R2, R3	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	new band 6 midwives are also supported initially by the preceptor lead to ensure they are welcomed into the service in a consistent manner. A line manager is allocated and the new Retention and Recuitment Midwife provides 1:1 support. regular staff meeting with the Associate Director of Midwifery on Teams with good attendence mandatory training provides a day for all staff for multi-professional obstetric emergency training alongside updates and training on a wide variety of subjects - clinical and non-clinical (PMAs provide a restorative supervision session for example) midwives and doctors are expected to complete the K2 feta monitoring package annually. A day TOIL is granted on completion IV training is provided by the Education Dept and midwives are encouraged to book. All nightcore staff must be proficient in this. new equipment is introduced alongside a training programme and record of competencies. For example, we have new CTG machines and they will not be used until we are satisfied that all relevant staff have been trained and competencies signed off
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	as above
9	R2	Review the current induction programme for locum doctors	there is a locum pack provided and the locum doctor is paid to attend their shift early so they can spend some time with the outgoing doctor. However, if the locum is only attending for a small number of shifts, there is no comprehensive induction programme. Long term locums attend all the mandatory training provided for substantive staff.
10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.	there is a locum pack provided and the locum doctor is paid to attend their shift early so they can spend some time with the outgoing doctor. However, if the locum is only attending for a small number of shifts, there is no comprehensive induction programme. Long term locums attend all the mandatory training provided for substantive staff.
11	R2	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	DCH does not access the AIMS course but acute illness management/the deteriorating patient, is incorporated into the PROMPT day. Including an AIMs day would require all staff to have a further study day bringing the total to 5 a year for every midwife - currently this is not a consideration due to the cost
12	R2	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	As an integrated service, all midwives attend all mandatory training and work across antenatal, intrapartum and postnatal care. This includes a session on ATAIN for all staff. The postnatal lead midwife works closely with the ANNP, the Lead Nurse for SCBU and the neonatal service.
13	R2	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	The deteriorating patient is covered in PROMPT and a recent case of a woman who returne to theatre is used by the Safety Team in mandatory training as a case review attended by all midwives
14	R2	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	Cases are reviewed by the Safety Team. Learning shared in the newsletter, at Clinical Governance meetings, on the CG board, emails to staff (where appropriate), M&M, staff meetings, themed learning boards
15	R3	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.	integrated workforce across community, the maternity unit, intraprtum, antenatal and postnatal -= established for >25years
16	R2, R3, R4	Review and update the Education Strategy	
17	R3	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations	The term, "supernumerary" is contentious; only working effectively if the midwife provides no hands-on clinical care and instead shadows a midwife. However, this is not an enriching experience for a new member of staff (the midwife often doing less than a student). Therefore, supernumerary staff are suprted by the coordinator with a smaller workload and a named midwife to work with, seek advice etc. Ongoing staffing challenges contribute to varying degrees of success with this approach. The preceptor lead or recruitment and retention lead midwife follows-up with new starters to see how the supernumerary status is working for them. The Clinical Leaders Meeting notes those midwives who are new in post, or require extra support. Recently the PMAs have started working 1:1 with midwives who need support (for a variety of reasons). Midwives in the band 7 developmental programme, work alongside an experienced midwife coordinator to learn how to manage the maternity unit until they identify themselves as confident to run the unit. This progamme provides regular 1:1 meetings with a matron to assess progress and address any concerns
18	R3	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status	
19	R5	Develop a list of current MDT meetings and events and share with staff across the directorate	
20	R8	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	with the appointment of the recruitment and retention midwife, this will now be actioned

21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas	
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention	with the appointment of the recruitment and retention midwife, this will now be actioned.
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns	a very well attended Staff Meeting monthly on Teams - usually between 30-35 attending. The unit is also hosting a post-doctoral research midwife who is studying staff wellbeing, resiliance and "What a good day looks like". Her findings are rich, multi-layered and have provided rich and diverse material across all staff groups
24	Only applicable to multi-site trusts.	Improve working relationships between the different sites located geographically apart but under the same organization.	
25	R9	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.	
26	R11, R12	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.	all new midwives spend half a day with the Safety Team. New doctors are taught about the incident reporting process in their induction.
27	R11, R12	Including a review of the processes for disseminating and learning from incidents	
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All RCAs are led by the Safety Lead Midwife or her deputy - both have received training. Doctors contribute to RCAs and are supported in this by the Safety Lead. Ther eis ongoing support from the Trust Risk Department as and when required.
			All RCAs are reviewed at the Trust Learning from Incident Panel, chaired by the MD, CNO or CEO. Concerns about the quality of an investigation are raised and acted on (if identifed). All investigations are accessible through the Trust Risk Department. SIs, HSIB investigations and RCAs are shared at the LMNS Safety Meeting and learning is dissmeninated through the local service as detailed above
29	R12	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents	
30	R12	Ensure that all Serious Incidents (SI's)are fedback to the staff	
31	R12	Identify ways of improving attendance of midwives at SI's feedback sessions	
32	R13	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports
33	R14	Review the current obstetric clinical lead structure	
34	R15	Review past SI's and map common themes	Thematic reviews
35	R23	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports
36	R26	Ensure that all staff are aware of how to raise concerns	Staff are actively encouraged to raise concerns and praised for doing so - in the response from the Safety Team and in a personal email from the DoM if appropriate
			There are Safety Suggestion Boxes on the maternity unit and in the doctors' office. Many suggestions are submitted. All receive a reponse from the DoM, in the newsletter and every suggestion is considered. The suggestions are also detailed on the CG display board
			The CNO conducts regular safety walkabouts on the Maternity Unit, chatting informally to staff
37	R31	Provide evidence of how we deal with complaints	All complaints are managed by the DoM. Telphone contact is made to acknowledge the complaint. An investigation is carried out and a response drafted, addressing all points raised. Learning points are identified in the letter. The complaint is used as a learning opportunity at the CG meeting, on the CG display board and at Clinical Leaders' Meeting and the Consultants' Meeting (as appopriate). if the complainant would like to meet with a member of the team, that is offered and arranged
38	R31	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required
39	R32	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model
40	R38	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager
41	R39	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	Benchmarking against the most recent MBRRACE was considered at the CG meeting and reported in the monthly Maternity Safety Report submitted to Quality Committee and to Board. Actions agreed and will be monitored.

