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 **25th May 2022** at **8.30 am to 12.30pm** via MS Teams.

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Patient Story**	Presentation	Nicky Lucey Alison Male	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 30th March 2022	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**CEO Update**	Enclosure	Nick Johnson	Note	9.00-9.10
4.	**Review of Previous Year Committee Priorities, This Year's Priorities and Work Plans**	Enclosure	Committee Chairs	Approve	9.10-9.20
5.	**Quality Account**	Enclosure	Nicky Lucey	Approve	9.20-9.30
6.	**Annual Licence Condition Declarations** (May RAC)	Enclosure	Mark Addison Trevor Hughes	Approve	9.30-9.35
7.	**Safe Staffing Return** Deferred from March	Enclosure	Nicky Lucey	Approve	9.35-9.45
8.	**Ockenden Report Update**	Enclosure	Nicky Lucey	Note	9.45-9.55
9.	**Learning from Deaths Q3 and Q4 Reports** (April and May QC)	Enclosure	Alastair Hutchison	Approve	9.55-10.00
Coffee Break 10.00-10.10					
10.	**COVID-19 Update**	Verbal	Anita Thomas	Note	10.10-10.15

11.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (April and May 2022) a) People and Culture Committee b) Quality Committee c) Finance and Performance Committee (including Ambulance Handovers) d) Risk and Audit Committee e) Charitable Funds Committee f) System Performance Update (Standing Item)	Enclosure	Committee Chairs and Executive Leads	Note	10.15-10.35
12.	**DCH Strategy Implementation Update**	Enclosure	Nick Johnson Paul Lewis	Note	10.35-10.50
13.	**Board Assurance Framework and Risk Register** (May RAC)	Enclosure	Nick Johnson Paul Lewis	Note	10.50-11.00
14.	**Well Led Review – Action Plan**	Enclosure	Nick Johnson	Approve	11.00-11.10
15.	**Medical Education Report** Item Deferred from March 2022	Presentation	Alastair Hutchison Paul Murray	Note	11.10-11.20
	Coffee Break 11.20-11.30				
16.	**Integrated Care Provider Engagement Activity**	Presentation	Sam Crowe Director of Public Health	Discuss	11.30-12.00
17.	**Guardian of Safe Working Hours Annual Report** (May PCC)	Enclosure	Kyle Mitchell	Note	12.00-12.10
18.	**Freedom to Speak Up Report** (May PCC)	Enclosure	Julie Barber	Note	12.10-12.20
19.	**Questions from the Public**	Verbal	Mark Addison	Note	12.20-12.25
	CONSENT SECTION				12.25-12.30
	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.				
20.	**Maternity Safety Update**	Enclosure	Nicky Lucey	Note	-
21.	**Quarterly Communications Activity Update**	Enclosure	Nick Johnson	Note	-

22.	**Any Other Business** Nil notified				
23.	**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 27th July 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 30th March 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
Paul Goddard	PG	Chief Financial Officer
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
Stuart Parsons	SP	Non- Executive 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)*
Owen Clements	OC	Digital Team DCHFT, Staff Story
Paul Lewis	PL	Deputy Director of Strategy and Transformation *(item BoD12/121)*
Laura Symes	LS	Corporate Business Manager
Members of the Public:		
Tony Armstrong	TA	KickStart programme Lead
Simon Bishop	SB	DCHFT Public Governor
Kathryn Harrison	KH	DCHFT Public Governor
Zoe Sheppard	ZS	Head of Research
Apologies:		
Jo Hartley	JH	Head of Midwifery

BoD21/108	**Staff Story**	
	DH introduced OC, a graduate and participant of the KickStart Scheme to the meeting. The programme formed part of the Trust's commitment to social value. The Board noted that the Department of Work and Pensions scheme was drawing to a close but noted the importance of providing ongoing employment and work experience opportunities for young people. OC joined the Digital team having had no prior no experience and had performed well, gaining a staff award and a substantive post in April. This had been an opportunity that would not have been available to him had he not joined the KickStart scheme. OC highlighted that the Trust's commitment to supporting future employment post participation in the scheme was a major factor in attracting him to the Trust. He had enjoyed the KickStart scheme which had been informative, welcoming, supportive of future employment opportunities and was supported by the senior team.	

	The scheme was consistent with the Trust's values and the programme aimed to give young people the skills and confidence to prepare for future employment. Whilst undertaking the scheme, OC had been able to shadow various teams across the Trust, improving his understanding of the NHS. Following his substantive appointment, OC had been given a variety of responsibilities. Whilst some members of the team had been helpful than others and customers had occasionally been rude, OC stated that he had felt well supported by his manager. OC's experience of the Trust and the scheme had been excellent and provided great opportunities for young people leaving education. His experience had been that scheme participants had been well received by services and their level of performance had helped to promote a positive learning experience for staff and participants. A significant number of scheme participants had subsequently attained substantive employment. The Board heard that greater use of social media and maximising outreach opportunities at transition points in young people's lives, in addition to adopting a values-based recruitment model would help in attracting young people to the Trust. NJ thanked DH, SC and TA for their passion and support for the scheme and noted OC's earlier comment that he felt that DCH had wanted to help provide him with a future. The KickStart scheme provided an excellent example of the Trust's commitment to adding social value.	
	Resolved that: the Staff Story be heard and noted.	
BoD21/109	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed members of public and Governors to the meeting. He also formally welcomed NJ to his first Board meeting as Interim Chief Executive Officer. MA extended the Board's thanks to Natalie Violet, Corporate Business Manager who had been seconded to the Integrated Care System and welcomed LS to the meeting who had succeeded her. There were no apologies for absence. MA opened the meeting by noting the extreme pressures that the Trust was experiencing currently due to urgent and emergency care demand and rapidly increasing cases of COVID, and thanked the Executive team and all staff for their extraordinary efforts.	
BoD21/110	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	

BoD21/111	**Minutes of the Meeting held on the 26th January 2022**	
	Members of the Board considered the minutes of the meeting held on 26th January 2022 and these were approved as an accurate record**.**	
	Resolved: that the minutes of the meeting held on 26th January 2021 were approved.	
BoD21/112	**Matters Arising: Action Log**	
	The action log was considered and updates were noted with approval 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.	
BoD21/113	**CEO Update**	
	NJ reported that NL had agreed to undertake the role of Deputy Chief Executive. He summarised the current operating context that was being impacted by: • Operational planning requirements and future financial challenges • Increasing operational pressures across the system. • The war in Ukraine • Cost of living crisis • Vaccination as a condition of employment no longer being a requirement for NHS staff • Challenging elective recovery targets • ICS development delays There had recently been a greater number of staff absences than those experienced in the first wave of the pandemic and unlike at that time, the hospital was operating at over 100% capacity. He noted the additional and exceptional contribution of Executive colleagues and staff. Progress on the development of the ICS was being made and it was anticipated that the ICS would be in place from July 2022. Progress was also being made on the New Hospitals Programme and the recent national team visit had gone well. The Maternity Survey and patient survey feedback had remained positive. A number of items of the meeting Agenda included proposals being taken forward to support elective performance and recovery and, whilst the hospital was incredibly busy, some programmes of work provided optimism. SA congratulated DCH on their hard work and recognised the difficult time for the NHS currently. The Board noted the major impact of COVID on public health and the NHS and expressed concern that more ought to be done nationally to address the situation. Clear messaging of the need to continue with public health precautions and action to identify solutions to patient flow issues was needed	

	particularly given that patient satisfaction levels nationally were at an all time low. The Board expressed concern that central demands on the NHS for the coming year were not realistic and would significantly impact on services and the workforce. Changes in infection prevention and controls guidance were being discussed at a national level and the Trust would continue to reinforce the public health messages whilst these were awaited. The management of patients with 'no reason to reside' was deteriorating. Regional and national work was in progress to address this, particularly with acute sector providers and DCH was reviewing current capacity and working with local authority partners on solutions. The need to engage with local politicians and system partners on public messaging was noted and the Trust would continue to focus on solutions within the Trust's gift whilst continuing to raise concerns through system and national forums. The further development of partnership working was paramount and would support the engagement of local politicians to ensure a fuller understanding of the issues and the Board noted the role of NHS Providers who could constructively escalate concerns nationally. MA and NJ undertook to review and escalate the Board's concerns.	**MA / NJ**
	Resolved: that the CEO Update be received and noted.	
BoD21/114	**Enabling Plans**	
	The Board were reminded of their prior review of the plans in development and were invited to approve the principles and format of the respective plans. **Clinical Plan** AH noted the foreword linking the plans together and outline the intension to further engage with clinical departments in the development of local plans for the coming years. The Board noted the linkages with the People and Digital Plans and that the plan would continue to evolve. **People Plan** DH highlighted that the plans were integrated and outlined the work to roll out the plan across services and to monitor implementation through the existing performance management arrangements. **Digital Plan** SS apologised for late circulation and the plan and noted that the Digital plan was reactive to the Clinical and People Plans and was impacted by national drivers e.g. to consolidate patient records. Deliverability of the plan was also largely dependent on external factors.	

	MA noted the work to ensure consistency of the plans with the wider system and highlighted the extensive engagement undertaken in their development. Board discussion of the plans included: • assurances that metrics and priorities were aligned and accepted by the Executive team, • patient pathways needed to be further emphasised - from prevention through treatment to rehabilitation, • the need to promote basic data and numeracy skills in support of the Digital Plan, • divisional actions to address inequalities would need to be made more overt within the Clinical Plan, • community engagement and the patient perspective would need to be more explicitly reflected within plans and monitoring metrics, • the population health and community treatment centre approach to the plans was welcomed, • the need to ensure that organisational sustainability was reflected within the Clinical and People Plans, particularly in relation to specialist services, • the Board requested that quarterly trajectories be included within divisional reports to better facilitate monitoring, • the need to develop a short user-friendly document for the public, staff, partners and governors, The Board noted the strong alignment of plans with the Integrated Care System and that plans would continue to evolve and the ICS plans evolved. The need to signpost other enabling and cross cutting plans i.e. The Green Plan and System Inequalities Plan, Net Zero Carbon, Social Value was also noted in order to avoid duplication. The Board were informed that a strategic dashboard was in development in order to monitor implementation progress going forward and that six monthly updates would be presented to the Board. The Board approved the plans and the basis for monitoring the strategy going forward. MA summarised the discussion and thanked the teams involved in their development for their considerable effort and hard work.	
	Resolved that: the Enabling Plans be approved.	
BoD21/115	**Committee Reviews**	
	MA advised that committee forward plans and priorities would be presented to the Board in May 2022. The paper outlined the feedback of the committee review process and had identified some common themes which included the need to strengthen reports and front sheets and the timeliness of Board and committee paper publication. The Board acknowledged the logistical and timing challenges	

	associated in producing and validating data for reports. MA thanked TH for coordinating the review process and compiling the report. Further discussion of quality metrics and monitoring was agreed (in particular Sepsis) and would be progressed via the Quality Committee The Board emphasised the importance of concise and comprehensive front sheets and the format of this document in adding value to Board discussion. The Board also noted the significant level of detail contained within some reports and the importance of producing succinct reports that focussed on key risks, mitigations and decision making.	**EJ / NL**
	Resolved that: the Committee Reviews be received and noted.	
BoD21/116	**Recovery Report**	
	The Board noted that the recovery agenda formed part of the Trust's day-to-day business and that various elements of the report, including people and elective recovery, would be incorporated within respective committee reports going forward. The Board were assured that performance against Trust and system trajectories would continue to be monitored. DCH continued to perform well against the recovery trajectories despite the current challenge, the Board approved the recommendation to cease production of a separate report.	
	Resolved that; The Recovery Report be received and noted and that the recommendation to cease future reports be approved.	
BoD21/117	**COVID-19 Update**	
	AT reported that there had been an increasing number of inpatients admitted for treatment and had subsequently tested COVID positive. The Trust Incident Management Centre was in operation and a significant and increasing amount of staff absence had been experienced due to COVID the previous week. A similar situation was reflected across the region in both health and social care sectors and was affecting patient flow. Revised national infection prevention and control guidance was awaited. The Trust's current focus was maintaining safe staffing levels and critical services and additional staff volunteering was being encouraged. There were currently 102 COVID positive patients in hospital and all but one ward was affected. The number of patients with 'no reason to reside' had stabilised but remained high at 63. Ambulance handover performance had deteriorated and the position was exacerbated by the high number of patients remaining in hospital when they were medically fit for discharge. Estates developments which were also currently limiting capacity. Cancer services performance had been maintained although the Diagnostic services had been affected by staff losses in month.	

	AT reported that health and social care staff would continue to be supported with access to COVID testing. Concerns remained however, around the stopping of free testing for visitors who were required to undertake Lateral Flow Testing prior to visiting. Tests would cost circa £6 per test and may be unaffordable for some population groups. The recent increased community prevalence of COVID had seen a significant four-fold increase in the number of referrals to the neutralising monoclonal antibody service which was not currently funded.	
	Resolved: that the COVID-19 Update be noted.	
BoD21/118	**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 February 2022, noting the Escalation Reports and highlighting key points: **People and Culture Committee:** • The sustained difficult operating challenges for staff, • MB's appointment to the role of Wellbeing Guardian, • Nation Staff Survey results returning above the national average scores, • Funding for health and wellbeing and signposting of options, • The Gender Pay Report submission. **Quality Committee:** • Continued pressures on staff, • The Trust remained on routine CQC surveillance, • In depth review of maternity services and monthly oversight of Ockenden and Kirkup actions, • Positive national patient survey feedback but recognition of the need for further work, • Pressure Ulcer and Clostridium Difficile performance was within the expected range despite increasing incidents nationally. • The Board noted that the Ockenden 2 Report was due for publication the same day and that DCH would take the learning from this review. • Excellent team work has resulted in the maintenance of quality performance despite the operational challenges currently, • Single sex accommodation challenges persisted but effective patient engagement and communication had resulted in no subsequent complaints. **Finance and Performance Committee:** The Board noted further planned financial discussion later in the Board meeting and that the trust was forecasting year-end breakeven position. The new presentation of data had been helpful and facilitated greater triangulation. Whilst the Trust continued to meet the waiting	

	list trajectories, it was anticipated that recent COVID increases and subsequent impact on staffing would have an adverse impact. MA reminded that the Board were due to receive further information about data presentation from NHSE/I at a near future meeting. **Risk and Audit Committee:** • Discussion of the Board Assurance Framework and the requested for inclusion of risk mitigation trajectory timescales, • High fraud awareness amongst staff, • A positive DCH Subco Board Governance Internal Audit Report, • A high degree of confidence that that the Trust would meet the Data Protection and Security Toolkit evidence submission requirements, • A good level of challenge at committees. **Charitable Funds Committee** • Reserves had stabilised above the established limit, • The revenue income limit had been reduced slightly, reflecting the impact of the pandemic, • The Charitable Business Plan had been supported, • The Capital Appeal Plan had been supported, • Conclusion of the governance review and charitable funds restructure proposals had been supported. **System Performance Update** This report was provided for information.	
	Resolved: that the Performance Scorecard, Board Sub-Committee Escalation Reports and System Performance Update be noted.	
BoD21/119	**Medical Education Report**	
	This item was deferred.	
	Resolved: that Medical Education Report be deferred.	
BoD21/120	**Guardian of Safe Working Hours Report**	
	KM attended to present this item highlighting three key points: • Compliance with safeguarding aspects of the junior doctor rota and DCH being considered to be a good place to work and a positive employer, • High numbers of undischarged patients within trauma and orthopaedic and geriatric services requiring ongoing care beyond the scope of the junior doctor role, • Current pandemic challenges had impacted the ability of the Junior Doctor Forum to meet. Going forward, it was planned that a bi-monthly lunchtime meeting would be catered in order to facilitate meeting participation to promote two way communications, providing an opportunity for junior medical staff to raise any concerns.	

	The Board recognised the value of the Junior Doctors' Forum and supported arrangements to facilitate re-establishment and of the forum's meetings. In discussion of the Chief Registrar vacancy, the Board heard that current service pressures and other professional priorities were inhibiting motivated trainees from undertaking the role. It was hoped that this was a short-term issue and that the position would improve when the staffing situation improved and the current pandemic wave subsided. NJ supported arrangements for the re-establishment of the Junior Doctors' Forum within infection prevention and control guidance and thanked KM for the report.	
	Resolved: that the Guardian of Safe Working Hours Report be received and noted.	
BoD21/121	**Board Assurance Framework (BAF) and Risk Register**	
	PL attended for this item and highlighted the risk Heat Map which provided an indication of the level of risks in support of the narrative concerning risk movement. He noted the need to include risk mitigation trajectories and timelines in future reports. Clinical coding remained a high risk and arrangements were under review. Other high level risks included maintaining high quality, safe care and fiscal challenges. PL assured that risks and mitigations were tracked and monitored by the Risk and Audit Committee. SP commended the report, noting that it was a live document that was being effectively used within the organisation. The Board noted that the New Hospital Programme risk score had reduced and that the programme lead would commence in post in June 2022 when a further review of the risk would be undertaken. SA noted the need to reflect net zero carbon and other cross cutting themes such as inequalities more clearly within the BAF and to ensure consistency with the Action Log items. EJ suggested that the mitigation aspects of the report could be further developed. NJ and PL undertook to discuss further identification of these items within the report. **Corporate Risk Register** The Board noted that corporate risk mitigations were updated and monitored via committees and requested that mitigations relating to high scoring risks be made clearer. NL noted the Board discussion of the COVID, staffing and the impact of patients remaining in hospital and long waiting time risks by the Board. She noted the longevity of some of these risks and advised that this picture was reflected nationally.	**PL / NJ**

	NL reported that the long-awaited national guidance concerning liberty protection safeguards had still not been released and that the Deprivation of Liberty safeguarding risk would be updated once this had been published. MA sought an update regarding the mortality risk. AH advised that the risk related to coding capacity which had been impacted by the refocus on elective activity coding and a reduction in coding capacity due to COVID. A plan was in place to update and input data prior to the deadline date of mid May 2022. Other available data sources had not indicated issues regarding mortality within the Trust.	
	Resolved: that the Board Assurance Framework be received and noted.	
BoD21/101	**Well Led Review – Final Report**	
	MA advised receipt of the final report following the PriceWaterhouseCoopers (PWC) review at the end of the previous year which had been positive overall. He noted that the action plan in response to action recommendations would returned to the Board for approval in May 2022. NJ advised that development of the action plan response had been commenced although operational pressures had inhibited conclusion of the plan and that actions identified would be commenced in the meantime. ST commended the positive report and noted PWCs constructive comments. This was echoed by NL, who added that that staff felt able to raise concerns and felt they were heard. The Board had good governance and oversight of the Trust's business and provided effective challenge. NL stated that the independent report recognised and reflected the positive progress that the Board had made.	
	Resolved: that the Well Led Review Final Report be received and noted.	
BoD21/122	**Questions from the Public**	
	KH thanked the Board for the level of discussion and the positive actions being taken to support the Trust and offered the continued support of Governors. This would be reflected in the the weekly CEO Brief.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD21/123	**DCH Charity**	
	Business Plan 2022 / 23 **Capital Appeal Plan** **Charitable Funds Restructure Proposal** The Board was assured that the proposed fund structure changes would not affect legacy donations held within restricted funds.	