Recommendations from the published Kirkup report

1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.
4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.
8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.
12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.
16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.
Recommendations for the wider NHS	
19	In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.
20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.
23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.
27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.
31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.
34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.
37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health
41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All* , and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.
44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current

Meeting Title:	Board of Directors Part 1
Date of Meeting:	30th March 2022
Document Title:	**National Staff Survey results**
Responsible Director:	Dawn Harvey – Chief People Officer
Author:	Julie Barber – Head of Organisational Development Ebi Sosseh – Inclusion Lead, Organisational development

Confidentiality:	Yes – results embargoed until 30th March 2022
Publishable under FOI?	Yes (after embargo lifted)

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	21st March 2022	

Purpose of the Paper	To share National Staff Survey 2021 results, high-level analysis and next steps.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The national staff survey was undertaken between September and December 2021. A full census survey was undertaken, with a 47% response rate which is 4% above average for Acute Trusts in England (43%). 1,517 staff responded to the national survey from a usable sample of 3,240. The questionnaire content is agreed nationally and covers themes relating to the working environment and staff experience within the workplace. The 2021 Staff Survey contained a mix of historic and new questions, referred to as indicators. The survey contains 63 original indicators and 35 new ones. This means that whilst there is comparator data for each indicator, around a third of questions have no year-on-year comparator data. For 2021, the themes have been aligned to the NHS People Promise. There are 7 People Promise themes plus two additional themes: Staff Engagement and Morale. The majority of the People Promise scores for the 2021 NHS Staff Survey (NSS) for Dorset County Hospital NHS Foundation Trust (DCHFT) are significantly better than the sector scores for similar organisations surveyed by Quality Health. Now that we have the full NSS results we can see that we are ***higher nationally in all nine themes***. The ED&I Staff Survey results indicate we are heading in the right direction but we also recognise there is more work to do. During April, summary results will be shared at Divisional and Care Group/Department level, with facilitated discussions at approriate meetings supported by slide pack to help services identify next steps.							

Action recommended	The Board is recommended to: 1. **NOTE** the report 2. **APPROVE** the Next Steps

Governance and Compliance Obligations

Legal / Regulatory	N	No specific implications relating to results and next steps.
Financial	N	No specific implications relating to results and next steps.
Impacts Strategic Objectives?	Y	People - focusing on making DCH a great place to work: Looking after and investing in our staff, developing our workforce to support outstanding care and equity of access and outcomes, creating an environment where everyone feels they belong, they matter and have a voice
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	The National Staff Survey results are used as one way of gauging staff experience within the Trust alongside other data sets and alongside agreed actions provide assurances to the CQC for Well-Led Domain.
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	

People & Culture Committee – National Staff Survey Results

Executive Summary

The national staff survey was undertaken between September and December 2021. A full census survey was undertaken, with a 47% response rate which is 4% above average for Acute Trusts in England (43%). 1,517 staff responded to the national survey from a usable sample of 3,240.

The questionnaire content is agreed nationally and covers themes relating to the working environment and staff experience within the workplace. The 2021 Staff Survey contained a mix of historic and new questions, referred to as indicators. The survey contains 63 original indicators and 35 new ones. This means that whilst there is comparator data for each indicator, around a third of questions have no year-on-year comparator data.

For 2021, the themes have been aligned to the NHS People Promise. There are 7 People Promise themes plus two additional themes: Staff Engagement and Morale.

The majority of the People Promise scores for the 2021 NHS Staff Survey (NSS) for Dorset County Hospital NHS Foundation Trust (DCHFT) are significantly better than the sector scores for similar organisations surveyed by Quality Health. Now that we have the full NSS results we can see that we are ***higher nationally in all nine themes***.

At a sub-theme level, out of the 21 sub-scores, 12 scores are significantly better than the sector score and 9 scores are in line with the sector score. This is a positive sign and indicates that the Trust is performing well.

The themes of Morale and Staff Engagement remain key performance indicators for organisations. Staff Engagement is significantly better than the sector score and Morale is in line with the sector score.

This report provides a high-level analysis of the overall findings of the 2021 Staff Survey, identifies individual areas of concern and considers implications for employee engagement. By measuring staff experience we can look to understand the ongoing impact that the COVID-19 pandemic has had on staff, as well as identifying areas of adaptation and recovery. Next steps include dissemination of results to SLG, Trust Board and Divisions/Departments across the Trust.

The results are embargoed for distribution outside the Trust prior to the publication of full results, due on 30th March 2022, but can be used for operational purposes internally. This report is therefore offered in that context.

The Committee is asked to note the contents of the report and approve next steps.

1. Introduction

The Trust recognises the important link between staff engagement and improved patient care. Understanding how staff experience their work environment is critical to the success of any organisation and the NHS National Staff Survey provides an important insight into how our staff experience work at DCHFT. We are proactive in analysing staff experience data monthly through the People Dashboard, but the NSS helps us understand how we compare nationally.

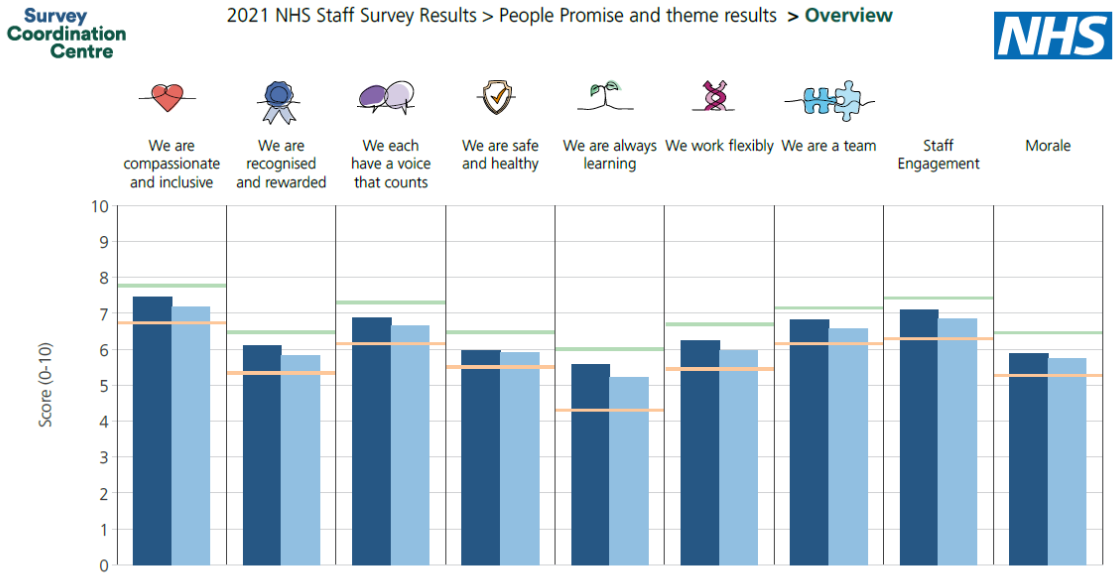
This 'soft' data is one way our people can communicate opinions and views about working here at the Trust. It provides an anonymous forum for staff to give their views on issues which they may not feel comfortable or safe to air via other routes. As the Trust undertakes focused interventions on culture, inclusion, management and leadership, we will expect to see the impact of these in the responses our people give.

The most critical part of this process is not just about reviewing the results but being clear about where we want to be as an organisation and what needs to be done differently to ensure we are.

2. Overall results

For 2021, the themes have been aligned to the NHS People Promise. There are 7 People Promise themes plus two additional themes: Staff Engagement and Morale.

Now that we have the full NSS results we can see that DCHFT scores ***higher nationally in all nine themes***.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.4	6.1	6.9	6.0	5.6	6.2	6.8	7.1	5.9
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,515	1,514	1,497	1,501	1,431	1,508	1,511	1,515	1,516

3. Results by theme

The majority of the People Promise scores for the 2021 NHS Staff Survey for DCHFT are significantly better than the sector scores for similar organisations surveyed by Quality Health.

At a sub-theme level, out of the 21 sub-scores, 12 scores are significantly better than the sector score and 9 scores are in line with the sector score. This is a positive sign and indicates that the Trust is performing well. *People Promise elements, themes and sub-scores generic information is shown at Appendix 1.*

The themes of Morale and Staff Engagement remain key performance indicators for organisations. Staff Engagement is significantly better than the sector score and Morale is in line with the sector score.

3.1 We are compassionate and inclusive

75% of staff think that the organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) – ***this is 8% higher than the national comparator and may be an early indication of the positive impact our inclusion work is having***, including the Inclusive Leadership Programme which commenced in June 2021.

All 4 new questions see the Trust exceeding the national comparator, examples are: 70% of staff say the people they work with are kind to each other, 71% say the people they work with are polite and treat each other with respect.