	DP commented the he would welcome greater reflection of the Trust's diverse workforce in the hospital's artwork moving forward.	
	Resolved that: the DCH Charity • **Business Plan 2022 / 23** • **Capital Appeal Plan** • **Charitable Funds Restructure Proposal** **Be approved.**	
BoD21/124	**Maternity Safety Update**	
	SA requested that the report be formally noted as an item for the Board's consideration.	
	Resolved: that the Maternity Safety Update be received and noted.	
BoD21/125	**Staff Survey Action Plan**	
	Resolved: that the Staff Survey Action Plan be received and approved	
BoD21/126	**Annual Patient Survey**	
	Resolved: that the Annual Patient Survey be received and noted.	
BoD21/127	**Any Other Business**	
	The Board noted a recent meeting between NHSE/I and the CEO, South West Chairs regarding ambulance handovers and the focus nationally on this issue.	
BoD21/128	**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.**	

Action Log – Board of Directors Part 1

Presented on: 25th May 2022

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 30th March 2022						
BoD21/113	**CEO Update**	Further discussion regarding escalation of the Board's concerns about current service pressures, increasing COVID transmission and future performance and activity targets to be had	**MA / NJ**	May 2022		
BoD21/115	**Committee Reviews**	Further discussion to be had regarding quality indicators (Sepsis)	**NL / EJ**	April 2022		
BoD21/121	**Board Assurance Framework (BAF) and Risk Register**	To progress greater identification / inclusion of cross cutting themes such as health inequalities and net zero carbon within the BAF	**PL / NJ**	May 2022	These themes will feature in the ICS strategy development, and are included in the Social Value Action Plan, and Sustainability and Efficiency Workstream Plan.	
Meeting Dated: 26th January 2022						
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
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	NJ would discuss with the Director for Medical Education and PM.	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~~ July 2022	Ongoing – action paused to summer	No
Actions from Committees…(Include Date)						

Meeting Title:	Board of Directors
Date of Meeting:	25 May 2022
Document Title:	**Chief Executive's Report**
Responsible Director:	Nick Johnson, Interim Chief Executive
Authors:	Laura Symes, 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	18/05/2022	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 Government has removed its advice for staff and students in most education and childcare settings to undertake routine twice weekly asymptomatic testing, along with updated infection prevention control (IPC) guidance for NHS Trusts. • The final report for the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was published. In addition to the 7 Immediate and Essential Actions (IEAs) first identified, the final report identifies 15 new themes with a series of further recommendations. • NHS England published the Workforce Race Equality Standard 2021 which noted the continued growth in ethnic minority representation in the NHS workforce, at 22.4%, up from 21% last year. • The Health and Care Bill received Royal Assent by Her Majesty the Queen. • The number of hour-plus delays to handing over patients from ambulances to emergency departments in March was the highest ever recorded. • Waiting for Care and Support report shows that more than half a million adults are waiting for social care assessments. Although hospital patients who are medically fit for discharge are made a priority for assessment, any delay to those assessments means a delay to people receiving the care they need and makes it difficult to maintain the flow of patients through the NHS.							
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 – May 2022

Strategic Update

National Perspective

COVID-19 Testing Updates
On 29 March 2022 Sajid Javid, Secretary of State for Health and Social Care, confirmed the Government has removed its advice for staff and students in most education and childcare settings to undertake routine twice weekly asymptomatic testing. The Government has started the process of reducing its testing and tracing infrastructure, in preparation for the end of free universal testing from 01 April. Most visitors to adult social care settings, and visitors in the NHS, prisons or places of detention will no longer be required to take a test.

The Government will continue to provide free symptomatic testing for:

- patients in hospital, for whom a test is required for clinical management or to support treatment pathways.
- people who are eligible for COVID-19 treatments because they are at higher risk of getting seriously ill from COVID-19. People in this group will be contacted directly and sent lateral flow tests to keep at home for use if they have symptoms as well as being told how to reorder tests.
- individuals who live or work in high-risk closed settings, for example in some NHS, Social Care and Prison (and other Places of Detention) settings where infection needs to be identified quickly to minimise outbreaks.

Ockenden Report
On 30 March 2022 Donna Ockenden published the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. The final report follows on from the first report which was published in December 2020. In addition to the 7 Immediate and Essential Actions (IEAs) first identified, the final report identifies 15 new themes with a series of further recommendations. It contains 66 for local Trusts, 15 for the wider NHS and 3 for the Secretary of State.

All Trust are requested to review the report and take action to mitigate any risks identified, and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:
1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

There is also wider implications for services beyond Maternity & Neonatal, especially given reflections on governance, learning from incidents, culture, complaints, listening to patients & families and Freedom to Speak Up.

Workforce Race Equality Standard 2021
On 07 April 2022 NHS England published the Workforce Race Equality Standard 2021. Sir David Sloman, Chief Operating Officer for NHS England, noted that it was encouraging to see the continued growth in ethnic minority representation in the NHS workforce, at 22.4%, up from 21% last year. However, ethnic minority colleagues remain under-represented in senior positions and in executive board roles so there is certainly a very long way to go, despite evidence of some sustained improvements which I know we are all committed to building on.

Mental Health & Wellbeing Plan: Discussion Paper
On 12 April the Department of Health and Social Care released its Mental health and wellbeing plan: discussion paper and call for evidence to ask the public a range of questions to help develop the new plan. The discussion paper is asking people of all ages who have experienced or been affected by mental ill-health to feedback their views on what the Department of Health and Social Care can do to promote positive mental wellbeing, prevent the onset of mental ill-health, improve the quality and

effectiveness of treatment for mental health conditions. They will then work with different sectors, including the NHS, to develop a society-wide plan for mental health. Chris Hopson, Chief Executive of NHS Providers, responded that trusts will welcome the potential for it to bring a strategic and systemic approach to mental health policy-setting and delivery over the longer term.

High Court Ruling on the Discharge of Untested Patients to Care Homes
On 27 April the High Court ruled that the Government policy to discharge patients into care homes in England without testing them for COVID-19 at the start of the pandemic was unlawful. When COVID-19 hit in early 2020, patients were discharged into care homes without testing, despite the risk of asymptomatic transmission, with government documents showing there was no requirement for this until mid-April. Lord Justice Bean and Mr Justice Garnham found the decisions of the then Health Secretary to make and maintain a series of policies contained in documents issued on 17 and 19 March and 02 April 2020 were unlawful. They ruled this was on the grounds the drafters of those documents failed to take into account the risk to elderly and vulnerable residents from non-symptomatic transmission.

Health and Care Bill Update
On 28 April the Health and Care Bill received Royal Assent by Her Majesty the Queen, marking a milestone in the recovery and reform of how health and care services work together. The act introduces measures to tackle the COVID-19 backlogs and rebuild health and social care services from the pandemic, backed by £36 billion over the next 3 years through the Health and Care Levy. It will also contain measures to tackle health disparities and create safer, more joined-up services that will put the health and care system on a more sustainable footing.

Savid Javid, Health and Social Care Secretary, said The Health and Care Act is the most significant change to the healthcare system in a decade and will put it in the strongest possible position to rebuild from the pandemic, backed by our record funding. These measures have broad support and will harness the best ways of working to ensure people are receiving high quality, joined-up care.

Ambulance Handover Times
Figures collected by the Association of Ambulance Chief Executives show that the number of hour-plus delays to handing over patients from ambulances to emergency departments in March was the highest ever recorded, following steep increases since last summer. The national issue has been linked to hospital occupancy as a result of delayed discharges and a lack of staff, along with absences, particularly in social care services, and reduced capacity/flow due to COVID-19 infection prevention control measures. NHS services are working collaboratively in line with actions set out for systems to prevent ambulance handover delays.

NHS England has tendered a contract worth up to £30m for auxiliary ambulance services following the concerns at ambulance trusts' ability to respond to patients fast enough. There has been particular concern around category two patients – which includes those with suspected strokes and heart attacks – where responses took an average of over an hour in March, against a target of 18 minutes. The contract will surge capacity to enhance the response, conveyance and support to ambulance trusts across England, specifically for the provision of emergency and non-emergency ambulance crews with capacity to respond to callouts across categories 1-4.

Workforce Disability Equality Standard Report
Following the NHS England and NHS Improvement's latest Workforce Disability Equality Standard report, Miriam Deakin, Director of Policy and Strategy at NHS Providers, confirmed that it's encouraging to see that the number of disabled people at board level has almost doubled since 2019 and that the chances of shortlisted disabled staff being appointed have improved again this year. However, there is still concern that disabled staff are nearly twice as likely to be referred to a performance management process, and significantly more likely to suffer bullying, harassment and abuse from patients and colleagues compared to staff who are not disabled. Trust leaders and colleagues in national NHS bodies and government must continue to focus on creating inclusive environments.

ADASS Report – Waiting for Care and Support
On 13 May, Miriam Deakin, Director of Policy and Strategy at NHS Providers, responded the Waiting for Care and Support report from Association of Directors of Adult Social Services (ADASS) which shows that more than half a million adults are waiting for social care assessments. She noted that the report paints a worrying picture of unmet care needs and lays bare the pressures on the social care system. Although hospital patients who are medically fit for discharge are made a priority for assessment, any delay to those assessments means a delay to people receiving the care they need and makes it difficult to maintain the flow of patients through the NHS. The ADASS report highlights once again the urgent need to properly fund and reform the adult social care system.

Local Relevance

Urgent Treatment Centre & Minor Injuries Unit Service Models
At the end of March 2022, there was strong discussion on the need for the Urgent Treatment Centre and Minor Injuries Unit service model to be reconsidered rapidly. Partners have been reviewing the 'Home First' model that should operate in Dorset, and have now reached agreement, with work to begin shortly on implementing the new arrangements. Additionally, it has been agreed by health and care partners that improving flow within our hospitals should be one of four top priority areas that need addressing if we are to recover the Dorset system position and use all resources to best effect. While this system work is ongoing, at DCH we will continue to look at ways to alleviate some of our underlying challenges, including using underutilised capacity elsewhere and applying for capital funding to create more beds for elective activity on site.

Parking Charges for NHS Staff
On 29 March 2022, the Government announced that from 01 April 2022 free parking for NHS staff will cease. Sajid Javid, Secretary of State for Health and Social Care, said that parking fees were waived in March 2020, but charges were now being re-introduced as the pandemic had moved to a new stage. DCH cannot afford to continue indefinitely without any car park permit income from staff. However, with the rising cost of living we are conscious of the impact of adding to the financial burden, so we are exploring options for moving to a progressive charging regime aligned to banding, with those on lower banded roles paying a lower charge for a permit. Other Trusts have already reintroduced charges for staff, but the Executive Team have agreed to defer bringing back charges for staff at DCH until the multi-storey car park is open in the summer (currently planned for the end of June).

Living with COVID – Financial Regime
As part of the Government's 'Living with COVID' approach, the financial regime for the NHS for the 2022/23 financial year has changed following two years of pandemic financing. NHS income has been reduced and the additional costs that Trusts have built up over the past couple of years mean that all NHS providers are facing significant financial deficits. DCH are forecasting an approximate £15million deficit. While we will keep patient safety and staff wellbeing at the forefront of our minds, the position means that the Trust will all need to make some difficult decisions. It is recognised that our costs are driven in part by operational challenges outside of our control, however, we need to increase our financial focus and look to reduce our spend, deliver efficiencies and forgo budget growth. Work continues to support all departments in developing plans to identify and deliver a 2.5% saving on their budget by the end of March 2023.

COVID-19 Infection Prevention and Control Guidance Update
On 14 April the Department of Health and Social Care (DHSC) updated the COVID-19 Infection Prevention and Control (IPC) guidance for Hospitals. Inpatients who are considered contacts of COVID-19 cases are no longer required to isolate if they are asymptomatic. If symptoms occur they should be tested and isolated or cohorted with other symptomatic contact cases. Also, where available, a locally decided testing protocol can be used to reduce the isolation period down from 10 days in patients who meet this clinical criteria. These tests can be Lateral Flow Device (LFD) tests or other rapid antigen detection tests. Patients should have two negative tests taken 24 hours apart as well as showing clinical improvement as above, before being moved out of isolation.

At DCH the Elective Admissions Pathway has been updated in accordance with the national guidance as per 'Living with COVID-19 – testing update', and changes have been made for inpatients who are contacts of a patient COVID positive case. From now on, patients who have been found to have been in contact with a COVID positive patient need a lateral flow test within 48 hours of the known contact. A PCR will only be carried out if the lateral flow test is positive.

NHS Financial Regime 2022/23
As part of the Government's 'Living with COVID', the financial regime for the NHS for the 2022/23 financial year has changed following two years of pandemic financing. NHS income has been reduced which mean that all NHS providers are facing significant financial deficits.

DCH are planning a £17million deficit this year as a result of changes in commissioned income. While we will keep patient safety and staff wellbeing at the forefront of our minds, the position means that we need to increase our financial focus and look to reduce our spend, deliver efficiencies through our cost improvement plans (CIPs) and forgo budget growth. We will be putting enhanced financial oversight and support in place to support CIP delivery and budget delivery.

NHS Dorset Board Appointments
NHS Dorset announced a number of Board appointments; Stephen Slough to the role of Chief Digital and Information Officer Designate, Dr Paul Johnson to the role of Chief Medical Officer Designate, David Freeman to the role of Chief Commissioning Officer Designate, Rob Morgan to the role of Chief Finance Officer Designate, and Dawn Harvey to the role of Chief People Officer Designate. The recruitment campaign for the remaining chief roles continues.

DCH Performance

Royal College of Anaesthetists Review
On 28 March 2022, the Royal College of Anaesthetists (RCA) visited DCH to review our Anaesthesia Clinical Services Accreditation (ACSA). Following the visit, the Anaesthetists Department met 146 of the 147 standards, with the other standard met shortly after the visit. The review team were really impressed at the cohesive nature of the Anaesthetic Department and the way they integrate with other services across the Trust to deliver excellent, safe care. They found the staff within the department and theatres to be resilient and positive in spite of the current pressure we all face arising from two years of COVID. RCA will now produce a report and make a recommendation to the ACSA Committee at the College on our Accreditation.

South Walks House Update
On 31 March 2022, following Board approval, we signed the lease for South Walks House in Dorchester town centre. We have been using it successfully for the last six months as an Outpatient Assessment Centre and it has been welcomed by staff and patients. Securing it on a longer-term basis means we will be able to expand our clinical offer and provide replacement office accommodation. It will help us move forward with development plans as part of the Your Future Hospital programme and maximise the use of clinical space on the hospital site – helping us create extra bed space and tackle waiting lists for elective surgery. We also hope it will help boost the local economy by providing services in Dorchester town centre and supporting our Social Value Pledge to improve the overall wellbeing of our local communities. This has been a real team effort and I'd like to thank everyone involved in getting us to this point. We will keep you updated on plans as they develop

NHS Staff Survey Results 2021
On 31 March 2022 the Trust NHS Staff Survey results for 2021 were released. The initial results indicate that 85% of staff said they enjoy working with their colleagues, 70% feel valued by their team and 66% feel a strong personal attachment to their team. I was also delighted to see that 75% of staff think that the organisation respects individual differences (cultures, working styles, backgrounds, ideas, etc), reflecting our aim to make DCH a place where everyone feels like they belong and can bring their true self to work. The Staff Survey also highlights the pressure on the whole NHS in the themes of staff engagement and morale. The Trust equaled the national comparator with 21% of staff saying they find

work emotionally exhausting and 16% saying they feel worn out at the end of their shift. We remain absolutely committed to doing all we can to make DCH a great place to work for everyone.

DCH Operational Plan 2022/23
As part of the Trusts Operational Plan for 2022/23 some of the key target areas identified for elective recovery are restoring productivity across planned care activities and ensuring delivery of 104% at minimal additional cost/dependency on outsourcing. For COVID-19 costs a system wide review of all costs funded from Covid and agree a consistent plan for reduction to funded levels. For urgent & emergency care to accelerate transformation and delivery programmes with maximise focus on discharge and patient flow.

DCH Greatest Need Appeal
As DCH continues to operate under immense pressures, Dorset County Hospital Charity has set up the DCH Greatest Need Appeal to help fund projects across the whole of the hospital, providing vital support for patients and staff at this difficult time. The Greatest Need Appeal will encourage support for those areas where funding is needed most – on Wards and in specialist clinical units, for the enhancement of the hospital environment and treatment facilities and for the ongoing wellbeing of DCH staff.

Nick Johnson
Interim Chief Executive
18 May 2022

Meeting Title:	25th May 2022
Date of Meeting:	Board of Directors
Document Title:	**Review of Previous Year's Committee Priorities, Priorities for the Coming Year and Annual Work Plans**
Responsible Director:	Committee Chairs Lead Executives
Author:	Trevor Hughes, Head of Corporate Governance

Confidentiality:	Not confidential
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Board of Directors	March 2022	Committee Terms of Reference approved.
Respective Committees	May 2022	Recommend to the Board

Purpose of the Paper	These papers provide a review by respective committees of achievements against the agreed priorities for the year 2021/22, the respective committee priorities for the year 2022/23 and the annual committee work plans.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	As part of the annual review of effectiveness undertaken by Board sub-committees, the committee Chairs and lead Executive Directors undertake an evaluation of performance against the previous year's priorities in order that the outcome can inform development of committee priorities for the coming year. The priorities help to also inform the annual programmes of work for each committee. The Terms of Reference for respective committees were approved as part of the effectiveness review, by the Board of Directors in March 2022. The revised Terms of Reference for the Remuneration and Terms of Service (RaToS) Committee were amended to ensure alignment with the Trust's Constitution and are also included for approval. Also included are the revised Terms of Reference for DCH Subco Ltd, a subsidiary company of the Trust, which were updated following a review of effectiveness undertaken by the DCH Subco Ltd Board. The Board is asked to note these.							
Action recommended	The Board of Directors is asked to: 1. **NOTE** the review of progress made against previous year committee priorities, 2. **APPROVE** the Committee Priorities for the coming year 3. **APPROVE** the committee Annual Work Programmes. 4. **APPROVE** the Terms of Reference for RaToS 5. **NOTE** the DCH Subco Board Terms of Reference							

Governance and Compliance Obligations

Legal / Regulatory	Y	It is good governance epractice for committees and Boards to review their

		effectiveness and to set priorities and annual work programmes
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	N	
Decision to be made?	Y	Approval of Terms of Reference, Committee Priorities and Annual Work Programmes
Impacts CQC Standards?	Y	Maintaining good governance practice contributes to achievement of the Well Led domain
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Finance and Performance Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board had has no executive powers other than those specifically delegated to it via these Terms of Reference. The Standing Orders of the Trust, Standing Financial Instructions and Scheme of Delegation shall apply to the conduct of the working of the Committee.

Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and is authorised to seek any information that it requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary.

The Committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The purpose of the Committee is to provide a forum for the Board to seek additional assurance in relation to relevant aspects of the 'Place' and 'Partnerships' Strategic Objectives; including all aspects of financial and nationally set and locally agreed performance targets, monitoring the impact of the Cost Improvement Programme (CIP) and monitoring of the Service Transformation Programme (STP).

The Committee will also ensure the adoption and application of best practice governance and decision making processes for making investments in line with the NHS Act 2006 (as amended by the 2012 Act) and the NHS Improvement "Supporting NHS providers: guidance on transactions for NHS foundation trusts" guidance (updated March 2015).

The Committee will be responsible for the scrutiny of risks identified within the Board Assurance Framework and Corporate Risk Register relating to finances and the use of resources and will work collaboratively with the Quality and People and Culture Committees to ensure that the impact on quality and the workforce of financial decision making is scrutinised.

Membership

Membership of the Committee will be appointed by the Board and shall consist of three Non-Executive members; one of which will be appointed by the Board as Chair and a further member will be a clinical Non-Executive member of the Committee. The following Executive Directors will also be members of the Committee or their nominated deputy:

Chief Executive
Chief Finance Officer
Chief Operating Officer
Chief People Officer
Director of Strategy, Transformation and Partnerships
Either the Chief Medical Officer or the Chief Nursing Officer

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

Attendance

The following will usually be in attendance:

Divisional Senior Manager representation
Head of Corporate Governance
Associate Director of Performance

Other Directors and Officers of the Trust and independent advisors will be required to attend the Committee to present reports and assist the Committee in its consideration of investments.

Quorum

The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

Frequency

The Committee shall meet not less than 10 times per financial year. The Chair of the Committee may convene additional meetings as they deem necessary.

Members the Committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The Committee has the following specific duties and functions:

a. Finance

Financial Strategy

- Consider the Financial Strategy, ensuring that the financial objectives of the Trust are consistent with the strategic direction.
- Periodically review the medium- and long-term Financial Strategies.
- Review key medium term planning assumptions.
- Review external publications around the financial and operating environment and their link to planning assumptions and models.

Monitoring of the Financial Position

- Monitor the achievement of the financial strategy, financial targets and associated activity targets.
- Regularly scrutinise financial performance, trends, projections and underlying data.
- Oversee the development of financial reporting, to include:
  - Appropriate emphasis on interpretation of the financial position and development of corrective plans where necessary.
  - Structuring monitoring reports around the key financial statements, income and expenditure, balance sheet, cash flow, capital, efficiency savings, and Service Line Reporting when implemented.
  - Developing high level metrics to focus the Committee on areas where corrective action may need to be developed.
  - Linking the narrative to implications of compliance with the FT licence, in particular the financial and governance risk ratings.
- Consider the annual reference costs and review profitability analyses.

Business Case Consideration and Capital Programme Management

- Scrutinise an assure major investments and disinvestments proposals.
- Seek assurance of the overall controls which govern business case investments, using NHSI's guidance on Risk Evaluation for Investment Decisions. In accordance with the Reservation of Powers and Scheme of Delegation rigorously scrutinise business cases.
- Seek assurance that robust processes are followed, evaluating, scrutinising and monitoring investments and disinvestments so that benefits realisation can be confirmed.