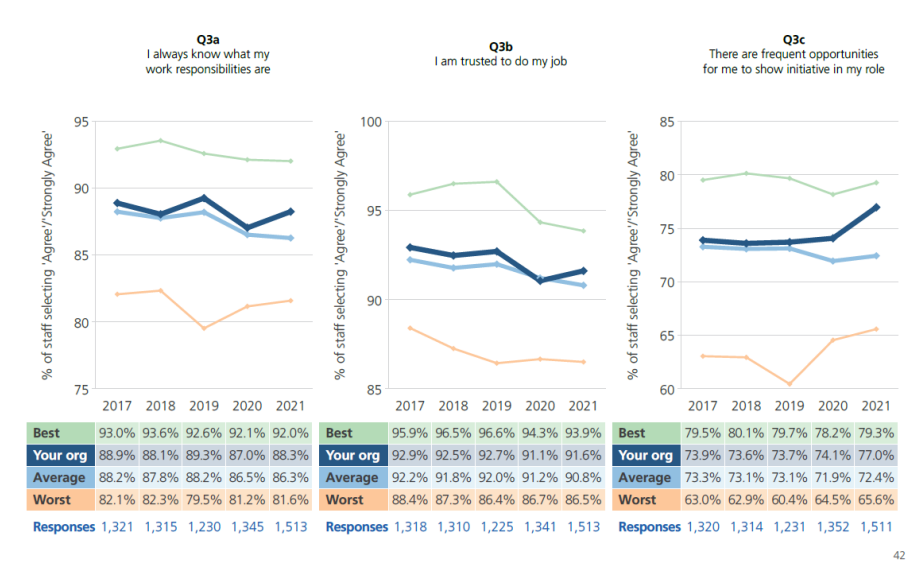
3.2 We are recognised and rewarded

We are above average on all the indicators but have slightly declined from last year. With 'My immediate manager values my work', the Trust stands at 75%, **6% above average.**

Other indicators where the Trust is above average:

3.3 We each have a voice that counts

The Trust is above national average in all indicators with improvements from the previous year.

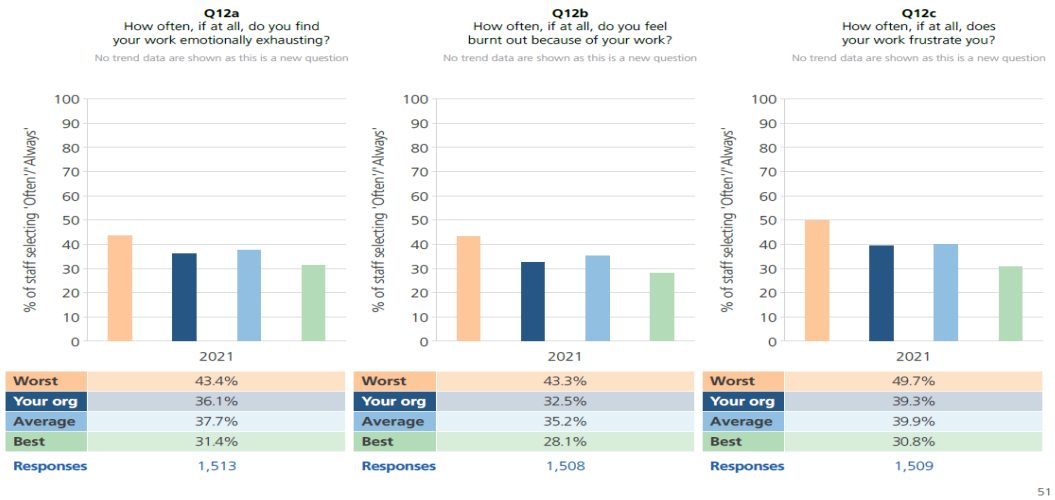


3.4 We are safe and healthy

2 of the new questions see the Trust exceeding the national comparator, including 59% of staff reporting that the organisation takes positive action on health and wellbeing.

This is 3% higher than national comparator but indicates an area for improvement as more than a third of staff disagree or have no view.

2 of the new questions see the Trust equalling the national comparator – 21% of staff say they find work emotionally exhausting and 16% say they feel worn out at the end of the working day/shift.



4 new questions see the Trust below the national comparator, including 37% of staff saying they feel exhausted at the thought of another day/shift at work and 52% reporting that they feel every working hour is tiring

Of the remaining 27 original indicators, there is positive movement in 13 of these, including: increased reporting of physical violence at work (63% - an increase in 5% from previous year), increased reporting of harassment, bullying or abuse at work (46% - an increase in 3% from previous year), feeling secure raising concerns about unsafe clinical practice (75% - up 4% from previous year).

There has been a downward trend in 9, including: 4% more staff than last year reporting harassment, bullying or abuse at work from patients/service users (26%), 53% of staff report coming into work despite not feeling well enough (6% increase) and a 2% increase in staff working additional paid hours over and above their contract.

5 of the original indicators have remained static – including 22% of staff report personal experience of harassment, bullying or abuse from other colleagues, 1% of staff report experiencing physical violence from managers. *These remain worrying figures.*

3.5 We are always learning

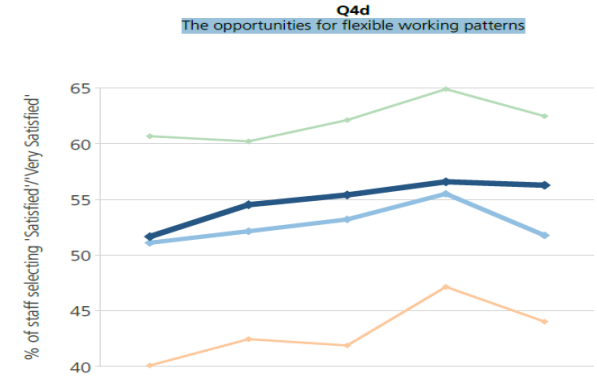
In 8 out of the 9 new questions, the Trust exceeds the national comparator figures, *and* ***matches the national comparator of 81%*** *for staff reporting having an appraisal or development review within the last 12 months.*

However – only 23% of staff said it helped them improve how they do their job, 35% said it helped agree clear objectives and 36% said the appraisal/review left them feeling valued by the organisation *(7% above comparator, but an area for significant improvement).*

In terms of staff viewing the organisation as a whole, 74% reported they are offered challenging work, 71% said they have opportunities to improve knowledge and skills and 57% felt supported to develop their potential.

3.6 We work flexibly

The opportunities for flexible working patterns remain the same as last year but still above the national average.

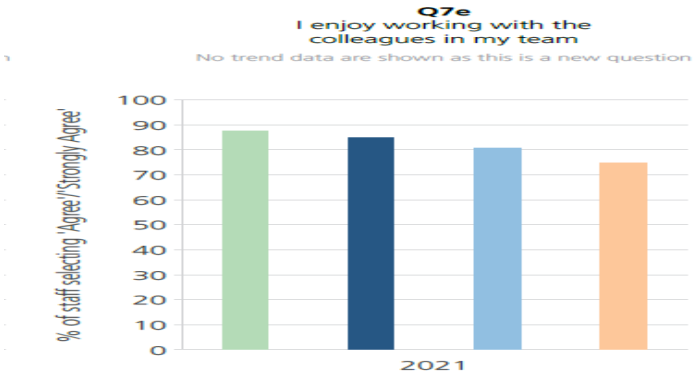


	2017	2018	2019	2020	2021
Best	60.7%	60.2%	62.1%	64.9%	62.5%
Your org	51.7%	54.5%	55.4%	56.6%	56.3%
Average	51.1%	52.1%	53.2%	55.5%	51.8%
Worst	40.1%	42.5%	41.9%	47.2%	44.0%
Responses	1,319	1,315	1,229	1,351	1,510

We are also better than the national average on the commitment to help balance work and home life, to achieve a good balance between work life and home life and in approaching 'my immediate manager to talk openly about flexible working'.

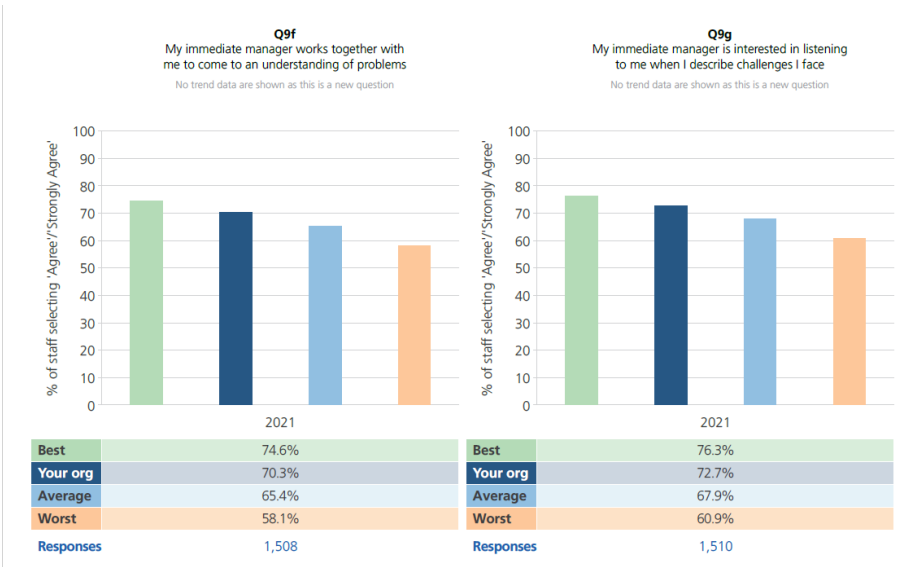
3.7 We are a team

All 6 new questions see the Trust exceeding the national comparator, examples are: 85% of staff say they enjoy working with their colleagues, 70% of staff say they feel valued by their team, 66% say they feel a strong personal attachment to their team.