- To ensure testing of all relevant options for larger business cases
- Focus on financial metrics within business cases e.g. payback periods, rate of return etc.
- Oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board of Directors accordingly.

Other Financial Matters

- Provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge.
- Consider ad hoc financial issues that arise (e.g. check Private Patient Cap, estate revaluation etc.)
- Develop the Trust's Treasury Policy in line with NHSI's guidance on Managing Operating Cash.
- Scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.
- Consider such other matters and take such other decisions of a generally financial nature as the Board of Directors shall delegate to it.

The Committee will be exclusively responsible for determining the selection criteria; selecting, appointing, and setting the Terms of Reference for any external consultants who advise the Committee.

b. Performance

- Review performance against key national, local and internal targets and indicators.
- Review exception reports and action plans for those targets and indicators where delivery is at risk.
- Review the contractual risk attached to non-achievement of national and local targets.
- Agree the composition of the performance scorecard on an annual basis.
- Receive a view of performance against relevant national productivity metrics and agree action where performance falls below agreed benchmarks.

c. Subsidiary Companies and Joint Ventures

Where the Trust establishes either a subsidiary company or a joint venture, the Finance and Performance Committee will be responsible for maintaining oversight of the activity and governance arrangements surround each respectively. The Committee will ensure that the Trust's Standing Financial Instructions and Scheme of Delegation reflect the delegated authorities provided under each arrangement and seek assurances of compliance on behalf of the Board. The Committee will require the following after a meeting of any subsidiary company or Joint Venture Board:

- Summary of activities undertaken and decisions made

- A report assuring statutory compliance with applicable regulations and submission of statutory returns
- Timely escalation of identified risk and mitigating actions agreed.

d. General

- Review its own performance, constitution and Terms of Reference on an annual basis to ensure it is operating at maximum effectiveness.
- Review and approve Trust policies that fall within its remit.

Policy Approval

1. Approving strategies that are within the remit of the Committee and are deemed appropriate for Committee approval by the Board, as provided for in the Trust's Standing Orders.
2. Ratifying policies approved by the sub-committees that report to this Committee on behalf of the Board, ensuring that due process has been followed.

Maintaining Board Oversight

In line with recommendations outlined in the NHSE/I review of Board Non-Executive Director Board Champion roles undertaken in 2021 and the subsequent guidance published in December 2021 *Enhancing Board Oversight: A new approach to NED champion roles,* the following responsibilities were remitted by the Board in January 2022 to be discharged by the Finance and Performance Committee:

- Procurement
- Cyber security

Reporting

The Chair of the Committee will report in writing to the Board at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the Committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive for action.

The Chair of the Committee will also attend the Audit Committee to provide assurance on the Committees processes and the work that it has undertaken.

The Committee will receive Exception Reports from the sub-groups that it formally establishes to enable timely escalation of any issues. The core business of the sub-groups is routinely reported through the Agenda of the Committee. The Committee has established the following sub-committees:

- Better Value Better Care
- Medical Devices Group

- Sustainability and Travel Working Group
- Capital Planning and Space Utilisation
- Elective Performance Management Group
- Emergency and Resilience Planning Group
- Digital Portfolio Group

The Committee will also receive reports on activities and assurances of regulatory compliance from:

- DCH Subco Ltd
- Dorset Estates Partnership Joint Venture

Administration

The Finance and Performance Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in 12 months unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors.

Approved by Finance and Performance Committee on
Ratified by the Board – Date

Dorset County Hospital NHS
NHS Foundation Trust

Finance and Performance Committee Work Plan: Proposed Work plan overarching priorities 2021/22

The Finance and Performance Committee (FPC) work plan reflects the Board Assurance Framework (BAF) strategic objectives 'Collaborative: working with patients and partners', 'Sustainable: Productive, effective and efficient' and 'Integrated: Joining up our services' and is aligned to national priorities integrated care provision that provides efficient and effective use of resources.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to optimise integrated care provision across the local health and social care system as the country emerges from the pandemic and as in line with the national direction to promote collaboration between system partners in support of Integrated Care System (ICS) development. The work plan will be consider the Trust's risk appetite, including financial implications of the emerging agenda.

FPC has an administration and reporting plan that underpins its agenda planning on core business of the committee, such as activity and financial performance reports, annual sub-groups reporting etc. The administration plan supports the effective organisation and management of financial and partnership governance and associated standards, including:

- Risks management relating to finance and activity,
- Assurance and identification of any gaps in control in improvement to deliver the strategic objectives
- Lessons learnt that aid improvement and learning to improve efficiency in performance and financial sustainability
- Adherence to national guidelines and contractual standards
- Service transformation, estates and infrastructure development and the wider partnering agenda
- Policies that apply to financial management.

To support this work FPC propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous service improvement and efficiency. They reflect the learning over the last year and the recovery priorities for the NHS and Trust in the forthcoming year.

FPC will undertake quarterly deep dives on key risk areas in order to gain a higher level of assurance and challenge.

Underpinning these priorities are key themes and enabling strategies that will support delivery of the overall objectives. These include: Digital Strategy; collaborative system working; capacity and demand as outlined in the business planning assumptions; Estates Strategy; and the Peoples' Strategy. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded.

Work plan priorities	Regulatory Reference	Outcome
1. Planning framework including: ▪ H1 and H2 submission; and ▪ Elective service recovery ▪ ERF trajectory monitoring	BAF Risk Objective 2, 3, 5 CRR 919, 709, 710, 641, 461 CQC Domain: Effective, Well Led	H1 and H2 financial plans submitted to timetable and the actual performance delivered the financial plan by the end of year. Waiting list reduction and clock stopping activity

Work plan priorities	Regulatory Reference	Outcome
		delivered in line with the H" planning guidance requirements
2. Winter Plan: ▪ Surge demand and capacity plan ▪ Associated workforce models for escalation areas and increased emergency activity	BAF Risk Objective 1, 2 CRR 919, 450, 461 CQC Domain: Effective, Well Led	Covid 19 waves were significant in the final Quarter and tested the Surge Plan fully. Pre-planning on low cost agency and bank pre-booking for surge areas worked very well and gave confidence for continuous opening throughout the period, however additional areas were required due to volume of admissions and increasing number of NRTR patients.
3. Underlying financial deficit: ▪ understanding the con: ▪ text of this on the trust as well as the rest of the ICS and the consequences on the deficit once the implications of the H2 planning period are known	BAF Risk Objective 5 CRR 919 CQC Domain: Effective, Well Led	The underlying deficit has crystallised as a consequence of the planning guidance for 22/23 and the removal of CoVID funding. System financial recovery programme under construction.
4. Capital Programme, in particular the two key strategic projects but also the risks associated with the internal programme: ▪ ED15; and ▪ HiP2	BAF Risk Objective 5 CRR 919 CQC Domain: Effective, Well Led	SOC submitted and approved for HiP2 and OBC under construction. ED15 due to complete in summer 2022. Capital Programme for 21/22 exceeded £26m.
5. In year performance monitoring: ▪ Operational standards; and ▪ Performance against the H1 and H2 Financial Plans	BAF Risk Objective 1, 2, 3 and 5 CRR 919, 709, 710, 461 CQC Domain: Effective, Well Led	H1 and H2 financial plans delivered by year end 21/22.

To support the above, ongoing communication and triangulation will be required with other Board committees. The assurance responsibilities and key priorities / work streams of other sub-board committees that link to the work of FPC are outlined below:

Shared Priorities with other Sub-Board Committees	
Sub-Board Committee Work Plan Priorities	**CQC / BAF / Recovery / Annual Plan Reference**
1. Quality Committee (QC): Waiting list recovery, clinical validation and harm reviews FPC will oversee and link performance indicators / information that relate to this priority (e.g. length of wait, Activity, discharge data, average length of stay, bed occupancy, partnership arrangements) FPC will oversee recovery activity in line with national guidance with QC maintaining oversight of the clinical impact of long waiting times and clinical prioritisation.	BAF Risk Objective 1, 2, 3 and 5 CRR 919, 709, 710, 463 CQC Domain: Effective, Well Led
2. People & Culture Committee (PCC): Staff recovery aligned with Safe Staffing / staff experience FPC will oversee expenditure to support delivery of the Safe Staffing and provision of equipment and services to ensure staff are able to operate in a safe environment and that sufficient resources are available to ensure their ongoing well-being.	BAF Risk Objective 5 CRR 919, 710 CQC Domain: Effective, Well Led
3. Risk & Assurance Committee (RAC): Risks related to operational recovery and the Trust strategy FPC will keep under review the trust's appetite on financial risks in its decision making, triangulating these with the trust's appetite for ensuring safe outstanding care; recording and escalating risks to the Corporate Risk Register and BAF.	BAF Risk Objective 3 CRR 919 CQC Domain: Effective, Well Led
4. Digital Portfolio Board (DPB): FPC will maintain oversight of the expenditure required to support delivery of the digital infrastructure, balancing and triangulating this with information and safety priorities identified by other Board sub-committees in line with the Trust's appetite for risk.	BAF Risk Objective 3 CRR 919 CQC Domain: Effective, Well Led

Finance and Performance Committee Work Plan: Proposed Work plan overarching priorities 2022/23

The Finance and Performance Committee (FPC) work plan reflects the Board Assurance Framework (BAF) strategic objectives 'People', 'Place' and 'Partnerships'.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to optimise integrated care provision across the local health and social care system as the country emerges from the pandemic and as in line with the national direction to promote collaboration between system partners in support of Integrated Care Board (ICB) development. The work plan will consider the Trust's risk appetite, including financial implications of the emerging agenda.

FPC has an administration and reporting plan that underpins its agenda planning on core business of the committee, such as activity and financial performance reports, annual sub-groups reporting etc. The administration plan supports the effective organisation and management of financial and partnership governance and associated standards, including:

- Risks management relating to finance and activity,
- Assurance and identification of any gaps in control in improvement to deliver the strategic objectives
- Lessons learnt that aid improvement and learning to improve efficiency in performance and financial sustainability
- Adherence to national guidelines and contractual standards
- Service transformation, estates and infrastructure development and the wider partnering agenda
- Policies that apply to financial management.

To support this work FPC propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous service improvement and efficiency. They reflect the learning over the last year and the recovery priorities for the NHS and Trust in the forthcoming year.

FPC will undertake quarterly deep dives on key risk areas in order to gain a higher level of assurance and challenge.

Underpinning these priorities are key themes and enabling strategies that will support delivery of the overall objectives. These include: Digital Strategy; Clinical strategy collaborative system working; capacity and demand as outlined in the business planning assumptions; Estates Strategy; and the Peoples' Strategy. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded.

Work plan priorities	Regulatory Reference	Outcome
1. Planning framework including: ▪ 2022/23 Operational Plan submission; and ▪ Elective recovery – ▪ ERF 101% against 2019/20 baseline ▪ 104/ 78/ 52 week waits against stated reductions ▪ Virtual Appointment trajectory	BAF Risk Objective PL 1.3, PL 1.6, PL 1.9 CRR 919, 1221, 641, 461, 690 CQC Domain: Effective, Well Led	

Work plan priorities	Regulatory Reference	Outcome
▪ PIFU take up trajectory ▪ System commitment to NRTR reduction		
2. Seasonal Surge Plan: ▪ Surge demand and capacity plan ▪ Associated workforce models for escalation areas and increased emergency activity	BAF Risk Objective PL1.5, PL 1.6 CRR 919, 450, 461, 690, 463, 468 CQC Domain: Effective, Well Led	
3. Financial recovery of underlying deficit: ▪ Delivery of the £20m system Financial Improvement Programme (FIP) and the DCH elements (once identified) ▪ Delivery of the 2022/23 CIP target (£5.7m)	BAF Risk Objective PL 2.2, PL 2.3, PA 2.1, PA 2.2, PA 2.3 CRR 919, 1252 CQC Domain: Effective, Well Led	
4. Capital Programme, in particular the key strategic NHP project but also the risks associated with the internal programme: ▪ NHP and ▪ Completion of ED15	BAF Risk Objective Pl 2.1 CRR 919, 1252 CQC Domain: Effective, Well Led	
5. In year performance monitoring: ▪ Operational standards; and ▪ Performance against the 2022/23 Financial Plans	BAF Risk Objective PL 1.3, 1.5, 1.6, 1.9, 2.1, 2.2, 2.3 PA 2.1, 2.2, 2.3 CRR 919, 1221, 461, 450, 472 CQC Domain: Effective, Well Led	

To support the above, ongoing communication and triangulation will be required with other Board committees. The assurance responsibilities and key priorities / work streams of other sub-board committees that link to the work of FPC are outlined below:

Finance and Performance Committee Work plan - 2022/23

	Author	Committee Action	Frequency	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance Reporting															
Operational Performance ~~inc Divisonal Exception reports~~ incluing verbal Covid-19 updates and EPMG updates	AS	Note	Monthly												
Divsional Escalation Reports	SC/AM	Note	Monthly												
Finance inc monthly and predicted year end outturns, CIP and deficit position	PG/CA	Note	Monthly												
EPRR Assurance Report (Annual)	Mark Taylor	Approve	Annual												
Cyber security and risk upates	SS	Note	Quarterly												
Financial assurance															
Business planning Process for next year (to approve)	PG	Approve	Annual												
Draft Budgets to be approved	PG	Approve	Annual												
Final budgets to be approved	PG	Approve	Annual												
NHSI Draft Operational Plan to be approved	PG	Approve	Annual												
NHSI Final Operational Plan to be approved	PG	Approve	Annual												
Review of cash flow reporting and borrowing requirements - only in the event of cash flow issues - ad hoc report	PG	Approve	Annual							Ad hoc report if needed					
Assurance on Financial Reforecast Process	PG	Approve	Annual												
Update on Invest to save in Recruitment team and impact on Agency excpenditure	HH	Note	Quarterly												
Business and investment cases/contracts	Ad-hoc	Approve	Monthly												
Operational Performance assurance															
Post investment business case review	SC/AM	Note	Annual												
Seasonal Surge Plan	AT	Approve	Annual												
Referrals From Other Committees	Ad-hoc	Ad-hoc	Monthly												
Estates and Facilities Assurance															
Capex Risk Mitigation - assurance on mitigation processes for projects delayed	PG	Note	Annual												
Strategic Estates Masterplan update	BP	Note	Quarterly												
ED 15 Update	Toby Hood	Note	Bi-monthly												
Premises Assurance Model	DT	Approve	Annual				Deferred to Sept 22								
Strategic Estates Partnership including Business Cases															
DEP Management Board - Activity and escalation report - as and when	NJ	Note	?												
Governance															
DCH Subco Ltd - Quarterly Performance Report to shareholder	Andy Harris	Note	Quaterly	Q4			Q1			Q2			Q3		
DCH Subco Annual Performance Report and Financial Statements - prior to Board Approval	Andy Harris	Note	Annual												
DCH Subco Terms of Reference	TH	Approval	Annual												
Board Assurance Framework	Ciara Darley	Note	Bi-monthly												
Other															
Review of Terms of reference, Work Plan and Priorities	TH	Approval	Annual												
Review of Effectiveness of FPC	TH	Approval	Annual												
Escalation Reports															
Better Value Better Care Group - assurance review on CIP	PG	Note	Monthly												
Capital Planning and Space Utilisation to include reports from- Space utilisation, sustainability and capital planning. Head of EFM to attend	PG	Note	Monthly												
DCH Subco Escalation Report	Nick Jones	Note	Quarterly												
Sustainablity and Travel working group	Isabel Bourne	Note	Bi-monthly												
Digital Portfolio Board	SS	Note	Quarterly												
Medical Devices Group	Matthew Hough	Note	Bi-monthly												
Emergency and Resilience Planning Group	AT	Note	Bi-monthly												
Digital Portfolio Group	SS	Note	Quarterly												

PEOPLE AND CULTURE COMMITTEE PRIORITIES AND WORKPLAN 2022/23

Executive Summary

The People and Culture Committee (PCC) work plan reflects the overarching Trust strategy and the Board Assurance Framework (BAF) objectives. The three People elements of the Trust strategy are:-

- 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

The priorities and work plan align with the delivery of the 2022-25 People Plan and with the NHS People promise, supporting development of an inclusive culture and staff experience that underpins effective workforce supply and redesign, retention and availability and inclusive leadership.

Key People metrics in the monthly People Dashboard and wider finance and performance data are used for monitoring and assurance.

In addition, PCC receives regular divisional performance updates and undertakes deep dives on key areas to gain a higher level of assurance and challenge.

This paper outlines an overview of progress against 2021/22 committee priorities and proposes priorities and work plans for the coming year (appendix 1-3).

These align to CQC 'well-led' requirements and the Board Assurance Framework (BAF).

1. Delivery against 2021/22 priorities

- **Deliver the 'Transforming people practices' programme to support inclusive culture development (Recruitment, Appraisal & succession planning, Performance management & disciplinary) and positively impact retention and availability** – This programme of work remains on track and improvements in DCH's inclusive culture are reflected in National Staff Survey (NSS) results and WRES indicators embedded within this.

- **Supporting retention and availability through Health and Wellbeing focus** - Wellbeing focus accelerated throughout 2021 as staff came under increasing Covid related pressure. The DCH and System wellbeing offer is extensive and well utilised, yet anxiety, stress and depression remain the top reason for absence and sickness overall averaged 1% higher over the year. Staff turnover increased by approximately 2% over the period. Despite this, DCH NSS results show an improvement in staff feeling their manager takes an interest in their health and wellbeing.

- **Continuing to grow opportunities for Education and Development and deliver social value as an anchor organisation –** Despite the continued challenging environment caused by ongoing pandemic response, apprenticeships have continued to grow across DCH and the Kickstart scheme, a key element of our social value proposition was an enormous success with almost all participants securing ongoing employment at DCH.

- **Increasing Workforce Planning and redesign capacity to address workforce supply challenges –** Workforce planning, and redesign capacity has increased from 1 WTE to 2.6 WTE through restructuring of the People Division and securing funds as part of the New Hospital Programme. The additional capacity is aligned to clinical and non-clinical divisions and a dedicated resource will soon be working as part of the New Hospital Programme. This will further support ability DCH's ability to develop new roles and ways of working to improve recruitment and retention.

- **Reduce Bank and Agency Usage by improving supply, retention, and availability -**The continued challenging context and ongoing response to staff shortages driven by Covid have impacted ability to reduce temporary spend. Agency spend continues to track above target but has decreased from a high of over 8% to below 6%. This has mainly been driven by a reduction in medical agency spend and the beginnings of increased bank engagement and use. Work to improve this position is ongoing and tracked through FPC.

2. 2022/23 Priorities

The priorities outlined in the appendix below reflect the 2022-2025 People Plan, an enabler to deliver the Trust strategy:-

- 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

3. Conclusion

This has been a challenging year for People at DCH. The work on creating inclusive cultures has supported improvements in a staff experience for minority communities and the accelerated health and wellbeing focus is reflected in DCH's NSS results.

Successful participation in the Kickstart scheme, adding social value as an anchor organization is to be celebrated and this work will continue through widening participation approaches.

Workforce planning and redesign capacity has increased and a robust multi professional work program to reduce agency spend is in place with green shoots of improvements emerging.

During 2022/23 the direction of travel set out in the People Plan will build on this work and the People Dashboard and PCC workplan will continue to provide PCC with assurance on progress.

4. Recommendation

The Board is recommended to:-

1. **NOTE** the report.

2. **APPROVE** the 2022/23 priorities and workplan and Terms of Reference.

Name and Title of Author: Dawn Harvey
Date: 06.05.2022

Appendices
Appendix 1 – PCC Terms of Reference
Appendix 2 – PCC Priorities
Appendix 3 – PCC Workplan

Dorset County Hospital NHS
NHS Foundation Trust

People and Culture Committee priorities 2022/23

The People and Culture Committee (PCC) priorities reflect the overarching Trust strategy, the enabling People Plan, and the Board Assurance Framework (BAF) objectives. The three People elements of the Trust strategy are:

- 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

The priorities and those shared with other Board Sub-Committees reflect the need to attract and retain a workforce aligned with our commitment to sustainability, i.e.

- 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.

Local and national workforce key performance indicators are used for monitoring and assurance e.g. monthly people performance dashboard, national staff survey data, WRES and WDES data.

The PCC receives regular divisional performance updates and undertakes deep dives on key areas to gain a higher level of assurance and challenge. PCC has shared priorities with Quality Committee relating to safe staffing and quality and with Finance and Performance Committee relating to management of temporary staffing spend.