Best	87.6%
Your org	84.9%
Average	80.7%
Worst	74.9%
Responses	1,513

- Upward trend includes: 74% of staff saying their immediate manager encourages them at work (***5% higher than national comparator***).
- 62% of staff say their immediate manager asks for their opinion before making decisions that affect their work (***6% higher than national comparator***).
- **All 4 new questions see the Trust exceeding the national comparator.**



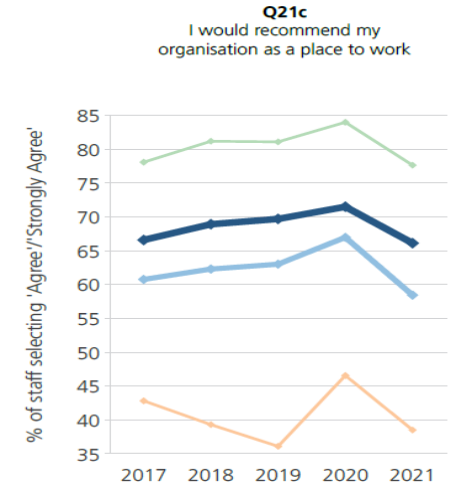
Best	74.6%
Your org	70.3%
Average	65.4%
Worst	58.1%
Responses	1,508

Best	76.3%
Your org	72.7%
Average	67.9%
Worst	60.9%
Responses	1,510

3.8 Staff Engagement

Looking forward to going to work, enthusiasm for their job and ability to meet conflicting demands all declined between 4-5%.

Downward trends include whether staff would recommend the organisation as a place to work (66%, down 5% from last year) or to a friend or relative needing treatment (74%, down 6% from last year). However, these figures are 7% and 6% (respectively) above the national comparator.



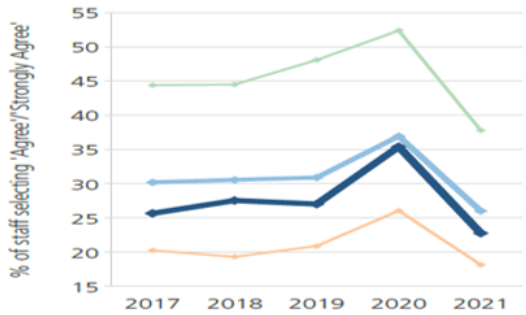
	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	66.6%	68.9%	69.7%	71.5%	66.1%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%
Responses	1,310	1,308	1,204	1,344	1,508

3.9 Morale

There are negative trends in 5 indicators and positive movement in 3 of the original indicators.

There was **positive movement** in terms of staff thinking about leaving the organisation (45%) and probably looking for another job in the next 12 months (53%). These figures represent a 7% improvement in last year's figures, with staff less likely to do so.

Q3i
There are enough staff at this organisation for me to do my job properly



	2017	2018	2019	2020	2021
Best	44.4%	44.5%	48.1%	52.4%	37.8%
Your org	25.7%	27.6%	27.0%	35.4%	22.8%
Average	30.2%	30.6%	30.9%	36.9%	26.0%
Worst	20.3%	19.3%	20.9%	26.1%	18.2%
Responses	1,316	1,310	1,228	1,349	1,508

An upward trend on 5 indicators includes 2% less staff feeling relationships are strained (although we know this is a prominent theme from counselling data, so staff are seeking help in this area).

The ***new question received a response 2% above national comparator***, with 50% saying that if they spoke up about something that concerned them, they would be confident the organisation would address their concern. *With only half of respondents believing this, this is another area to focus on during 2022*

3.10 Questions not linked to the People Promise elements or themes

- 40.2% work above their contracted hours and this is higher amongst ethnically diverse staff.
- The rate of pressure to come to work from their managers has declined from the previous year from 24 to 22%.
- 89% feel that the organisation acts fairly in terms of career progression /promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age

4. Equality Diversity and Inclusion (including WRES and WDES)

The Workforce Race Equality Standard (WRES) is the national framework through which Trusts measure their performance against nine key indicators around race and ethically diverse staff. Four of the Staff Survey questions are used as indicators within the WRES.

Three indicators show positive trajectories including less staff reporting harassment and bullying from staff (down 11%).

Likewise The Workforce Disability Equality Standard (WDES) is similar to the WRES, but looks at the experiences of staff with disabilities or long term health conditions (LTCs). Nine of the Staff Survey questions are used as indicators within the WDES.

Six indicators show positive trajectories including more staff saying they would report experiences of bullying and harassment (up 7%). The staff engagement score has remained static at 6.9 but is higher than the national average for staff with LTCs.

The ED&I Staff Survey results indicate we are heading in the right direction but we also recognise there is more work to do.

More information is available on our Equality Diversity and Inclusion page of the DCHFT website.

A snapshot of some of the ED&I results from the 2021 Staff Survey:

Positives	Could Improve
Higher positive score of ethnically diverse staff saying that they were looking forward to going to work (64%)	Experiencing harassment from patients up by 9% from 2020 for staff with disabilities
(76%) feel empowered to make suggestions to improve their work (ethnicity)	(54%) (ethnically diverse) reported a negative score having worked extra hours on top of their normal contracted hours compared to white staff (35%)
(75%) feel that their line manager is encouraging at work 71% for white staff) (ethnicity)	(Bullying and Harassment in terms of ethnicity) the numbers that had negative experiences was still higher than white staff (34% to 25%)
Equal opportunities for career opportunities up by 17% and 11% above average (ethnicity)	Figures are down by 1% on previous year on reasonable adjustments (Disabilities) but still high at 75%
Equal opportunities for career opportunities up by 4% (staff with Disabilities)	
Pressure for staff with disabilities to come to work when unwell are down by 3%	

5. Next Steps

Following this report to PCC, on 30th March the Staff Survey results will be presented to SLG and to the Trust Board.