PCC propose these overarching priorities (below) which align to the CQC 'well-led' requirements and the Board Assurance Framework (BAF).

Work plan priorities	Regulatory reference	How will we know we achieved it?
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	CQC ref: Well-led BAF risk objective: PE 1.1 PE 1.2 PE 2.1 PE 3.1 PE 3.3	Sustainable workforce plans are in place at care group level based on demand and capacity planning Reduced temporary spend Career pathways in place across professions Positive improvements in the monthly People Performance Dashboard in:

Work plan priorities	Regulatory reference	How will we know we achieved it?
where staff feel safe themselves We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect		• Turnover • Vacancy gap by profession • Agency & temp spend • Mandatory training • Inclusive leadership attendance data • Appraisal compliance • Appraisal quality data • Exit interview thematic analysis • Shortlist to hire equalities data • Increased diversity in roles 8a & above • Apprenticeship and widening participation growth • National staff survey • Quarterly pulse check • WRES, WDES and gender pay gap • FTSUG data and thematic analysis • Shift from formal to informal resolution of ER issues • Guardian of safe working reports
Underpinning fundamental CQC standard – WELL LED		

To support the above the ongoing triangulation across committees will be required. Below outlines key priorities/ work streams the other sub-board committees have assurance responsibility for that link

Shared Priorities with other Sub-Board Committees	
Work plan priorities	**Sub-Board committee/ CQC/BAF reference**

1. Quality Committee (QC): Staff recovery aligned with Safe Staffing/ staff experience QC will oversee and link any quality and safety indicators/ information that relate to this priority (e.g., incidents, complaints, patient experience, clinical outcomes, clinical audit, legal claims, safety reports, external and internal inspections) This will also include any Health and safety at work related to Covid-19 (PPE/ space and IPC practices and testing). In addition staff wellbeing and health promotion aligned to staff staffing, including protecting high risk staff groups (e.g.: immune suppressed staff; BAME)	CQC domain: Safe and Well-led BAF risk objective
2. Finance and Performance Committee (FPC): Staff recovery aligned with Safe Staffing / staff experience FPC will oversee expenditure to support delivery of the Safe Staffing and provision of equipment and services to ensure staff are able to operate in a safe environment and that sufficient resources are available to ensure their ongoing well-being.	BAF Risk Objective CQC Domain: Effective, Well Led

TERMS OF REFERENCE
PEOPLE AND CULTURE COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the People and Culture Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The Committee is invested with the delegated authority to act on behalf of the Board of Directors. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee (above) and subject to the rules on Reporting, as defined below. The Committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Committee in the conduct of its inquiries.

The Committee is authorised by the Board to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

The Committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Committee but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The purpose of the Committee is to be responsible to the Trust Board for oversight of the development and delivery of the 'People' pillar of the Trust Strategy. The committee will monitor delivery of the People Plan and Objectives. Consideration will be given to matters relating to People and Organisation Development with responsibility for workforce planning and redesign, attraction and recruitment, retention, leadership development and talent management; education and training; people policies, processes, and systems; equality, diversity and inclusion, health and wellbeing and developing a culture that supports a great experience for all staff.

The Committee will ensure that leadership style and supporting employment processes are in place to embed the values and behaviours of the organisation and will assure the Board on statutory and regulatory compliance requirements including CQC essential standards.

Membership

Membership of the Committee will be appointed by the Board and shall consist of Three Non-Executive Members; one of which will be appointed by the Board as Chair and the following:

- Chief People Office
- Chief Executive
- Chief Operating Officer
- Chief Nursing Officer
- Medical Director
- Director of Strategy, Transformation and Partnerships

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

In attendance will be:

- Deputy CPO
- Medical Workforce Representative
- Director of Medical Education,
- Head of Education
- Head of Workforce Resourcing,
- Head of HR Operations
- Workforce Business Partners
- Head of Organisation Development
- Divisional Manager for Surgery and Family Services
- Divisional Manager for Urgent and Integrated Care

Three governors will be invited to attend each meeting as observers.

Other individuals may be invited to attend for all or part of any meeting, as and when required for particular agenda items.

Quorum

A quorum shall be two Non-Executive Directors and two Executive Directors. No business shall be transacted unless the meeting is quorate. A duly convened meeting of

the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.

Frequency of Meetings

The Committee shall meet not less than 10 times per financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

Members the Committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The People and Culture Committee will:

- Oversee the development and delivery of the People Plan and objectives
- The Committee will give particular attention to the delivery of the following;
    - Workforce planning & redesign that utilises skills mixing and new roles to support productivity, efficiency, and long-term sustainability of the workforce.
    - Attraction and retention
    - Apprenticeships, widening participation and adding social value through employment opportunities
    - Inclusive culture development
    - Equality and Diversity
    - Implementation of just and learning culture and aligned people policies
    - Freedom to Speak Up
    - Leadership and management development
    - Learning, Development, Personal Growth
    - Talent Management, appraisal, and succession planning
    - Health, Safety and Wellbeing
    - Consider external and national workforce developments and best practice and oversee the Trust contribution to system wide people strategy
    - Seek assurance on behalf of the Trust Board for the response to people risks which appear on the Board Assurance Framework and on the Corporate Risk Register.
    - Seek assurance on behalf of the Trust Board that workforce systems, practices and policies are in place to support safe staffing across the Trust.
    - Oversee the performance on workforce KPIs and the increased effectiveness and efficiency of workforce functions.
    - Ratify and approve policy which falls under its remit as part of the governance arrangements for policy development.
    - Seek assurances on behalf of the Board that arrangements are sufficient and effective in respect to the Guardianship of Safe Working Hours.
    - Seek assurances on behalf of the Board that Health and Safety arrangements within the Trust are effective.

- To review its own performance, constitution and terms of reference on an annual basis to ensure it is operating at maximum effectiveness.
- To review and approve Trust policies that fall within its remit.
- To set the direction and monitor the work of the reporting groups that inform the work of the Committee () and receive, review and ratify the Minutes of said groups.

Maintaining Board Oversight

In line with recommendations outlined in the NHSE/I review of Board Non-Executive Director Board Champion roles undertaken in 2021 and the subsequent guidance published in December 2021 *Enhancing Board Oversight: A new approach to NED champion roles,* the following responsibilities were remitted by the Board in January 2022 to be discharged by the Risk and Audit Committee:

- Security Management – violence and aggression

Reporting

The Chair of the Committee will report in writing to the Board at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the Committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive for action.

The Chair of the Committee will also attend the Audit Committee to provide assurance on the Committees processes and the work that it has undertaken.

The Committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Committee has established the following sub-committees:

a. Equality, Diversity & Inclusion Steering Group

b. Operational Education Group

c. Medical Education Group

d. People Recovery Steering Group

e. Medical and Dental Local Negotiating Committee

f. Partnership Forum

The Committee will also receive Escalation Reports from Divisional Leadership / Governance meetings and Divisional representation at committee will be required.

Administration

The People and Culture Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in 12 months unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors.

Approved by the People and Culture Committee
Ratified by the Board –

People and Culture Committee Work plan - 22 23

	Frequency	Author	Committee Action	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Standard Reporting and Metrics												
People Performance Report and Dashboard	Monthly	Emma Hallett	Note	x	x	x	x	x	x	x	x	x
People Plan Progress - Annual Review	Annual	Emma Hallett	Note									
Bank and Agency Usage and Expenditure Report	Quarterly	Hilary Harrold	Note	x			x			x		
Staff Survey results	Annual	Julie Barber	Note									
Board Assurance Framework	Bi-Monthly	Ciara Darley	Note		x		x		x		x	
We will look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes												
Workforce Planning Progress and Insights	Bi-Annual	Sara Collinson/Sam Dewar	Note				x					x
Leavers & Retention Report	Bi-Annual	Catherine Youers	Note			x					x	
Apprenticeship and Widening Participation Report (social value)	Bi-Annual	Elaine Hartley	Note			x						x
Workforce Health and Wellbeing Review	Bi-Annual	Julie Barber	Note					x				
We will create an environment where everyone feels they belong, they matter, and their voice is heard												
Freedom to Speak Up Report	Bi-Annual	Julie Barber	Note		x						x	
Equality, Diversity & Inclusion Report (Includes WRES and WDES)	Annual	Julie Barber	Approval				x					
Gender Pay Report	Annual	Catherine Youers	Approval									
We will improve safety and quality of care by creating a culture of openness, innovation and learning where staff feel safe themselves												
Ward Accreditation and Learning from Excellence Update	Bi-Annual	Emma Hallett	Note	x						x		
Just and Learning Culture Update	Bi-Annual	Catherine Youers	Note			x						x
Undergraduate Learner Feedback Update	Bi-Annual	Elaine Hartley	Note						x			
Review of Whistleblowing arrangements	Annual	Catherine Youers	Note								x	
We continue to create collaborative and multidisciplinary professional team working to maximise skills, knowledge, and respect												
Education, Training and Development Report (inc Maternity Education and Training - annually)	Bi-Monthly	Elaine Hartley	Note	x		x		x		x		x
Library services annual report	Annual	Elaine Hartley	Note									
GMC survey action plan	Annual	Elaine Hartley	Note						x			
Transactional People Processes as a Strategy Enabler												
Inclusive Recruitment Update	Bi-Annual	Hilary Harrold	Note						x			
Talent Management and Appraisal Report	Annual	Julie Barber	Note					x				
Divisional People reports												
FSS division	Bi-Monthly	Stuart Coalwood	Note	x		x		x		x		x
UIC division	Bi-Monthly	Andy Miller	Note		x		x		x		x	
Estates & Facilities	Quarterly	Don Taylor	Note		x			x			x	
Informatics / BI	Quarterly	Ruth Gardiner	Note	x			x			x		
Governance												
Workforce Risk Report	Quarterly	Mandy Ford	Note	x			x			x		
Medical Revalidation Report	Annual	Catherine Youers	Note			x						
Guardian of Safe Working Report	Quarterly	Catherine Youers	Note		x			x			x	
Sub Committee Escalation Reports												
Medical and Dental Local Negotiating Committee (LNC)	Bi-Annual	Catherine Youers	Note					x				
ED&I Steering Group	Quarterly	Julie Barber	Note		x			x			x	
People Recovery (Health and Wellbeing) Steering Group	Quarterly	Emma Hallett	Note	x			x			x		
Partnership Forum	Bi-Annual	Catherine Youers	Note						x			
Other												
Review of Terms of Reference, Workplan and Priorities	Annual	Trevor Hughes	Approval									
Review of Effectiveness	Annual	Trevor Hughes	Note									

Dorset County Hospital NHS
NHS Foundation Trust

Quality Committee Work Plan: Proposed Work plan overarching priorities 2022/23

The Quality committee (QC) work plan reflects the Board Assurance Framework (BAF) strategic objectives people, Place and Partnership, aligned to national priorities for safe, well-led, quality care. This is aligned to the CQC standards and any updated actions for continuous quality improvement.

This work plan has been updated to reflect any current learning from the Covid-19 pandemic, with ongoing review to fully integrate as part of our quality and safety priorities. This will be considered in line of the Trust risk appetite, including financial implications of Covid-19.

Quality Committee has an administration reporting plan that underpins its agenda planning on core business of the committee, such as quality performance report, annual sub-groups reporting etc. The administration plan supports the effective organisation management of clinical governance and associated CQC standards, including:

- Risks management relating to quality and safety
- Assurance and identification of any gaps in control in improvement to deliver the strategic objective
- Lessons learnt that aid improvement and learning to benefit quality, safe care and best practice including clinical audit.
- Clinical adherence to national guidelines or standards such as NICE
- Patient and public feedback including complaints, plaudits, surveys and patient involvement in services (such as volunteers experience and carers' experience).
- Policies that apply to quality and safety principles.

To support this work Quality committee propose these overarching work plan priorities (below) which align to the corporate risk register (CRR), Board Assurance Framework (BAF) and assist in the triangulation for continuous quality improvement. They reflect the learning over the last year and the restart, recover priorities for the NHS and Trust in the forthcoming year.

Quality Committee will undertake quarterly deep dives on key risk areas of safety to gain a higher level of assurance and challenge.

Underpinning all of these priorities are key themes that run as a golden thread, these are: Clinical Plan; People Plan; and Digital Plan. In addition, there may be other emerging strategies or guidelines that result in the priorities changing or being expanded as the ICS develops and embeds.

Work plan priorities	Regulatory reference
1. In partnership with the Digital Board to further develop the intelligence for the committee that includes key information needed for assurance and quality improvement and health inequalities. Strategy link: **Partnership**	CQC ref: Effective, Well-led BAF risk objective PA.1.2, PL 1.11, PL 3.1 CRR: 641, 464, 690
2. Quality improvement through a focus upon health promotion and health inequalities, including: - Assurance upon clinical pathways that reduce variation in outcomes in the population	CQC domain: Effective, Responsive BAF risk objective: PL 1.1, PL 1.2, PL 1.5, PL 1.6, PL 1.10, PL 3.1, PL 4.1, PL 4.2, PA 1.2

Work plan priorities	Regulatory reference
- Deep dives in clinical services led by the clinical divisional teams - Oversight and scrutiny of the clinical audits and learning from them that feed into quality improvement for improving health inequalities and outcomes (such as peer reviews/ Getting It Right First Time (GIRFT) Strategic Link: **Place**	CRR: 472, 840, 1221, 450, 464, 461
3. As part of recovery the need to balance quality, safety of patient experience with staff experience to achieve a blended quality improvement. Strategic Link: **Partnership**	CQC domain: Responsive, Well-led BAF risk objective: PA 1.3, PA 1.4, PA 3.1, PA 3.3, CRR: 461, 450, 1221, 919
4. Maternity and Neonatal Transformation for quality and safety: to provide oversight and assurance on the implementation of the Ockenden recommendations and the maternity and neonatal transformation programme Strategic Link: **Place & Partnership**	CQC domains: Safe, Well-led BAF Risk objectives: PL 1.1; PL 4.1; PL 4.2; PA 1.2; PA 1.3 CRR: 919; 1221
Underpinning fundamental CQC standards (Regulation8)	
Underpinning performance reporting on quality account quality priorities; contracted quality surveillance targets; and CQUINs	

To support the above the ongoing triangulation across committees will be required. Below outlines key priorities/ work streams the other sub-board committees have assurance responsibility for that link

Shared Priorities with other Sub-Board Committees	
Work plan priorities	**Sub-Board committee/ CQC/BAF reference (as of April 2022)**
1. Finance & Performance Committee (FPC): Waiting list recovery and harm reviews QC will oversee and link any quality and safety indicators/ information that relate to this priority (e.g. incidents, complaints, patient experience, clinical outcomes, clinical audit, legal claims, safety reports, external and internal inspections) As a result of the pause from Covid-19 waiting lists are longer, with potential impact on clinical and mental health of	CQC domain: Responsive BAF risk objective: PA 1.4, PL 1.2, PL 1.5, CRR: 1221, 472, 450, 461

those waiting for treatment. Clinical prioritisation in line with any revised guidance as part of Restart will have Quality Committee oversight and share with FPC.	
2. People & Culture Committee (PCC): Staff recovery aligned with Safe Staffing/ staff experience QC will oversee and link any quality and safety indicators/ information that relate to this priority (e.g. incidents, complaints, patient experience, clinical outcomes, clinical audit, legal claims, safety reports, external and internal inspections)	CQC domain: Safe and Well-led BAF risk objective: PE 1.1, PE 1.2, PE 3.1, PL 1.1 CRR: 468; 463; 979
3. Risk & Assurance Committee (RAC): Risks related to operational recovery and the Trust strategy QC will oversee and link any quality and safety indicators/ information that relate to the overall risk appetite and risk management. Key consideration of any indicators that will help inform this will be reviewed at QC and triangulated with the corporate risk register and BAF. Financial risks will be considered triangulated with safety.	CQC domain: Well-led Full BAF and Corporate risk register links
4. Digital Portfolio Board (DPB): the development of clinical pathways supported by digital innovation alongside the development of 'knowing how we are doing' in patient and staff experience with the development of business intelligence.	CQC domain: Effective, Well-led BAF risk objective PA.1.2, PL 1.11, PL 3.1 CRR: 641, 464, 690

TERMS OF REFERENCE
QUALITY COMMITTEE

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Quality Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board had has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The committee is invested with the delegated authority to act on behalf of the Board of Directors. The limit of such delegated authority is restricted to the areas outlined in the Duties of the Committee. The committee is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the committee in the conduct of its inquiries.

The committee is authorised by the Board of Directors to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

The committee is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Quality ommittee, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

The committee is authorised by the Board to delegate power to the Clinical Practice Group to approve all clinical policies, procedures and guidelines provided that at least one Clinical Director and one of the Chief Nursing Officer or Chief Medical Officer is in attendance.

Purpose

The purpose of the committee is to maintain oversight of the clinical strategies; scrutinising delivery of quality care and strategy outcomes in order to provide assurance to the Risk and Audit Committee and to the Board that risks to delivery of the clinical strategies are being managed appropriately. This would support the signing of the Annual Governance Statement and Quality Accounts. The committee will ensure that all aspects of quality governance, patient safety and experience are subject to scrutiny in order to provide assurance to the Board.

Additionally, the committee has responsibility for scrutinising and assuring delivery of relevant aspects of the Trust's 'Place' objective and ensuring that associated risks are

adequately mitigated; supporting the identification and promotion of shared learning, best practice and outstanding care.

Membership

Membership of the committee will be appointed by the Board and shall consist of three Non-Executive members; one of which will be a clinical Non-Executive who will be appointed as Chair and the following:

Interim Chief Executive
Chief Nursing Officer
Chief Medical Officer
Chief Operating Officer

Deputies

Executive members are expected to nominate suitable deputies to attend committee meetings in their place, should circumstances prevent members' own attendance.

In Attendance

Senior clinical divisional representatives will be required to attend the committee in order to provide an Escalation Report of key issues arising from Divisional Leadership / Governance meetings. Other members of Trust staff, including other Directors and Non-Executive Directors, may be invited to attend to present and/or discuss particular items on the Agenda, and up to three Public Governors will be invited to observe the meeting. Patients and/or carers may be invited to attend meetings of the committee to discuss particular items.

The Head of Corporate Governance or his/her nominee shall act as Secretary to the committee.

Quorum

The committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Chief Medical Officer). A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the committee.

Frequency of Meetings

The committee shall meet not less than 10 times per financial year. The Chair may request an extraordinary meeting if he/she considers one to be necessary.

Members the committee must attend at least eight of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The committee has the following primary duties and functions:

1. To approve the Trust's clinical strategies and Quality Priorities; scrutinising performance against Quality Account priorities.
2. To provide assurance to the Board of adherence to all of the areas of CQC work within the 5 domains reflecting the Key Lines of Enquiry;
3. To receive key regulatory and other inspection reports and scrutinise delivery of any associated action plans.
4. To provide a forum for scrutiny of any of the Trust's clinical quality indicators;
5. To provide assurance to the Board that risk within the Outstanding Care domain is being managed and to ensure that risks are escalated to the Board as appropriate.
6. To guide and instruct the direction of Clinical Audit on behalf of the Board where performance, incidents or strategic clinical risks are identified in order to provide assurance of improvement and effectiveness of mitigations to the Board.
7. To consider any national and/or strategic drivers that may impact on the quality agenda at the Trust.
8. To review the learning from complaints, incidents (serious incidents and Never Events) and claims and ensure all associated action plans are delivered and completed.
9. To monitor the development and implementation of the Trust's Quality Improvement Strategy

General

The committee will:

1. Review the adequacy of the Trust's clinical strategies and monitor delivery of outcomes;
2. Monitor strategic risks within the Board Assurance Framework and the Corporate Risk Register to ensure that risks are being managed and mitigated sufficiently, and that risks are escalated appropriately.
3. Receive details of all Serious Incidents, escalating to the Board where appropriate and receive assurance around the actions taken to prevent recurrence.
4. Monitor on-going compliance with Care Quality Commission Standards and seek assurance that any areas of weakness are being addressed.
5. Monitor on-going compliance with the Well Led element of the CQC Standards as they relate to the Board to ensure maintenance/improvement of the Trust's governance risk rating.
6. Monitor compliance in relation to safeguarding children and adults.
7. Ensure procedures stipulated by professional regulators of chartered practice (i.e. General Medical Council and Nursing and Midwifery Council) are in place and are complied with to a satisfactory standard.

8. Monitor the impact of Cash Releasing Efficiency Programmes and significant service changes on quality.
9. Receive updates on an exception basis against key strategies that are approved by the Committee and those that are approved by the Board where deemed appropriate, escalating to the Board as necessary

Clinical Governance:

1. Undertake in-depth reviews of the Clinical Quality Indicators reported to the Board.
2. Undertake scrutiny of the Quality Accounts to provide assurance to the Board and Audit and Risk Committee of their accuracy prior to approval.
3. Oversee the implementation and monitoring of the research programme and that the governance framework is implemented and monitored.
4. Approve and monitor the outcomes and learning arising from the Clinical Audit Plan and review the findings of all audits and the adequacy of the management responses. The committee will seek assurances as to quality improvements and how clinical risks have been identified and informed the Clinical Audit Plan.
5. Monitor the Patient Experience; through receipt of information relating to patient surveys, complaints, claims, PALS contacts and incidents.

In consideration of reports, the committee will review the improvement required, availability of resources and outcomes.

Policy Approval

1. Approve strategies that are within the remit of the committee and are deemed appropriate for committee approval by the Board, as provided for in the Trust's Standing Orders.
2. Ratify policies approved by the sub-committees that report to this committee on behalf of the Board, ensuring that due process has been followed.

Maintaining Board Oversight

In line with recommendations outlined in the NHSE/I review of Board Non-Executive Director Board Champion roles undertaken in 2021 and the subsequent guidance published in December 2021 *Enhancing Board Oversight: A new approach to NED champion roles,* the following responsibilities were remitted by the Board in January 2022 to be discharged by the 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

Reporting

The Chair of the committee will report in writing to the Board at the Board meeting that follows the committee meeting via an Escalation Report. This report will summarise the main issues of discussion and the Chair of the committee will ensure that attention is drawn to any issues, risks or decisions that require escalation to the Board or Executive for action.

The Chair of the committee will also attend the Risk and Audit Committee to provide assurance on the committee's processes and the work that it has undertaken.

The committee will receive Escalation Reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Committee has established the following sub-committees:

- Clinical Practice Group
- Medicines Committee
- Infection Prevention and Control Group
- Safeguarding Adults and Children Group
- Clinical Safety Group
- End of Life Care Group
- Patient Experience Group
- Mortality Group
- CQC Inspection Steering Group

The committee will also receive Escalation Reports from Divisional Leadership / Governance meetings and divisional representation at committee will be required.

Administration

The Quality Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in 12 months unless there is a requirement to do so earlier.

Appraisal

The committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors

Approved by Quality Committee – Date
Ratified by the Board –

Quality Committee Work plan - 2022/23

	Author	Committee Action	Frequency	April	May	June	July	August	September	October	November	December	January	February	March
SAFETY & QUALITY															
Quality aspect of integrated performance report: Patient Safety, Effectiveness and Experience Report - including safer staffing	Kerry Little	Note	Monthly												
Divisional escalation / exception reports - including Clinical Audit Outcomes, improvement actions & monitoring process, with particular reference to quality improvement.	Sonia/Jodie	Note	Monthly												
Learning from Deaths (Mortality) Report	AH	Note	Quarterly		Q4			Q1			Q2			Q3	
Transformation Update	Toby Hood	Note	Quartlerly												
Clinical Audit Bi-Annual Report (From Divisions - having been presented to the Divisional Governance meetings first)	Divisional Managers	Note	Bi-annual												
Maternity Safety Report	JH	Note	Monthly												
Continuity of Carer Report (Maternity)	JH	Note	Quarterly												
Board Assurance Framework	Ciara Darley	Note	Bi-monthly												
ANNUAL ASSURANCE															
Annual Quality Report	KL	Approve	Annual	DRAFT	FINAL										
Committee Annual Review of ToRs, workplan and priorities	TH	Approve	Annual												
Committee Annual Review of Effectiveness	TH	Approve	Annual												
Safeguarding Children and Aduts Annual Report	Sarah Cake	Note	Annual												
Infection Prevention and Control annual report	Emma Hoyle	Note	Annual												
Risk Management Strategy update	MF	Approve	Annual												
Annual patient surveys and action plan	Ali male	Approve	Annual												
Assurance Report on Nutrition Strategy	Kathryn Cockerell	Note	Annual												
QI Strategy Report	Toby Hood	Note	Bi-annual												
PLACE Annual Review	Sarah Jenkins	Note	Annual						TBC (Nationally set)						
Complaints Annual Report	Ali Male	Note	Annual												

TERMS OF REFERENCE
RISK AND AUDIT COMMITTEE

Constitution

The Board of Directors (the Board) hereby resolves to establish a Committee to be known as the Risk and Audit Committee (the Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee is authorised to establish short life working groups to undertake specific pieces of work and the Committee shall establish Terms of Reference accordingly. The Committee may not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Board.

Purpose

The principle purpose of the Risk and Audit Committee is to ensure that there are effective systems of financial and corporate governance, risk management and internal controls in place within the Trust and to provide assurance to the Board on the same. This includes financial, clinical, operational and compliance controls and risk management and corporate governance systems. The Committee is also responsible for maintaining an appropriate relationship with the Trust's auditors. To this end, the Committee will seek assurances from Board Committees regarding the scrutiny and oversight of the strategy and risks to achievement of the Strategic Objectives within the Board Assurance Framework and Corporate Risk Register; escalating these to the Board as necessary.

Membership

The Committee shall be appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of not less than three members (including the Chair), one of whom shall possess recent, relevant financial experience, the Chairs of other Board Committees and the following:

- Chief Finance Officer
- Deputy CEO / Director of Strategy, Transformation and Partnerships
- Chief Operating Officer
- Medical Director and or Chief Nursing Officer
- Chief Executive Officer (Annual Governance Statement and Accounts only)

Deputies

Executive Members are expected to nominate suitable deputies to attend Committee meetings in their place, should circumstances prevent members' own attendance.

Attendance

The following will normally be in attendance:

- Head of Internal Audit
- A representative from External Audit
- Local Anti-Fraud Specialist.
- Head of Corporate Governance (Minutes and to support the Chair)

The Chairs of the Quality, Finance and Performance and People and Culture Committees will attend to report on the assurance that their committees have obtained in relation to the monitoring and management of governance and risk in the areas of their responsibility and delegated authority at least annually.
At least once a year, the Committee shall meet privately with the External and Internal Auditors.

The Chief Executive and other Executive Directors may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

Up to three members of the Council of Governor will be invited to observe the meeting.

Quorum
The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors and two Executive Directors (one of which must be the Chief Nursing Officer or Medical Director). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.
The Chair of the organisation shall not be a member of the Committee.

Frequency

Meetings shall be held at least four times a year. The Chair of the Committee may convene additional meetings as they deem necessary. The External Auditor or Head of Internal Audit may also request a meeting if they consider that one is necessary.

Members the Committee must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The duties of the Committee are as follows:

Governance, Risk Management and Internal Control

The Committee shall ensure effective system of integrated governance, risk management and internal control is in place across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- processes to ensure appropriate information flows to the Risk and Audit Committee from Executive Management and other Board committees in relation to the Trust's overall internal control and risk management position in liaison with the Quality, Finance and Performance and People and Culture Committee Chairs.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Protect.
- The process for declarations of interest and gifts and hospitality

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Executive Directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

The Committee will use the Board Assurance Framework to drive its programme of work and that of the audit and assurance functions that report to it. The Committee will ensure that the Board Assurance Framework acts as a key driver of committee and operational plans and that it is appropriately informed by operational risks arising through the Corporate Risk Register and that mitigations are adequately identified to ensure delivery of the trust's Strategy.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Risk and Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment and ongoing provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.

- Review and approval of the Internal Audit strategy and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified by the Board Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall approve the Annual Counter Fraud Work Plan and review the outcomes of counter fraud work.

External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Develop and agree with the Council of Governors the criteria for the appointment, re-appointment and removal of the External Auditors.
- Make recommendations to the Council of Governors in relation to the above.
- Approval of the remuneration and terms of engagement of the External Auditor, supplying information as necessary to support statutory function of the Council of Governors to appoint, or remove, the auditor.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all External Audit reports and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Review and monitor of the external auditor's independence and objectivity and the effectiveness of the audit process, taking into account relevant UK professional and regulatory requirements.
- Ensure there is a clear policy in place for the engagement of External Auditors to undertaken non audit services.

Other Assurance Functions

The Risk and Audit Committee shall review the findings of other relevant significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Regulators/Inspectors (e.g. NHS Improvement, CQC, NHS Resolution, etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other Board committees within the organisation, whose work can provide relevant assurance to the Risk and Audit Committee's own scope of work.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Risk and Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Risk and Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Risk and Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of Representation.
- Qualitative aspects of financial reporting.

Quality Reporting

The Risk and Audit Committee shall monitor the integrity of the Trust's Quality Report and any formal announcements relating to the Trust's clinical outcomes and quality standards.

The Committee should ensure that the systems for quality monitoring and reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

The Risk and Audit Committee shall review the annual Quality Report before submission to the Board.

Reporting

The Chair of the Committee will report in writing to the Board, at the Board meeting that follows the Committee meeting via an Escalation Report. This report will summarise the main issues of discussion and decision making and the Chair of the Committee will ensure that attention is drawn to any risks or issues that require escalation to the Board or Executive for action.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the Quality Accounts.

The Committee will receive an Escalation Report from the sub-committees that it formally establishes that records key issues and decision making and escalation of risks and issues for the Committee's attention. The Committee has established the following sub-committees:

- Information Governance Group
- Health Informatics Project Board
- Winter / Emergency Planning and Resilience Group

Administration

The Risk and Audit Committee will be serviced by the Corporate Governance Team who will agree the agenda and Committee Work Plan with the Chair of the Committee.

Review

These Terms of Reference will be reviewed in December 2020 unless there is a requirement to do so earlier.

Appraisal

The Committee will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors via an Annual Report.

Approved by Risk and Audit Committee
Ratified by the Board – 26/05/2021

Risk and Audit Committee Cycle of Business 2022-23

	Author (exec)	Comm Action	Jul-22	Sept 22	Nov 22	Jan 23	Mar 23	May 23
Governance								
Review the BAF	CD (NJ)	Note	X	X	X	X	X	X
Corporate Risk Register	MF (NL)	Note	X	X	X	X	X	X
Review Standing Orders, SFIs, and Scheme of Delegation	TH/ML (PG)	Approve			X			
Review Losses and Special Payments	ML (PG)	Note						X
Review of Tender Activity and Waivers	ML (PG)	Review			x			
Annual Review of Risk Appetite	TH/NL	Review				x		
Annual Clinical Audit Assurance Report (Mapping the Clinical Audit Programme for the forthcoming year to the Corporate Risk Register, How clinical risks have been identified, managed and mitigated) AH and the divisional leads	AH, Divisional Leads	Note					x	
Charitable Funds Consolidation (Annual Accounts)	JC (PG)	Approve					X	
Review of accounting policies areas of estimation	ML, JC, JH (PG)	Note					X	
Going Concern Report	ML (PG)	Approve					X	
Engagement of External Auditors for Non-Audit Services Policy Annual Review	ML (PG)	Approve		X				
Annual EPRR Core Standards Self Assessment Assurance Statement (forward to Board)	EPRR Head (AT)	Recommend to B		X				
Annual Report and Accounts (inc Quality Account)								
Draft Annual Report and Accounts	DCH	Approve						X
Draft Quality Account	DCH	Approve						X
ISA 260 Report	KPMG	Receive						X
Annual Audit Report	KPMG	Receive						X
Draft External Audit Opinion	KPMG	Receive						X
Draft Letter of Representation	KPMG	Receive						X
Report on the Quality Account	KPMG	Receive	??					
External Audit - KPMG								
Agree final annual report and accounts timetable and plans	KPMG	Approve			X			
External audit plans and fees	KPMG	Approve					X	
Review the effectiveness of external audit	KPMG	Review		x				
Review external audit progress reports, technical update and benchmarking	KPMG	Review	N/A	X	X	X	X	X
Anti Crime (Previously Counter Fraud) - TiAA								
Approve the annual work plan	TiAA	Approve						X
Progress Report	TiAA	Review	X		X		X	
Review the effectiveness of counter fraud	TiAA	Review				X		
Review the annual report on counter fraud	TiAA	Review	X					
Self Review Tool	TiAA	Review						X
Internal Audit - BDO								
Review and agree work plan	BDO	Approve				Draft	Final	
Progress Report	BDO	Review	X	X	X	X	X	X
Recommendations Follow Up Report	BDO	Review	X	X	X	X	X	X
Internal audit reports - as per the Audit Plan	BDO	Review	EPRR	Temporary Staffing; Operational Business Planning	Safeguarding	Key Financial Systems	DSP Toolkit	Cross Health Economy Work
Review the annual effectiveness of internal audit	BDO	Review					X	
Internal Audit Annual Report and Annual Statement of Assurance, inc Head of Internal Audit Opinion	BDO	Review						X
Other								
Annual Declarations of compliance with License conditions (prior to May Board)	TH	Approve						X
Review of Terms of Reference	TH	Review					X	
Review of Effectiveness of Audit Committee	TH	Review					X	
Committee Workplan and Priorities	TH	Review					X	
Declarations of Interest and Register of Gifts and Hospitality	TH	Review					X	
Auditors meet Chair without management	N/A	N/A		X			X	
Referred items from other committees/emerging themes - as required	TBA	TBA	X	X	X	X	X	X
Escalations from Sub-Groups								
Information Governance Group	DG	Receive	X	X	X	X	X	X
Emergency and Resilience Planning Group	AT	Receive	X	X	X	X	X	X

Terms of Reference
DCH SubCo Limited Board of Directors

Constitution

The Board of Directors of DCH SubCo Ltd (the Board) is the key operational decision making body for the company and has delegated authority from the sole shareholder, Dorset County Hospital NHS Foundation Trust to make operational decisions as outlined within the Business Plan in line with the company's Articles of Association and financial limits established within the shareholder's Standing Financial Instructions.

Authority

DCH SubCo Board is invested with the delegated authority to act on behalf of the shareholder. The limit of such delegated authority is restricted to the areas outlined in the Articles of Association and matters reserved to Dorset County Hospital NHS Foundation Trust Board of Directors as the corporate shareholder. DCH SubCo Board is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Board in the conduct of its inquiries.

DCH SubCo Board is authorised by the shareholder to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

DCH SubCo Board is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Board, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Shareholder.

Purpose

The purpose of DCH SubCo Board is to review key contract and performance indicators, any safety and governance concerns and financial performance relating to DCH SubCo activity as a provider of Cancer Outpatient pharmacy services. Contract review meetings between DCH SubCo and the shareholder will take place on a quarterly basis and be reported to DCH SubCo Board at the following meeting. DCH SubCo Board will monitor the 5 year contract for the provision of outpatient pharmacy services to the shareholder and monitor the 3 year Service Level Agreement for the provision of services from the shareholder to DCH SubCo.

The Board will keep under review the operating model and take commercial decisions regarding the employment of staff, their terms and conditions of employment and medicines procurement arrangements, ensuring best value for money.

DCH SubCo Board will be responsible for delivery of the DCH SubCo growth strategy

Membership

The Board shall be appointed by the shareholder and will comprise the following as Directors of DCH SubCo Ltd:

- Non-Executive Director – Chair
- Commercial Director
- Director of Finance
- Pharmacy Director

The Head of Corporate Governance (DCHFT) will be in attendance as the Company Secretary.

Deputies

DCH SubCo Directors may appoint an alternative person to exercise Director's powers / carry out duties provided this is notified in writing or at a meeting of Directors and must be approved by the shareholder.

Quorum

DCH SubCo Board shall be deemed quorate if there is representation from three Directors. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Board. No decisions will be made should a meeting not achieve quorum.

Frequency of Meetings

The Board shall meet at least once each quarter. Members the Board must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The Board has the following duties and functions:

To monitor:

- service contracts with suppliers in order to ensure best value for money
- the contract and performance indicators with DCHFT
- financial performance ensuring a positive year end position is reported for the benefit of the shareholder and that the company remains a going concern.

- to maintain and report on mitigations to identified risks contained within the business plan (Changes to VAT / NHSE model / reductions in cancer drug spending)
- the outpatient lease arrangement
- directly employed staff terms and conditions, making recommendation on changes to the shareholder for approval where this may be necessary
- oversee the development of the company's annual report and accounts ensuring that this is independently audited and submitted to Companies House in a timely manner
- to mitigate risks as these are identified, escalating to the shareholder where necessary
- ensure that the shareholder is assured of the effective governance arrangements in place within DCH SubCo
- to review the Terms of Reference annually

Reporting

The Chair of DCH SubCo Board will report in writing to the shareholder's Finance and Performance Committee meeting that follows the Board meeting via a Performance and Escalation Report. This report will summarise the main issues of discussion and attention will drawn to any issues, risks or decisions that require escalation to the shareholder for a decision.

DCH SubCo Board will receive reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Board has established the following sub-committees:

- Contract Review Group
- Governance Review Group

Administration

The Board will be serviced by the DCHFT Head of Corporate Governance who will agree the agenda and Board Work Programme with the Chair.

Review

These Terms of Reference will be reviewed annually unless there is a requirement to do so earlier.

Appraisal

DCH SubCo Board will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the public sector Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors and shareholder annually.

Approved by DCH SubCo Board of Directors – 16th March 2022
Ratified by the Shareholder Finance and Performance Committee – Date

Remuneration and Terms of Service Committee
Terms of Reference

Constitution

The Board of Directors ("the Board") hereby resolves to establish a committee to be known as the Remuneration and Terms of Service Committee ("the Committee"). The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated to it via these Terms of Reference.

Authority

The committee is authorised to investigate any matter within its terms of reference and to be provided with the resources to do so. It also has the right of access to all information that it deems relevant to fulfil its duties and is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request from the committee.

The Committee has delegated powers to obtain any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary[1] and to determine the terms of reference for any remuneration consultants who advise the committee, in compliance with Trust procurement rules.

Purpose

The purpose of the Committee is to appoint and determine the starting salaries of the Chief Executive[2] and Executive Directors[3] and to review and make recommendations to the Board on its Executive composition, balance and skill mix, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise that are required within the Board to meet them. The committee is responsible for determining the remuneration packages for the Chief Executive and the Executive Directors and ensuring that adequate Executive succession planning arrangements are in place.

The committee is also responsible for maintaining oversight of special payment packages for the Chief Executive and Executive Directors ensuring that these represent value for money, and for approving exceptional and non-contractual payments[4]

[1] UK Corporate Governance Code Provision D.2.1
[2] Health and Social Care Act 2012
[3] Executive Directors includes non-voting members of the Board of Directors.
[4] 'Managing Public Money' – Treasury requirement for FTs to gain Treasury approval for non-contractual payments.

Membership

Membership of the Committee will comprise the Non-Executive members of the Board of Directors. The Chair of the Board shall be the Chair of the Committee; the Senior Independent Director may chair the meeting in his/her absence.

The Governor led Nominations and Remuneration Committee will be responsible for making recommendations regarding the appointment and remuneration of the Chair and Non-Executive Directors to the Council of Governors.

Quorum

A quorum shall be made up of four members.
No business shall be conducted unless a quorum is present.

Frequency of meetings

Meetings shall be held at least twice a year, but may be held more frequently should circumstances require (to be determined by the Committee Chair).

Attendees

The following are will normally be in attendance at each meeting:

- The Head of Corporate Governance,
- The Chief People Officer
- The Chief Executive, unless this is deemed inappropriate (for example, when discussing the Chief Executive's salary).
- Other Trust officers will attend as required by the Committee, at the request of the Chair.

Meetings are not open to members of the public or to Members of the Council of Governors.

Those in attendance do not count towards the quorum.

No independent external advisor shall be a member, nor have a vote on the Committee.

Committee's Duties

The duties of the committee are to:

- Ensure that the Board is effective in terms of its governance arrangements and composition and make recommendations to the Board for necessary changes
- To determine the starting salaries and remuneration package for the Chief Executive and Executive Directors and provide assurance that appropriate advice has been sought in so doing

- Ensure that succession planning arrangements are in place and that necessary action is taken to ensure the continued leadership of the Trust.
- Scrutinise non-contractual termination and special payment packages for the Chief Executive and Executive Directors, ensuring that these represent value for money.