During April, summary results will be shared at Divisional and Care Group/Department level, with facilitated discussions at approriate meetings supported by slide pack to help services identify next steps.

At divisional level we will help leadership teams to triangulate the survey data with the monthly people dashboard data and identify and prioritise the elements within the people plan that will assist them to make longer term improvements.

At the department discussions there will be space to identify smaller things that would make a big difference to the experience of working in that team.

Divisions and departments will be encouraged to champion:

- To create their own narrative with their staff on what to disseminate
- To seam the findings into their everyday practice in terms of improvements
- To have 'staff survey' conversations within their divisions/departments around improvements as the year progresses

6. Conclusion

6.1 The purpose of the staff survey is to provide a health check of employee engagement at DCHFT and identify areas of strength and weakness. Overall, the picture remains a largely positive one, with the Trust's People Promise scores being significantly better than the sector scores for similar organisations and scoring higher nationally in all nine themes.

6.2 Whilst the Trust response rate increased by 1% this year, we want to continue to improve this for the staff survey results to be more meaningful. Our monthly dashboard data and quarterly pulse surveys will combine with the NSS data to allow deeper dives and increased ownership of results at local level. Positive shifts to People Plan elements will arise from enhanced engagement with all of our staff data.

6.3 The survey results indicate that the experiences of disabled staff and those from minority ethnic groups are less positive than other groups of staff. Whilst we recognise there is more to do, we must also celebrate the significant progress that has been made, as shown in the positive snapshot results from the NSS (section 4 of this report). These encouraging trends are to be expected as we progress our inclusion activities, including the Inclusive Leadership Programme and Reciprocal Mentoring. The NSS results will be analysed further by the relevant staff networks and at divisional and departmental discussions.

6.4 Finally, we can't underestimate the ongoing effect of the pandemic on staffing levels and staff health and wellbeing (HWB). The NHS Staff Survey continues to provide an indication of the impact of the pandemic on NHS staff and divisional and departmental engagement will help inform ongoing HWB support for staff.

7. Recommendation

The Committee is recommended to:

1. **NOTE** the report
2. **APPROVE** the Next Steps

Authors:
Julie Barber, Head of Organisational Development
Ebi Sosseh, Inclusion Lead, Organisational Development

Date: 10th March 2022

Appendices:
Appendix 1: People Promise elements, themes and sub-scores

Appendix 1 – People Promise elements, themes and sub-scores

Survey Coordination Centre

People Promise elements, themes and sub-scores

NHS

Please note that you can navigate to the results of a particular score or question result by clicking on it in the table below.

People Promise element	Sub-scores	Question
We are compassionate and inclusive	Compassionate culture Compassionate leadership Diversity and equality Inclusion	Q6a, Q21a, Q21b, Q21c, Q21d Q9f, Q9g, Q9h, Q9i Q15*, Q16a, Q16b, Q18 Q7h, Q7i, Q8b, Q8c
We are recognised and rewarded	[No sub-scores]	Q4a, Q4b, Q4c, Q8d, Q9e
We each have a voice that counts	Autonomy and control Raising concerns	Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b Q17a, Q17b, Q21e, Q21f
We are safe and healthy	Health and safety climate Burnout Negative experiences	Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c
We are always learning	Development Appraisals	Q20a, Q20b, Q20c, Q20d, Q20e Q19a, Q19b, Q19c, Q19d
We work flexibly	Support for work-life balance Flexible working	Q6b, Q6c, Q6d Q4d
We are a team	Team working Line management	Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a Q9a, Q9b, Q9c, Q9d
Theme	**Sub-scores**	**Question**
Staff Engagement	Motivation Involvement Advocacy	Q2a, Q2b, Q2c Q3c, Q3d, Q3f Q21a, Q21c, Q21d
Morale	Thinking about leaving Work pressure Stressors	Q22a, Q22b, Q22c Q3g, Q3h, Q3i Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a
Questions not linked to the People Promise elements or themes		
Q1, Q10a, Q10b, Q10c, Q11e, Q15 (historical calculation)* , Q16c, Q22d, Q28b		

*Please note: The approach to calculating the results for Q15 has changed for 2021, to include 'don't know' responses. These results feed into the Diversity and equality sub-score and the We are compassionate and inclusive promise element, as well as the WRES and WDES indicators. The Q15 results based on the historic calculation are reported in this section for transparency, but do not feed into any measure.