The committee will execute these responsibilities through the following**:**

- Undertaking an annual review of the of the composition of the Board and make recommendations thereon
- Ensuring that appraisals are undertaken for Executive members of the Board in their capacity as Board members
- Ensuring that a robust appropriate process is in place for the appointment of the Chief Executive and Executive Directors and recommending the appointment of the Chief Executive to the Council of Governors.
- Approving a description of the role and capabilities required for the appointment of Executive Directors, taking into account the views of the Board of Directors on the qualifications, skills and experience required for each position
- Ensuring that the starting salary and remuneration of the Chief Executive and Executive Directors are sufficient to attract, retain and motivate high calibre individuals whilst ensuring that it is not more than necessary for this purpose.
- Determining the appropriate remuneration and terms of service of the Chief Executive and Executive Directors including:
    - All aspects of salary (including any performance related element/bonuses)
    - Provisions for other benefits, including pensions and cars
    - Agreement of contracts of employment and if applicable terms of office
    - Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as appropriate
- Consider any matter relating to the continuation of office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

Delegation

By approval of these Terms of Reference the Board delegates the following functions to the committee:

- Reviewing the composition and effectiveness of the Board on an annual basis and making recommendations to the Board thereon
- Researching market rates for the purpose of determining the remuneration for the Chief Executive and Executive Directors .

Scrutinising non-contractual termination or special payment packages for the Chief Executive and Executive Directors

Reporting

The committee is accountable to the Board of Directors and the Committee Chair will report regularly on the committee's proceedings.

The minutes of committee meetings shall be formally recorded and, as appropriate, made available to the Board of Directors.

On an annual basis, the committee will produce a Remuneration Committee Report in compliance with statutory and regulatory requirements for inclusion in the Annual Report.

Reporting Responsibilities

The committee chairman shall report to the Board on the proceedings after each meeting on all matters within its duties and responsibilities.[5]

Administration

The committee will be serviced by the Corporate Governance Team who will agree the agenda with the Chair of the committee

Review

These Terms of Reference will be reviewed on an annual basis unless there is a requirement to do so earlier.

Approved by the Board of Directors on

[5] FRC Guidance on Board Effectiveness, paragraph 6.2

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25 May 2022
Document Title:	**Draft Annual Quality Account 2021/22**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Kerry Little, Quality Assurance manager

Confidentiality:	*No*
Publishable under FOI?	Yes Once approved by Board and published

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	17 May 2022	

Purpose of the Paper								
	Note		*Discuss*	✓	*Recommend*		*Approve*	✓
Summary of Key Issues	Foundation Trusts are required to report on a prescribed set of Quality indicators in their Quality Accounts. Changes implemented this year have meant that the Quality Account no longer form part of the Annual Report and no external auditing of the report is required. The Report must conform with the specific requirements set out by NHS Improvement. Much of the information contained within is mandated; specific language and terminology must be applied. The source of the information contained within is also specified e.g. NHS Digital. Some of the information required is not nationally published until after the date of submission of the annual report; where this is applicable is noted within the report. The production of the Quality Report for 2021/22 remains affected by the national Covid pandemic. The impact has been: • Dorset CCG – will receive the DRAFT report, a statement is being produced and will be inserted as best practice following any recommendations made by the Quality Committee. • Although a suspension of Clinical Audit activity was announced, many of the national audits remained open on a voluntary basis, as specialities were keen to understand the impact of Covid-19, although publishing of reports was suspended. NCEPOD suspended all of their current studies during the pandemic. The responses from clinicians in relation to published reports have been affected as clinical priority took precedence over summarizing National reports. Some national audit data is also not available as a consequence. • Local clinical audit was suspended in line with the above. In reality some areas found they had capacity to carry on as part of quality improvement, and several Covid-19 related audits were registered							

	Key abridged Quality Report headlines: This report covers the period of April 2021 – March 2022. Quality achievements of particular success during this time period include: • Continued initiatives to support staff health and wellbeing • Reduction in falls which cause severe harm to our patients • Early identification and treatment of Sepsis and the Deteriorating Patient • Dorset wide launch of the Carers Passport in June 2022 Quality Report Priorities for 2022-2023: In line with published national guidance priorities for the forthcoming year are created, following engagement with all stakeholders. New priorities for 2022/23 are as follows: Priority 1 – • As part of the implementation of the Clinical Plan, DCH will work with system partners, to explore how to do things differently to understand and reduce health inequalities. Priority 2 – • Continued focus of the All-Cause Deterioration pathway and the Clinical Deterioration Proforma. • Work with the Integrated Care System Infection Prevention and Control Team. Networks will be available to support primary care and local patients, families and carers. Public Health will be working within this 'System Team' to integrate their work alongside the ICS IPC Team. Completion: • There are challenging timescales in which to complete the Annual Quality Account to ensure Trust Board sign-off prior to its submission through publication onto our internet site. With this in mind, We ask the Quality Committee to be mindful the draft report contains a few actions and additions to complete before Board Sign off. (these are referenced within the report) • Healthwatch Dorset will receive the draft report and commentary will be requested. (it should however be noted that in the previous year's Healthwatch Dorset exercised their right to decline to provide any written statement). • Dorset CCG will receive the draft report, and a commentary will be requested prior to submission.
Action recommended	The Quality Committee is recommended to: 1. Discuss the report and recommend any areas for improvement. 2. To recommend the Quality Account submission to Risk and Audit Committee for assurance and the Trust Board

Governance and Compliance Obligations

Legal / Regulatory	Y	Trust Boards must have oversight of the progress delivered against the Quality Account. Inability to achieve the improvements could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.
Financial	N	
Impacts Strategic	Y	In previous years, NHS Foundation Trusts have been required to publish a

Objectives?		Quality Account/Report each year in line with the NHS Act (2009) and quality account regulations (2010). The Quality Report will no longer be published as part of the Annual Report due to new guidance. The Quality Report will be submitted and published in line with the recommended deadline of 30 June 2021
Risk?	Y	External agencies that have previously been required to provide a statement are not required this year due to changes in guidance There remains National audit and performance data not yet available for inclusion within the report.
Decision to be made?	Y	Provide scrutiny of the report prior to publication. Recommend areas for improvements. Recommend submission to the Board as per the legislative timeframe
Impacts CQC Standards?	Y	As this report incorporates standards outlined by the CQC it is important to note progress or exceptions to these standards.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Respect
Integrity
Teamwork
Excellence

NHS
Dorset County Hospital
NHS Foundation Trust

Quality Account

2021 - 2022

Outstanding care for people in ways which matter to them

Quality Accounts 2021/22

Contents

Part 1

FOREWORD – Nicholas Johnson, Interim Chief Executive

It gives me pleasure to introduce the Quality Account for Dorset County Hospital NHS Foundation Trust (DCH) for the year 2021-2022.

This year has continued to be a testing time for many and I would like to acknowledge the tremendous hard work of the staff. Each person has shown their commitment to the shared Values of Integrity, Respect, Teamwork and Excellence all of which is reflected in the achievements outlined in this report.

I would also like to thank our patients, their families and the local community for the patience and support shown to us during the restrictions which have been in place throughout this year.

Despite the ongoing Covid-19 pandemic the Trust has maintained its focus on quality improvement and safety for the local population.

Through new ways of working, including virtual clinics and the recovery work underway, The Trust have continued to put the patient at the heart of everything we do, and this will continue this into the new phase of hospital changes in the coming months and years as DCH develop the hospital and the services with the engagement of the people that count, the people who use DCH services.

The following Quality Account details the progress made against the priorities set for last year; it will also detail the priorities set for the forthcoming year 2022-2023.

I am pleased to confirm that the Board of Directors has reviewed the 2021-2022 Quality Account and are assured that it is an accurate and fair reflection of the Trust performance.

The information contained within this report has been subject to internal review. Therefore, to the best of my knowledge, the information contained within this document reflects a true and accurate picture of the performance of the Trust.

Nick Johnson
Interim Chief Executive

Part 2

Quality Improvement Priorities 2021/2022

In line with national guidance, DCH have developed priorities for the forthcoming year following engagement with DCH clinical staff, partners, the executive team, local community representatives and, of course, patients and their families. No new priorities were set for 2021/22 due to the changes to National Guidance during the Pandemic. Acute providers were asked to concentrate resources to the pandemic effort and as a result DCH priorities changed direction as DCH were unable to achieve them due to the operational needs of the services and the Pandemic response effort.

Dorset County Hospital NHS Foundation Trust (DCH) continued to work to deliver changes to improve both the effectiveness and the quality of its services throughout 2021/22. For complete quality and performance data the public can access Trust Board papers

Below are listed some of the quality improvement work and how these have been monitored and reported:

- Health and Wellbeing of Trust staff
  The trust continued to implement initiatives to support staff health and wellbeing. See Part 3 for a report

- Falls resulting in severe harm
  The trust has continued to reduce the falls which cause severe harm to patients. There have been no falls of this severity in the reporting year. Reporting continues through Trust Governance Processes.

- Improved Mortality Surveillance and Learning from Deaths – This work continues and is reported through the quarterly mortality reports.

- Improving early identification and treatment of Sepsis and the Deteriorating Patient – Quality Improvement work continues with the implementation of all cause deterioration pathway. Monitoring of this work is undertaken through the Trust Governance Processes.

- Patient Experience – A Dorset wide launch of the Carers Passport in June 2022 will be the culmination of the work undertaken collaboratively by the Trust and regional colleagues.

Quality Improvement Priorities 2022-2023

Priorities for 2022-2023 are developed together with clinical staff, Trust partners, the executive team, patients, and their families. These priorities were presented to the Quality Committee in May 2022 and were approved at the Trust Board in May 2022.

The Trust Strategy outlines how DCH will put people first and work together to deliver accessible, outstanding care and help make the west of Dorset a healthier place for all.

The Trust vision is that Dorset County Hospital, working with health and social care partners, will be at the heart of improving the wellbeing of the local communities. The Trust mission is to provide outstanding care for people in ways which matter to them. Underpinning everything DCH does, are the Trust values of:

To achieve the mission and realise the vision, DCH will focus on the Trusts three strategic themes: People, Place and Partnership.

Quality Priorities for 2022/23.

Priority 1: PEOPLE – The Trust will improve safety and quality of care by creating a culture of openness, innovation, and learning

- Clinical Plan
  - Population Health Inequalities, as part of the implementation of the Clinical Plan, DCH will work with system partners, to explore how to do things differently to understand and reduce health inequalities.

Priority 2: PLACE – The Trust will delivery safe, effective, and high-quality personalised care for every patient, focussing on what matters to every individual

- All cause deterioration
  - The Trust will continue with its progress following implementation of the All-Cause Deterioration pathway and the Clinical Deterioration Proforma. The Patient Safety Specialist will work to take forward the nine national priorities and to support with aspects of the Risk Management Strategy
- IPC working with Trust Partners
  - The Trust will engage and work with the Integrated Care System Infection Prevention and Control Team. Within this work networks will be available to support primary care and local patients, families, and carers. Public Health will be working within this 'System Team' to integrate their work alongside the ICS IPC Team.

Priority 3: PARTNERSHIP - Working together to ensure outstanding services, accessible to patients and population.

- Patient engagement and co-design.
  - The Trust will involve local people and community to improve and develop DCH services at the Trust.
  - Transition Service - The Patient Experience Team will work in partnership with patients, families, and carers to develop a transition service ensuring that young patients have an opportunity to influence the transition service at the trust.
  - To increase the awareness of carers and to include carers in the discharge process. In collaboration with local carers groups to co-design training materials for Trust staff to highlight carer awareness.
  - Your Future Hospitals Project. The Trust will engage with many different patient groups including local disability groups and young patients to ensure that their experiences are considered during the design of new services and Trust estate.

Progress against these Quality Priorities will be monitored and reported through the Trust sub-board Quality Committee and reported to the local commissioners

Statements of Assurance from the Board

Review of Services

During 2021-2022, the Dorset County Hospital NHS Foundation Trust (DCH) provided and/or subcontracted 35 relevant health services.

The Trust has reviewed the data available to them on the quality of care in all these relevant services in line with the national pandemic.

The income generated by the relevant health services reviewed in 2020-2021 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2021 – 2022.

The Trust income in 2021-22 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework This was because of the changes in contracting arrangements due to COVID, as a result, defined CQUIN income was not received.

Clinical Audit

During 2021-22 52 national clinical audits covered relevant health services that the Trust provides.

During that period the Trust participated in 92% National Clinical Audits and 100% National Confidential Enquiries which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that the Trust was eligible to participate in during 2021-22 are as follows within the table.

The National Clinical Audits and National Confidential Enquiries that the Trust participated in during 2021- 2022 are as follows within the table:

The National Clinical Audits and National Confidential Enquiries that the Trust participated in, and for which data collection was completed during 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Covid-19 and Clinical Audit

With the advent of Covid-19, NHS England/Improvement took steps to reduce burden and release capacity within the NHS Care Settings. The impact of this on Clinical Audit was an immediate cessation of all audit activity, except for a few specific projects, to allow clinical teams to focus on the unfolding situation. Many of the national audits remained open, and clinical teams continued to submit data as they were keen to understand the impact of Covid-19 on their specific services. Publishing of National Audit, following the initial first waves of the pandemic were affected, and publication was suspended. This has recovered somewhat, and published reports are being received in the timeframes reminiscent of pre-covid timings. The number of National Clinical Audits has increased on the activity from 2020/21.

Local audit was suspended in line with the above, although some areas found they had capacity to carry on, and several Covid-19 related audits were registered. The number of local audits reviewed within the reporting year has increased on the previous 2020/21

Update on National Data Opt-Out

HQIP has been informed of the following by the DHSC Data Policy Team in the NHS Transformation Directorate:
'The mandatory implementation of the National Data Opt-Out (NDOO), deadline of 31 March 2022, has been extended until 31 July 2022. DCH does not intend to extend implementation of the deadline any further.

As set out in the Operational Policy Guidance, the opt-out applies to the disclosure of confidential patient information for purposes beyond an individual's direct care across the health and care system in England, unless an exemption has been granted.

National Clinical Audits

The NHS England-funded National Clinical Audit and Patient Outcomes Programme (NCAPOP) are a mandatory part of NHS contracts, and as such the Trust are required to participate in those that relate to services provided by this Trust. The following table describes the audits DCH have participated in, and the relevant compliance.

* Please note that in some cases the % of Registered Cases is above 100%; this is because the trust was able to identify additional cases than those identified by the HES (Hospital Episode Statistics) data

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% Of Registered Cases
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	218	100%
Cardiac Rhythm Management (CRM)	Y	Y	458	100%
National Heart Failure Audit	Y	Y	338	100%
Name of Audit	**Trust Eligible**	**Trust Participation**	**Cases Submitted**	**% Of Registered Cases**
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	471	100%
National Audit of Cardiac Rehabilitation	Y	Y	Data not available	Data not available
Diabetes (Paediatric)	Y	Y	Data not available	Data not available
National Diabetes Audit – Adults	Y	Y	833 submitted	100%
National Diabetes Foot Care Audit	Y	Y	100	100%
National Diabetes in Pregnancy Audit	Y	Y	14	100%
National Audit of Care at the End of Life	Y	Y	40	100%
National Audit of Dementia	Y	N (due to Covid an optional casenote audit was completed)	24 sets of casenotes reviewed for the Optional Casenote Audit.	24 sets of casenotes reviewed
National Asthma and COPD Audit Program	Asthma	Y	54	100%
	COPD	Y	226	100%
	Children and Young Peoples Asthma	Y	24	100%
National Lung Cancer Audit	Y	Y	39	100%
Sentinel Stroke National Audit Programme	Y	Y	548	100%

(SSNAP)				
Major Trauma Audit (TARN)	Y	Y	244	96%
PHE Surgical Site Surveillance Audits	Y	Y	Data not available	Data not available
National Audit of Breast Cancer in Older Patients	Y	Y	Data not available	Data not available
Inflammatory Bowel Disease (IBD) Registry Biologics Programme	Y	Y	Data not available	Data not available
National Gastro-Intestinal Cancer Programme	Oesophago-gastric Cancer (NAOGC)	Y	Data not available	Data not available
	Bowel Cancer (NBOCAP)	Y	Data not available	Data not available
National Emergency Laparotomy Audit	Y	Y	108	100%

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% Of Registered Cases
National Joint Registry	Knees primary/Revision	Y	Knees 131 primary +8 revisions	Nationally, elective joint replacement numbers halved from previous years due to the COVID pandemic, with cases being outsourced to other surgical centres
	Hips primary/revision	Y	Hips 124 primary +9 revisions Shoulder 21 primary +2 Revisions	
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service	Y	Data not available	Data not available
	Inpatient Falls	Y	5 in patient falls	100%
	Hip Fracture Database	Y	355 (308 NOF, 34 peri prosthetic, 13 Femoral)	100%
National Prostate Cancer Audit	Y	Y	Network submission via UHD-NHS	Network submission via UHD-NHS
National Audit of Rheumatoid and Early Inflammatory Arthritis	Y	Y (April to September)	80	(April to September) Since September all cases seen at UHD
Case Mix Programme ICNARC	Y	Y	640	100%
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE)	Y	Y	3	100%

National Maternity and Perinatal Audit (NMPA)	Y	Y	Data not available	Data not available
Child Health Clinical Outcome Review Programme	Y	Y	Data not available	Data not available
Neonatal Intensive and Special Care (NNAP)	Y	Y	Data not available	Data not available
National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	Data not available	Data not available
National Cardiac Arrest Audit (NCAA)	Y	Y	62	100%
National Ophthalmology Audit	Y	N	Medisoft software summer 2022 will then participate for 22/23 NOD	Nil
Name of Audit	**Trust Eligible**	**Trust Participation**	**Cases Submitted**	**% Of Registered Cases**
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	3	100%
Perioperative Quality Improvement Programme (PQIP)	Y	N	Ongoing local QI research project	Data not available
Serious Hazards of Transfusion: UK National haemovigilance scheme. Scheme (SHOT)	Y	Y	4	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) (49)	Y	Y	38	100%
Antenatal and new-born national audit protocol 2019 to 2022	Data not available	Data not available	Data not available	Data not available
Emergency Medicine QIPs [3]	Fractured Neck of Femur	Y	Data not available	Data not available
	Infection Control	Y	Data not available	Data not available
	Pain in Children	Y	Data not available	Data not available
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections.	Y	N	Local Audit	76.3% compliance
UK Renal Registry	Y	Y	836	100%

National Acute Kidney Injury programme				
Adult Smoking Cessation Audit July 2021- 31 August 2021	Y	Y	159	100%
Outpatient Management of Pulmonary Embolism	Y	Y	11	100%
Potential Donor Audit 2020 – 2021	Y	Y	3	100%
Pulmonary Rehabilitation-Organisational and Clinical Audit	y	y	273	100%

National Confidential Enquiries into Patient Outcome and Death (NCEPOD)

NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research.

At the beginning of the Covid-19 pandemic, NCEPOD also suspended all their current studies to allow clinical resource to be focused on the emerging situation.

Name of Audit	Trust Eligible	Trust Participation	Cases Submitted	% Of Registered Cases
Epilepsy Study 01/01/21 to 31/12/21	Y	Y	5	100%
Transition from Child to Adult Health Services 01/10/19 31/03/21	Y	Y	9	100%
Crohn's Disease Study 1/10/21 to 31/3/22	Y	Y	6	100%

The following shows the National NCEPOD reports published and a precis of their findings:

Report Title	Report Precis
NCEPOD Studies 2019/2022	NCEPOD Studies were suspended during the initial phase of the COVID 19 pandemic and were not due to resume until 2022. However, there have subsequently been 3 new studies published. • Dysphagia in people with Parkinson's Disease Submitted 31/12/2021 • Alcohol-Related Liver Disease Survey Submitted 12/10/2021 • Epilepsy Study Due 31/03/2022 29% complete • Transition from Child to Adult Health Services Submitted 9/2/22 • Crohn's Disease Study Oct 21 – To be released Spring 22

The reports of 5 National Clinical Audits were reviewed by the provider in 2021-22 and The Trust intends to take the following actions to improve the quality of healthcare provided, the number lower than expected as Covid-19 impacted on report publication.

The table below summarises the audit outcomes and the actions taken as identified by the review undertaken:

Audit / Clinical Outcome Review Programme	What this Trust learnt
National Audit of Percutaneous Coronary Intervention (PCI) 2020 #5031	**Key Audit Results:** National Audit shows: • reduction in the number of heart attack admissions, fewer patients with STEMI self-presented (proportionately more received primary PCI). • Levels of care for patients admitted with heart attack maintained. • Fewer elderly, female and patients with comorbidities admitted with NSTEMI (this subset had a higher mortality than usual). • Fall-off in the number of patients presenting to hospital with heart failure more dramatic than for heart attacks. • Reduction in elective cardiac procedures. • Increase in patients presenting with out-of-hospital cardiac arrest. • Black, Asian and Minority Ethnicity patients with acute coronary syndromes more affected by the pandemic than white patients. • Excess mortality in England and Wales during the COVID Pandemic with 10% of 30-day deaths occurring after PCI during the pandemic due to COVID-19. **Actions agreed:** Integrated analysis of national data may inform COVID-19 risk profiles for those returning to work. High quality research is required to understand the longer-term impacts of COVID-19. Lessons from COVID-19 experience should shape the way for rapid nationwide data reporting. In quickly redesigning services to deal with COVID-19, local systems show how they need to be the future focus for QI. **What this means for DCH:** As the Trust move into the recovery phase from COVID-19 there will be pressures at local level to determine a way forward and put in place the capacity needed.
National Diabetes Audit NDA 2019	**Key Audit Results:** • Decline in 8 care processes mainly due to lower urine albumin checks. • Most care processes well completed but lower for type 1 patients (10-70% vs 20-80%). • 15% of Type 1 (T1) and 5% of Type 2 (T2) patients did not have a HbA1c (glycated haemoglobin) check during the audit period. • Achievement of treatment targets have improved in T1 pts driven by improved HbA1c</=58 but not in T2 pts. • Some services achieving HbA1c>40%, BP>80%, statins >80% T1s and HbA1c >70%, BP >80% and statins >90% for T2s. • Lower rates of statin prescription for primary prevention in T1 vs T2 (some services achieving >75%). • More than 25% T2s not prescribed statins for primary prevention (some services achieving >85%). • Some areas achieve >30% T1 and >45% T2 pts. • Structured Education offer and attendance remains stable, but attendance recording remains poor.

	Actions: Improve quality of NDA data to benchmark the trust against national results
National Diabetes Audit 2019/20 re-audit of #4449	**Key Audit Results** • Number of T1 people at adult specialist service was low (36%) • Much lower level of participation for core and insulin pump datasets. • National rate of A1c </= 58 is 27.6% (range 18.4-40.9%). • Individuals with T1 are more likely to have recommended A1c levels if on pump. • 10% of people with T1 use pumps (range 3.2-24.6%), more than 70,000 ppl meet NICE criteria for pumps as on basal bolus and A1c >/=69. • T1 people are more likely to have high A1c levels if young, female, of minority ethnicity, live in area of high deprivation. **Recommendations:** • All specialist services providing type 1 diabetes care must contribute to future National Diabetes Audits which will enable them to benchmark their results and highlight areas for service improvement. • All specialist services and primary care providers should ensure provision of insulin pump treatment is equitable and as per NICE guidelines (HbA1c 69mmol/mol (8.5%) or greater and using basal-bolus insulin). • All commissioners, specialist services and primary care providers should ensure that provision of, and access to, expert diet and lifestyle guidance and support for people with type 1 diabetes and associated obesity is on a par with the rest of the population.
National Diabetes Inpatient Audit (NaDIA) Harms, 2020 #4995	**Key Audit Results:** Patients at higher risk of experiencing an inpatient harm include: • emergency admissions, • white ethnicity, • T1 Diabetes Mellitus not had 8 care process in last 12months, • Not met combined targets of Blood pressure/A1cohol/Cholesterol, have Cardiovascular or diabetes specific complications on or during admission e.g., strokes and HHS. **Recommendations:** • DCH participates in the NaDIA harms audit. • Each 'harm' or case has a DATIX submitted, so cases and learning are discussed via the Safe Diabetes Care Group locally to ensure learning is disseminated and steps taken to prevent harms are implemented. • DCH Patients for elective surgery who have diabetes are highlighted to have a PAS alert. Elective surgical cases are referred to diabetes teams for review if HbA1c >69 for optimisation prior to admission. • At DCH all CBG readings are networked and DSNs can access abnormal readings and review cases. • DCH; Ongoing outreach to wards including surgical wards along with networked CBG readings provide a way to identify patients with abnormal readings to DSNs to provide problem solving prior to DKA. • Ongoing education of diabetes topics to junior doctors and nurses and HCAs on wards. **What does this mean for DCH?** • Submit cases to NADIA, harms & review internally • Outreach diabetes with remote CBG monitoring • Education to medical & nursing staff on prevention of harms
National Cardiac Audit Programme (NCAP) Cardiac rehabilitation	**Key Audit Results:** • DCH Cardiac Rehabilitation (CR) programme was assessed and classified as Amber. • DCH met 6 out of the 7 required Key Performance Indicators (KPIs): ▪ Multidisciplinary team: KPI Met.

(January-December 2019 data) Report published October 2020	▪ Priority Groups: KPI Met. Duration (days): KPI Met. ▪ Percentage with Assessment 1: KPI Met. ▪ Wait time Coronary Artery Bypass Graft (CABG): KPI Met. ▪ Wait time Myocardial Infarct/Percutaneous Coronary Intervention: KPI Met. • In 2019, 91.3% (above National average) of patients appropriately referred to cardiac rehabilitation completed their Core Cardiac Rehabilitation Program • At the end of 2019, nationally, 26% of cardiac rehabilitation teams offered technology/online cardiac rehabilitation options. • The Trust helped develop the My heart app. • In 2020 CR face to face clinics and groups were suspended March 2020 due to the COVID 19 this had a significant impact on service provision. • Face to face clinics for cardiac surgery patients re-commenced in July 2020 due to clinical need. Non-surgical patients continue to be offered their clinical assessment by telephone consultation only. • All written, DVD and online and telephone options of cardiac rehabilitation are continuing throughout 2020. • Assessment 2 targets were not fully met in 2019 and due to the COVID19 and the Assessment 2 target will not be met for 2020
National Neonatal Audit Programme (NNAP) 1/1/2019 to 31/12/19 Published 12/11/2020 # 4731	**Key Audit Results** • The Audit found that 1 in 7 babies have too low a birth weight or have a medical condition that requires specialist treatment. • This report, focuses on key measures of the care provided to babies in 2019 in the 181 neonatal services in England, Wales, Scotland, and the Isle of Man. **Recommendations:** • Antenatal Steroids; Optimise the timing and dosing of antenatal steroids for eligible babies, • Antenatal magnesium sulphate: all women who may deliver at less than 30 weeks' gestational age, adopt, and implement guidance for improvement: • Birth in a centre with a NICU; Prioritise structural changes and operational management ensuring that babies who require intensive care are cared for in the unit's best equipped to deliver it. Local Maternity Systems (LMS) should ensure appropriate clinical pathways exist to enable delivery of intensive care to all infants where this is required, with a minimum of postnatal transfers. • Parental consultation within 24 hours of admission; reflect on rates of parental consultation, use a quality improvement approach. including virtual presence. • Parental presence at consultant ward rounds; Neonatal units, in collaboration with parents, should build relationships and trust between parents, family members and neonatal unit staff by understanding, involving & empowering them in care planning and decision making. • By identifying the reasons for any gaps in parental presence on ward rounds, and working with parents to address any barriers to participation • On-time screening for retinopathy of prematurity (ROP) in Neonatal Intensive Care Units (NICUs). • Infection: Ensure that their use of evidence-based infection reduction strategies is optimised and focussed on identification and implementation better practices including "infection prevention bundles". • Bronchopulmonary dysplasia (BPD); Implement potentially better care practices, including any identified from NICE guidance about specialist respiratory care • Necrotising enterocolitis (NEC); All neonatal units should compare their rates of NEC to those of other comparable units with validated data and seek to identify and implement potentially better practices to reduce the

	associated higher risk of mortality and, for those babies who survive, the risk of longer term developmental, feeding and bowel problems. • Minimising separation of mother and baby • Breastmilk feeding at discharge home; Focus on the early initiation and sustainment of breastmilk feeding by removing barriers, • Follow-up at two years of age; Produce plans to provide or organise follow up of care for preterm babies in accordance with NICE guidance • Mortality until discharge home in very preterm babies; Consider a quality improvement approach to the delivery of evidence-based strategies in the following areas to reduce mortality: timely antenatal steroids, deferred cord clamping, avoidance of hypothermia and management of respiratory disease. • Ensure that shared learning from locally delivered, externally supported, multi-disciplinary reviews of deaths • Nurse staffing in neonatal units; Ensure that sufficient resources are available for the education and employment of suitably trained professionals to meet and maintain nurse staffing ratios described in service specifications.
LeDeR Programme 2021-2022	For the year 2021-2022 DCH submitted **3** notifications to the LeDeR Programme. Learning was shared and progressed through the divisions.
National Emergency Laparotomy Audit (NELA) December 2018 – November 2019	National Report highlighted 5 Key Messages and made 11 Recommendations Key findings from DCH data • Ascertainment has slipped significantly, although this coincided with the first year of COVID-19 pandemic • Reporting of CT scans before surgery has fallen, which may relate to concerns about COVID-19 contamination and infection • New data collection on sepsis and antibiotic administration implies poor quality care, but this may be due to poor quality data • Pre-operative input from Consultant Anaesthetists and Intensivists has fallen, which again may relate to resource diversion to COVID-19 care • Input from Elderly Care remains below target and has fallen slightly • Outcome measures remain stable over time and are better than national averages **What does this mean for DCH?** DCH continues to deliver good care to patients with emergency abdominal pathologies requiring unplanned surgery. The year 2019-2020 included drastic changes to resource allocation but the outcomes remained stable and continue to be better than national average. There are several process measures that need to be inspected carefully in Year 8, which will hopefully show bounce-back after COVID-19.
National Child Mortality Database and Perinatal Mortality Review 2019/20 #4955	**Key findings:** A report of the analysis of a national dataset. • There is a correlation between the risk of death for children and the level of deprivation. 2.On average the risk of death increases by 10% for each decile of deprivation. • If the children in the most deprived areas had the same risk of death as those in the least deprived areas >1/5 of all deaths might be avoided. • The proportion of deaths with identified modifiable factors increases with the level of deprivation. • At least 1/12 deaths in the study had 1 or more factors linked with deprivation identified. The report included exemplars of good practice in areas where there is work being undertaken to try to reduce infant mortality. **Benchmarking** • The Pan-Dorset and Somerset Child death overview panel (CDOP) submits data to the national child mortality database. Local numbers of deaths make this sort of detailed analysis difficult and the strength of the

	NCMD is that it collates information about all deaths in England. • The largest group of children that die are infants. Many are neonatal deaths linked to prematurity, birth related problems or congenital problems. The other significant infant group is those presenting with sudden unexpected death. Multiple known risk factors are related to this, linked to social deprivation and this area has been actively trying to address this through antenatal and postnatal public health messages to both men and women. **What does this mean for DCH?** • DCH contributes to child death reviews for those infants and children that the hospital is involved with. • The report calls for all areas to work together to reduce social deprivation and inequalities and practitioners within DCH should comply and participate by engaging with evidence-based programmes • Continued engagement with public health campaigns around safe sleeping & safe sleeping when out of routine to be prominent in maternity and paediatric services. • A recent child death investigation (death in Dorset but child on holiday here) highlighted that although it was documented that safe sleeping advice had been discussed on several occasions, practitioners were not aware that the family had routinely co-slept with their baby from day 1. At a strategic level DCH should be advocating for improved services for families and young children in the community
Maternal, Infant and New-born Programme (MBRRACE-UK) * 2019 – 2022 # 4727	There were 8 Recommendations noted from this report. **What does this mean for DCH?** • All elements of 'Saving babies lives care bundle 2' is implemented. All perinatal pregnancy loss is reviewed using the PMRT with involvement of a neighbouring trust. Women who risk delivering before 32 weeks gestation are transferred out of DCH these cases are reviewed on an individual basis with learning shared if required. • Pathway designed with appropriate interventions in place to optimise fetal and maternal wellbeing. This is now being incorporated into the maternity digital system. • Data is reviewed and presented at Quality Committee. DCH currently sits at the expected perinatal level for an equivalent sized hospital. • Neonatal mortality rates are within the expected level for an equivalent hospital. • Updates on PM consent have taken place, there is very little ethnic diversity in perinatal pregnancy loss, and it has not been noted that any population group decline post-mortem examination. • Due to national shortage of perinatal pathologists undertaking PM examination there are long delays for families to receive results
National Pregnancy in Diabetes (NPID) 2020 # 5034	**What does this mean for DCH?** • The Trust are comparable to local neighbouring trusts in areas such as early pregnancy diabetes control in both type 1 and type 2 diabetes. Improvement could be made with type 1 and type 2 diabetes control in late pregnancy, DCH are close to national averages. • There has been improvement with preterm deliveries and SCBU admissions as well as with large for gestational ages for Type 1 diabetes. **Actions** • Highlighting importance of pregnancy planning to local primary and community colleagues, particularly for women with type 2 diabetes • Continuing with striving for good glycaemic control with all patients with known diabetes, actively offering CGM for all women with type 1 diabetes and are performing well as per feedback from CCG. • Ensuring the Trust highlights the fact that women with GDM are aware of the diabetes prevention programme

Inflammatory Bowel Disease (IBD) Registry Biologics Audit 2020/21 # 5043	**Key Audit Results:** • The audit has identified the growing IBD population and the need for team expansion to meet ongoing demand and to safely care for patients. **Benchmarking** • The biologics audit has allowed us to monitor steroid and biologic use to benchmark us against other Trusts and national statistics along with recommendations to assess cost and reduction in hospital admissions. • The growing patient population and increased demand has supported the development of the team in line with IBD national standards. **What does this mean for DCH?** • Biologic audits have been conducted in a timely manner over the Covid period despite pressures, highlighting areas for improvement that may impact on service development and the standard of patient care **Actions completed** • Employed an IBD Specialist Pharmacist who is overseeing the input of data for biologic initiation and carrying out IBD biologic clinic reviews in which they can capture biologics data at 3M & 12M for auditing purposes. • Introduction of pre-populated panels on ICE for pre-biologic screening to ensure patient safety needs are met when starting biologics and for monitoring purposes. • Identified a need for local audit identified as due to the submission of historic data at each audit it is often difficult to get a true reflection of DCH current progress from the data added from the past year.
National Child Mortality Database March 2020 – February 2021 # 5060	**Key Audit Results:** Good performance: • All pregnancy loss that fit the criteria for review using the PMRT is undertaken. This has led to a robust process with review of care given and suggested recommendations. **Areas of concern.** • United Hospitals Dorset Meeting attendance from DCH panel members due to timing and meeting clashes; has been raised with UHD. DCH consultants have been very good at attending for part of the meeting if DCH have a case to discuss. • All families are asked if they would like to participate in the review, led by the bereavement midwives, with proforma supplied to help them recall areas of the pregnancy/loss that they may wish to have addressed. • Limited feedback from families; Communications from bereavement lead to team to encourage them to ask for feedback from families using the PMRT paperwork provided. • All incidents which flag up care issues are escalated as a Serious Incident, investigated, and presented both internally and externally. Action plans are followed up once again internally and externally at the LMS safety meetings held bi-monthly. Shared learning with UHD takes place at this forum as does learning from the wider region. **What does this mean for DCH?** • System level changes are identified and once again reviewed internally and externally.
Potential Donor Audit 2020 – 2021 # 5073	**What does this mean for DCH?** • Continuation of the Potential Donor Audit in both departments (ED and ICU). • Ensure that all appropriate families are approached with the option of organ donation Teaching both departments about the appropriate timings of referrals **Actions identified** • To ensure all approaches concerning organ donation to involve a Specialist Nurse Organ donation/ Specialist Requestor (gold standard) • To ensure early referrals to allow the timely mobilisation of a Specialist Nurse/ Specialist Requestor

SAMBA (Society for Acute Medicine Benchmarking Audit) 17/06/2021 #5303	**Key Audit Results:** • High discharge rate from Acute Medical Admissions ward (78%), is associated with an increase in low acuity patients being admitted. The cause of this is multifactorial, but most likely represents a shortfall in the system's ability to manage these cases in the community. **Areas of good performance** • All patients receiving senior review within the target time **Areas of concern:** • High readmission rate (31%) representing a significant increase in comparison to previous years **Actions agreed:** • A review of pathways for readmissions, consider better utilisation of SDEC for these patients to avoid further inpatient stay.
National Lung Cancer Audit 2019 1/1/19 – 31/12/20 4797	**Key Audit Results:** Uses of rapid cancer registration dataset (RCRD), makes data available more quickly, some data on poorer prognosis patients missing. **What does this mean for DCH?** • Trusts should review their data completeness in the Cancer Services and Outcomes Dataset the MDT should participate in the NLCA. Dorset County Hospital was flagged as a trust with high data completeness. DCH participated in the NLCA and view this as an important part of their work. • Cancer alliances and clinical commissioning groups (CCGs) should examine the route of referral and stage at presentation for their population and look at ways to increase the numbers of patients diagnosed who are presenting with early-stage disease. DCH actively discus's this as part of the Lung SSG meetings and has GP and patient representation. DCH has undertaken several media campaigns, including interviews for BBC South and webinars. • DCH Lung Cancer Lead (and Lung Cancer SSG Lead) has taken on the role of Clinical Director for Targeted Lung Health Checks for Dorset. This allows DCH to effectively enter the National programme earlier than planned. Brining people into the Lung Cancer Pathway at an earlier stage of the disease is key to improving their outcome. • Cancer alliances with lower-than-expected curative-intent treatment rates for stage I/II PS 0-2 NSCLC should review their processes for selection of patients for such treatment, in order that a rate of at least 85% is achieved. DCH has reviewed their figures, from April 2020 to date, and with the low numbers involved are satisfied with an 82.1% rate.
National Hip Fracture Database 2020 01/04/20 – 31/03/2021	**Key Audit Results:** • Recommendations 1-9 as published in Facing New Challenges: The National Hip Fracture Database (NHFD) report 2020. **Good performance**: • Mortality consistently below national average (DCH 6.1%, NHFD overall 8.2%). Above average categories for KPI1, KPI2, KPI5. Average categories for KPI3, KPI6 **Areas of concern:** • Below average category for KPI4 – prompt mobilisation. **Benchmarking** • Mortality run charts; DCH crude mortality 6.9%, case mix adjusted 6.1%. NHFD average 8.2% • DCH crude Vs case mix adjusted mortality variation 0.8% • KPI 1 prompt Orthogeriatric review DCH in above average category 94%, NHFD overall 87% • KPI 2 prompt surgery DCH in above average category 86%, NHFD overall 69% • KPI 3 NICE compliant surgery DCH in average category 71%, NHFD overall 71% • KPI 4 prompt mobilisation DCH in below average category 67%, NHFD

	overall 81% • KPI 5 prompt delirium assessment DCH in above average category 71%, NHFD overall 58% • KPI 6 return to original residence DCH in average category 74%, NHFD overall 70% • Signpost NHFD patient and carer resources **What does this mean for DCH?** • Clinical leads to examine mortality run charts quarterly, to monitor current position. • Clinical leads to monitor KPI to ensure above average achievement maintained • Action plan to address reasons for failure to mobilise and monitored through monthly governance meeting **Actions** • KPI 4; prompt mobilisation; action plan to address improvement • Trauma ward to advertise resources to ensure patients and their significant others routinely well informed.
National Fracture Liaisons Services Fracture Prevention Patient Satisfaction Survey 2021 (September 2021 to Nov 2021) #5442	**Recommendations** • Local lists of private strength and balance classes are being collated, being a rural community is it extremely hard to reach elderly patients who are struggling with mobility and transport issues. **Learning points:** • Clearer patient information required to provide an understanding of bone health. • Patients would like swifter to follow up Local exercise's classes are opening back up, FLS are compiling information for patients.
National Joint Registry 2021 – 18th Annual Report 01/04/20 - 31/03/21 #5016	**Key Audit Results:** • Nationally, elective joint replacement numbers halved from previous years due to the COVID pandemic. • THR – Hybrid fixation with metal head and poly liner is most common (as it is at DCH) • TKR – Nationally, most TKRs are cruciate-retaining (in line with DCH practice). • Shoulder – The proportion of reverse polarity TSRs continues to increase nationally, in line with local practice. **Benchmarking** • All implants used at DCH are evaluated by ODEP and show excellent reliability and survivorship in the registry. **What does this mean for DCH?** • DCH continues to follow the national standards in implant selection and surgical technique. • They will have to critically consider surgeon-operating volume over future years as the pandemic recovery begins.
National Audit of Dementia Care in General Hospitals 2021 21/06/221 – 30/09/21 #5314	**Key Audit Results:** **Areas of Good Performance:** • Improvement in: Mobility& Nutritional assessments, Recording of Body Mass Index (BMI). • Increase in the number of therapy assessments recorded & In use of the Assessment test for delirium & cognitive impairment (4AT) on admission. **Areas of Concern:** • Decline in: Delirium screening, pressure ulcer assessment, continence assessments and pain assessments. • Decrease use of 'This is Me' and documented conversations with the patient and carer/relative regarding discharge plans. • Repeat cognitive assessment not being completed on discharge **Actions:**

	• All patient overs the age of 75 to have a 4AT delirium screen completed within 24 hours of admission. • Increased completion of MDT assessments. • Ensure patients and relatives are included in the conversations around discharge and this is documented. • Repeat 4AT on discharge.
National Audit of Inpatient Falls (NAIF) Annual report 2021 (2020 clinical and 2021 facilities audit data)	**Key Audit Results:** • Despite the challenges posed by COVID-19 in 2020, there have been small improvements in all the key performance indicators. However, there is still work to do to improve prevention and management of inpatient falls and fractures. • The evidence from this audit is that falls risk factors are prevalent in people who go on to sustain an inpatient femoral fracture, emphasising the importance of risk factor detection and management. • NAIF has defined what should be included in a multi-factorial risk assessment (MFRA). To effectively assess quality, future reports and KPIs will focus on individual components of MFRA as a marker of MFRA quality. The longer-term goal will be to reduce variability between trusts in the rate of inpatient femoral fracture.
National Audit of Inpatient Falls (NAIF) (2020 clinical and 2021 facilities audit data) report of audit findings for DCH	**Key Audit Results** • The Trust participated in the March 2021 facilities audit • 67% of fractures occurred on older person/frailty wards, 33% occurred on Surgical Wards. • 100% of patients had a multi-factorial risk assessment (MFRA) performed in the hospital before they sustained the IFF. Compared with 76% Nationally. • In 33% cases, the patient had fallen in the hospital before the fall that caused the fracture. Of the patients who had already fallen, 100% had a subsequent review of their MFRA after the previous fall. **Recommendations** • MFRA Components that require improvement are Vision assessment 33% and lying/standing BP 33%. • Compliance with care plan & documentation regarding Mobility and Walking aids being used. • Only 50% of patients audited had analgesia prescription recorded and average time analgesia given from fracture time was 336 minutes, delays of over 30 minutes were reported in 18% of cases nationally and 33% cases in this Trust. • Use of a screening tool to identify those at high risk is against NICE guidelines. • No bed rail audit has been recorded as completed. • Audit found no written information about falls prevention. • Falls training is not Mandatory at this Trust. • There is no Executive, or non-executive director with specific responsibility for falls.