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Meeting Title:	Board of Directors Part 1
Date of Meeting:	30th March 2022
Document Title:	**National Inpatient Survey 2020 Action Plan**
Responsible Director:	Nicky Lucey
Author:	Alison Male

Confidentiality:	*No*
Publishable under FOI?	*Yes*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Patient Experience Group	3rd February 2022	Advised to collate action plans from each division to have one action plan.
Quality Committee	22nd March 2022	

Purpose of the Paper	To provide an action plan in response to the National Inpatient Survey 2020 results previously shared with the Quality Committee.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	• Trust actions identified to be included on the Action Plan as: ➢ **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 disturbed by noise at night from other patients ➢ **Communication:** connecting with relatives during restrictions on visiting -							
Action recommended	The Board is recommended to: 1. **NOTE** the National Inpatient Survey 2020 Action Plan for the Trust.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Trust Boards must have oversight of the Inpatient survey results. Inability to achieve the improvements associated with these could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience in the hospital.
Financial	N	None currently identified
Impacts Strategic Objectives?	Y	NHS Foundation Trusts are required to publish Inpatient survey results. 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 results of the National Inpatient survey will have a negative impact on both staff wellbeing and patient care and strategic objectives
Decision to be	N	

made?		
Impacts CQC Standards?	Y	As the report of these priorities incorporates standards and metrics that are utilized by the CQC it will be important to note progress or exceptions to these standards.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

NATIONAL INPATIENT SURVEY 2020 ACTION PLAN

Reference Key				
IP18	Inpatient Survey 2020			

RAG Key			
Recommendation	Green = Recommendation action complete	Amber = Recommendation action in progress	Red = Recommendation action not fully development
Assurance	Green = Full assurance met	Amber = Partial assurance met	Red = No collated assurance met

No	Our Ref	Objective	Ref	Action required to meet objective	Target Completion Date	Lead Manager / Exec Lead	Evidence	Assurance
1		**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		1. review PROMS data and where improvements can be made	**June 2022**	DHoNQ	Improvements identified and implemented	Improved IP Survey results
				2. review all pre-operative literature given to patients and any website links on what to expect post procedure, with patient engagement to refresh where applicable	**June 2022**			Improved IP Survey results

Current status:

In Progress:

1. Next Sisters/Leaders/Care Group/Divisional meetings all teams to be asked to review literature given to patients to ensure current information is correct and up to date by Aprill 22

Complete:

1

No	Our Ref	Objective	Ref	Action required to meet objective	Target Completion Date	Lead Manager / Exec Lead	Evidence	Assurance
2		**Noise at Night:** patients not being bothered by noise at night from staff (Some areas are active throughout the night due to admissions from ED)		1.highlight needs of sleep and rest with clinical teams 2. Close bay doors 3. Keep noise down at clinical stations	**April 2022**	DHoNQ	Safety briefing on wards Staff newsletters & meetings including to those non clinical staff such as Porters and Domestic Staff.	Improvement in IP Survey results No complaints, support aids given to patients - – stock of ear plugs on wards to be given

Current status:

In Progress:

1. Further reminders to be given at next Sisters/Leaders meeting to be held with HoN, add to Comms z-mail – by April 22

Complete: 1								
3		**Noise at Night:** patients not being disturbed by noise at night from other patients		1.highlight needs of sleep and rest with patients and anyone else causing a disturbance e.g. in the course of moving patients in and out of bays	**April 2022**	DHoNQ Matrons & Clinical Leads	Safety briefing on wards Staff newsletters & meetings including to those non clinical staff such as Porters and Domestic staff	Improvement in IP Survey results No formal complaints, support aids given to patients patients – stock of ear plugs on wards to be given
Current status: **In Progress:** **1.** Further reminders to be given at next Sisters/Leaders meeting to be held with HoN, add to Comms z-mail – by April 22 **Complete:** 1								
No	**Our Ref**	**Objective**	**Ref**	**Action required to meet objective**	**Target Completion Date**	**Lead Manager / Exec Lead**	**Evidence**	**Assurance**
4		**Communication:** connecting with relatives during restrictions on visiting		1. Importance of patients being able to communicate with relatives	**April 2022**	DHoNQ Matrons & Clinical Leads	Safety briefing on wards Information leaflet for relatives Booking system	
				2. Ensure there is a dedicated telephone and mobile line for patients/relatives only to use	**April 2022**	DHoNQ/IT Matrons & Clinical Leads	Lines and mobiles in place	
				3. Inform switchboard of these numbers	**April 2022**	DHoNQ Matrons & Clinical Leads		
				4. Technology to be supplied (i.e. iPads)	**April 2022**	DHoNQ/ Matrons &	Volunteers answering phones & virtual	

						Clinical Leads	visiting	

Current status:
In Progress:
1. HoN to discuss with IT and DHoN by June 22 for completion – Budget to be identified for phones and lines with DM

Complete:
1

Actions identified by Divisional Heads of Nursing								
No	**Our Ref**	**Objective**	**Ref**	**Action required to meet objective**	**Target Completion Date**	**Lead Manager / Exec Lead**	**Evidence**	**Assurance**
5	Q38 FS	Given written/printed information about what they should or should not do after leaving hospital: 73%		1.resource support to complete information leaflets	**June 2022**	Matrons & Clinical Leads	Post-operative information discharge checklist Nurse led discharge	Improvement in IP Survey results Reduction in complaints

Current status:
In Progress:
1.

Complete:
1

No	**Our Ref**	**Objective**	**Ref**	**Action required to meet objective**	**Target Completion Date**	**Lead Manager / Exec Lead**	**Evidence**	**Assurance**
6	Q40 FS	Knew what would happen next with care after leaving hospital: 84%		1.keyworkers on Wards (business planning)	**June 2022**	Ward Leaders	Discharge plan checklist Communication with next of kin	Improvement in IP Survey results Reduction in complaints

Current status:
In Progress:

1.
Complete:
1