Local Clinical Audits

Local audits are carried out by the specialties in relation to areas of their work where they are wishing to explore quality improvement or risks in services for improving. These may be re-audits of past work, new services, audits relating to risk or service evaluations. 460 local audits were registered during 2021-22 and work will continue to see these through to completion.

The reports of 286 local clinical audits were reviewed by the provider in 2021-22.

A selection of these is catalogued below, and the Trust intends to take the following actions to improve the quality of healthcare provided:

Name of Audit	Finding	Learning points
Recording weights for inpatients in Orthopaedics #5055	• The key conclusions show that recording of weights on the electronic systems is variable. • There is no standardised equipment for recording weight, overall recording performance was 61.11%. More than 1/3 of patients are potentially exposed to mis-dosed medication. • Only 1/5th (18.51%) of patients on weight dependent drugs had their weight recorded on JAC where the actual prescribing takes place	Improvement of available equipment to cater for orthopaedic patients. Limiting factors in establishing patient weight is the difficulties putting patients on scales. Improvement of the equipment available seems to be the only way to improve compliance with weight standards and patient safety with weight specific medications.
Inpatient Laparoscopic Cholecystectomy Referrals #5410	A total of 26 patients were identified over the 4-month audit period. key conclusions: clinic appointments for this cohort of patients are avoidable using a simple proforma. The patients who required Telephone Appointment Clinic (TAC) only needed that because they had not been consented for surgery at the time the proforma had been filled out.	It is recommended to make the proforma virtual on DPR and to that the proforma should be incorporated as standard practice by the end of 2021.
Audit Compliance of the Local Safety Standards for Invasive Procedures (LocSSIP) Checklist for Laser Procedures within the Ophthalmology Department #5247	This retrospective audit aims to identify compliance and amendments with the LocSSIP Universal Safety Checklist for Interventional Procedures and to address any non-compliance through training and reflective practice for all staff involved. The findings showed 100% compliance with the checklist, except from; Sign in of expected eye and sign out of Registered Practitioner and Name of person undertaking procedure standards (95%). Overall, the checklist total was 99.3%	Mandatory use of the National Safety Standards for Invasive Procedures (NatSSIPs) and to continue educating staff in the completion of the checklist. Review of supporting documentation when new ways of working are introduced to ensure it still meets the requirements.
Project Title: Getting It Right First Time Audit: Procedure codes and patient outcomes in Orthodontics #5247	Key conclusions: Outcome forms are being completed for all patient appointments There is some variation in the orthodontic procedure codes (OPCS) codes marked on outcome forms	Monitoring of practices through Clinical Governance meetings importance of completion of the forms. An audit of the use of OPCS codes within departments to be undertaken to evaluate the useability of the OPCS codes and need for additional codes and/or modification of their definitions.
Do Not Attempt Resuscitation (DNAR) Audit – June 2021 #5319	To assess and evaluate DNAR documentation and completion within all relevant wards The findings showed 96.9% of forms were located at the front of the patients notes; 88.5% of DNAR decisions had been clearly documented in the patients notes either written or with a yellow sticker; 81.3% of decisions were made by the appropriate grade/trained clinician; 82.3% of decisions were discussed with the patient/family; and 83.55 of DNAR decisions were accompanied by a completed TEP form.	To continue DNAR training as part of Basic Life Support (BLS)/Mandatory training. To continue to reinforce the need for a Treatment Escalation Plan (TEP) to be completed with a DNAR decision. To request support from the medical director via Resuscitation Committee Chair as required.

Auscultation of fetal heart rate after the administration of spinal anaesthesia prior to elective caesarean section #5321	The aim of this retrospective audit was to assess whether midwives are listening to the fetal heart (FH) with a sonicaid for one full minute after spinal anaesthesia has been administered prior to elective caesarean section, and whether any abnormality has been appropriately escalated. 46 sets of notes reviewed for women who were booked to have an elective caesarean section between 01.03.21 and 31.05.21 The key findings showed 25/46 (54%) listened to with a sonicaid after spinal anaesthesia; of these all were within the normal range, therefore there was no need to escalate; 45/49 (91%) of babies had Apgar scores ≥7 at 1 minute and 48/49 (98%) had Apgar scores ≥7 at 5 minutes; and 3 babies were admitted to Special Care Baby Unit (SCBU); all 3 had had the FH listened to after spinal anaesthesia, all 3 FH rates were within the normal range, and all 3 had Apgar scores ≥ 7 at 1 and 5 minutes.	It is recommended to update guidelines to include listening to FH after spinal; to email a reminder to all appropriate staff and to paragraph in the next maternity newsletter.
Dietetics Mealtime Experience Audit #5264	The aim of this audit is to compare current mealtime practices at Dorset County Hospital to those recommended in the Food and Drink Policy (FDP; 2017), with the inclusion of patient reported outcomes measures. It sampled 2 bays on twelve wards, aiming for a sample size of 96-144 patients (i.e., 4-6 patients per bay). The resultant sample size was 102 patients in total.	The learning points from this audit were that there was significant variability in performance observed across wards. This could, perhaps, be attributed to staffing levels. There are some very basic standards that have not been met, and therefore intervention to improve upon this is required.
Electronic Prescribing and Medicines Administration (EPMA) Venous Thromboembolism (VTE) Assessment and VTE Prophylaxis Service Evaluation #5268	This audit aims to compare whether the EPMA VTE assessment is associated with an appropriate VTE prophylaxis prescription. The sample included a random collection of patients admitted to wards in May2021; a total of 100 patients. The key conclusions included 93 patients out of 100 had a completed VTE assessment. Out of 93 patients, 38 patients were not on VTE prophylaxis; among the 38 – 6 patients were not prescribed VTE prophylaxis, 22 were not on anticoagulation, 4 patients were suspected bleeding, 5 with low haemoglobin and 1 patient with low platelet. Overall VTE assessment is not 100% fully associated with VTE prescription	To encourage Doctors to prescribe the VTE prophylaxis. Reminder emails are being sent monthly.
Dorset County Hospital (DCH) Adult Physiotherapy Patient Survey for Obstetric Patients	The aim of this survey is to determine whether obstetric patients with pelvic girdle pain/back pain would prefer to have a 1:1 telephone appointment or a group, online class for their initial contact appointment with physiotherapy. The	This audit highlights some of the concerns that women may have regarding a virtual education group. It is therefore recommended that: All women have the choice of 1:1 intervention

with Pelvic Girdle Pain - Lower Back Pain Preference for Virtual Online Class or One-To-One Telephone Assessment #5280	sample involved a question to be asked to obstetric patients that are currently undergoing treatment for pelvic girdle pain/lower back pain during their phone consultation. The key conclusions included acknowledging data collection was unable to continue after 01/07/2021 due to staff re deployment to ward services; and a total of 16 patients were asked these questions at the beginning of their virtual, initial 1:1 Physiotherapy appointment. Of these 12 reported that they would not like to attend a virtual group setting for information regarding there back or pelvic pain. 2 patients reported that they did not mind either way and 2 reported that they had no preference.	or a group education class. During the class it will be made clear that Physiotherapist will be available after the session for questions that they do not feel they can ask in a group setting If the group session is not helpful the route to timely 1:1 treatment is easily accessible Any educational group that is offered to this patient group should have patient feedback specifically targeting the questions surrounding how comfortable patients felt asking questions
Assessing the improvement in the care provided to adult patients in the Emergency Department (ED) who have a confirmed diagnosis of fractured neck of femur (NOF) in ED setting after the introduction of the new FIB proforma (Re-audit #5152) - Phase 2 #5316	The aim of this retrospective data collection audit of 31 patients is to identify whether adult patients with fractured neck of femur (NOF) are receiving timely pain relief including Fascia Iliacus block (FIB)and whether post-procedural pain re-assessment, monitoring and documentation are appropriately done as per the Royal college of Emergency Medicine (RCEM) standards after the implementation of the new ED proforma, and the ED junior FIB teaching. The data was collected in ED at Dorset County Hospital Foundation Trust (DCH) from the period of June 1st, 2021, to June 30th, 2021. The findings showed significant improvement in FIB procedure documentation, post-procedural pain re-evaluation boosting the efficacy of delivering patient care; Evident improvement in post procedural observation, enhancing patient safety by allowing potentially life threatening and easily missed post FIB block complications to be promptly picked up; and Only mild improvement in initial pain assessment, pain management on arrival to ED and obtaining the essential diagnostic investigations, these, however, did not contribute to early admission or shorter stay in ED.	It is recommended for a longer time scale for data collection is required to demonstrate a clearer understanding of the emergency management of patients with confirmed NOF fracture and identify the reasons behind the delay in patients being seen by physicians, the delay in investigations and speciality admission; and to consider the introduction of validated pain assessment tool for patients with cognitive impairment such as Abbey Pain scale.
Dorset County Hospital (DCH) Home First: Inpatient Audit #5322	The aim of this Local Quality Improvement Audit is to understand how well patients are currently informed about their discharge plans and current treatment. The sample size aim was 110 (10 patients per ward); in total the responses of 78 patients were captured. The key conclusions were 56.4% of patients knew when they were going home; 42 participants stated that help was	It is recommended to ensure that discharge conversations are taking place, that there is an awareness of the treatment plan and estimated discharge date; Complex discharges will be made aware to the Discharge Team; and the findings of this audit will form the base of the communication plan.

	required at home and 69% had someone who could help; 61.5% participants that stated that they needed help had not been asked during their stay; 46.2% of patients did not require help at home, so are expected to be simple discharges. At the time of the audit, 8 out of the 13 patients who answered, 'they required support at home but had no offer of help', had a Length of Stay ranging from 1 to 42 days, which suggests various opportunities for discharge related conversations to have occurred.	
Gentamycin Use and Acute Kidney Injury #5214	This audit looked at a sample of 30 patients to determine the extent of Acute Kidney Infection (AKI) occurrence, and its severity with gentamycin dose, regardless of baseline serum creatinine and comorbidities in such patients. Gentamycin caused estimated glomerular filtration rate (eGFR) decline in 8 out of the 30 patients, although it could not be accountable solely, as the 8 patients had comorbidities and sepsis.	It is recommended to follow to eGFR three monthly after the last use of gentamycin in affected patients, to see if the baseline renal function has improved or not.

Clinical Research awaiting further information

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2021-2022 that were recruited during that period to participate in research approved by a research ethics committee was 1583. There was not an active recruitment target for this period due to the pandemic.

This is the highest level of involvement in the last few financial years and reflects an increased level of activity in covid-related research and vaccine studies. This also reflects the positive impact of having the income sustained rather than cut by the NIHR, directly leading to the resource involved in those projects, which DCH hope will continue to promote good quality research for patients.

It is worth noting that this period has seen success in the set up and delivery of Covid-19 studies, including high performance for CCP and RECOVERY projects at the site.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registered in full without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2021- 2022.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC suspended scheduled onsite inspections during the Covid-19 pandemic. A Monitoring Approach was implemented, and risk-based inspections were to be undertaken where appropriate. No risks have been identified in the reporting period and no actions required against DCH.

The Trust engages with all developments of the regulatory approach and supports the CQC's future developments

The Trust is currently rated 'Good' overall by the CQC following inspection of certain services in July – September 2018. The Trust continues to engage in quarterly meetings with the local and regional CQC inspection team.

The ratings grid below, as published by the CQC on its website, shows the ratings given to the core services and five domains at the time of their inspection (please note some areas were not re-inspected in 2018 following the 2016 inspection, therefore the 2016 rating stands for those services until the CQC re-inspect and rate accordingly):

Ratings for Dorset County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑ Oct 2018	Good ↑ Oct 2018
Medical care (including older people's care)	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good ↑ Oct 2018	Requires improvement → ← Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑↑ Oct 2018	Good ↑ Oct 2018
Outpatients	Good Oct 2018	N/A	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018
Diagnostic imaging	Good Oct 2018	Good Oct 2018	Good Oct 2018	Requires improvement Oct 2018	Good Oct 2018	Good Oct 2018
Overall*	Requires improvement → ← Oct 2018	Good ↑ Oct 2018	Good → ← Oct 2018	Good → ← Oct 2018	Good ↑ Oct 2018	Good → ← Oct 2018

Data Quality

The Trust submitted records during 2021-22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

	2017/18	2018/19	2019/20	2020/21	2021/22	National Average
Admitted Patient Care	99.9%	99.9%	99.9%	100%	99.9%	99.7%

Outpatient Care	100%	100%	100%	100%	100%	99.8%
Accident and Emergency Care	99.1%	99.0%	99.2%	99.7%	99.7%	96.0%

The percentage of records which included the General Medical Practice Code was:

	2017/18	2018/19	2019/20	2020/21	2021/22	National Average
Admitted Patient Care*	100%	100%	100%	100%	100%	99.7%
Outpatient Care	100%	100%	100%	100%	100%	99.6%
Accident and Emergency Care	100%	99.8%	100%	100%	99.7%	98.6%

*Please note that the latest figures for Admitted Patient Care cover the period April 21 to February 22 inclusive only. The Accident and Emergency Care figures cover April 21 to March 22 inclusive

The Trust was not subject to the Payment by Results clinical coding audit during 2021 – 2022.

The Trust will be taking the following actions to improve data quality:

- The Information Assurance Manager will continue to work with the Business Intelligence Team to validate the data held in the Patient Administration System to provide improved assurance to the end users of reports.

Data quality metrics and reports are used to assess and improve data quality. The Data Quality Maturity Index (DQMI) and the CDS (formerly SUS) Data Quality Dashboards are monitored, and reports run on a daily/weekly/monthly basis via the PAS system and the Data Warehouse to highlight and address areas of concern.

Data Security

As at the end of February 2022, the Trust submitted the interim Data Security and Protection Toolkit (DSPT) baseline submission to NHS Digital to demonstrate that it was compliant with 23 of the 38 assertions and 3 of the 10 national standards. The internal audit performed by BDO LLP in February 2022 confirmed that the evidence provided for 41 of the 48 mandatory sub-assertion included in the sample were found to be satisfactory, and in line with the requirements of the Independent Assessment Framework.

Through the efforts of the DSPT Working Group, the Data Protection Officer continues to gather the evidence needed to complete the 2021/22 Data Security and Protection Toolkit, which is due for submission on 30 June 2022.

Learning from Deaths

The Trust has a full complement of Medical Examiners who perform brief reviews of every in-patient death and identify those cases that require further in-depth reviews, using the Learning from Deaths

national guidance. ('*National Guidance on Learning from Deaths*', National Quality Board, March 2017).

During April 2021 – March 2022 819 of DCH patients died. This compromised the following number of deaths which occurred in each Quarter of that reporting period:

- 165 First Quarter
- 199 Second Quarter
- 245 Third Quarter
- 210 Fourth Quarter

By 01/04/2022 231 case record reviews and 20 investigations (mostly related to deaths involving covid-19) have been carried out in relation to the 819 deaths included in item 27.1.
In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 35 First Quarter
- 84 Second Quarter
- 74 Third Quarter
- 38 Fourth Quarter

7 representing 0.85% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.
In relation to each quarter, this consisted of:

- 0 of 165 representing 0% for the first Quarter
- 3 of 199 representing 1.51% for the second Quarter
- 4 of 245 representing 1.63% for the third Quarter
  0 of 210 representing 0% for the fourth Quarter

These numbers are derived from the judgement score for whether it is felt that the death was 'more likely than not' to have resulted from a problem in healthcare. All such cases are referred to, and reviewed by, the Hospital Mortality Group (HMG).

The HMG publishes a summary of outcomes from all reviews via its quarterly report to the Trust's public Board papers which are available via the Trust's internet site. Reports are shared internally by email newsletters. Any common themes identified feed into the quality improvement plans in the Trust, as part of the overall trust objective to deliver outstanding services every day. The notes of any patient who suffers a cardiac arrest are automatically subject to an SJR to examine whether it might have been preventable, regardless of the outcome.

Specific areas of learning:

- Poor handwriting and filing. Evidence on electronic systems of failure to capture relevant clinical information but hasn't caused poor care.
- Loose notes not filed. Incomplete or unclear documentation
- No times or dates attached to several of the entries making it very unclear when the patient was discharged and re-attended
- Scanned notes on DPR - difficult to review and therefore resource intensive

This reporting period was dominated by the covid-19 pandemic. Many comments within SJRs related to the quality of documentation which has been noted in previous years. DCH has now invested in a new fully electronic patient record which was introduced in ED and Acute Medicine on 26/04/2022, and which is expected to resolve most of these problems as it is rolled out to other parts of the Trust. However, it is unlikely to become a Trust-wide system within the coming financial year. Identified issues continue to be communicated across the Trust via a newsletter, and cases of suboptimal care are forwarded to departmental Morbidity & Mortality meetings and Divisional, Care Group and Specialty Governance meetings for further discussion and learning.

- AGYLE (Electronic Patient Record) software introduced 26/04/2022
- A repeat audit of Do Not Attempt Resuscitation (DNAR) forms was completed which identified that most forms are correctly completed, but that additional training would be beneficial on aspects of communication and documentation which have been problematic during the

COVID 19 pandemic. A training plan is currently being discussed and an action plan will be put in place.
- The redesigned patient record note paper containing printed watermark reminders to date, time, sign and record their PIN number with each entry is now in use across the Trust.
- Identification of a deteriorating patient, especially where sepsis or cardiac arrest occurs remains a priority. An 'All Cause Deterioration' pathway is in use across the Trust and will be audited once embedded.
- VTE assessment recording was changed to a different IT system (EPMA) from mid-July 2020 and resulted in immediate achievement of the 95% recording target. A subsequent audit has shown that prescription of thromboprophylaxis is in line with this figure.

The following is an assessment of the impact of the actions described above during the reporting period.

- Timing & signing of notes entries – Introduction of a partial Electronic Case Note Record commenced 26/04/22 and as it is rolled out, will solve any residual problems of signature and dating.
- Identification of a deteriorating patient is under constant review by the Trust's sepsis group, and the 'All Cause Deterioration' documentation is in use since 2020/21 Q4.
- All case notes involving the End-of-Life Care pathway are reviewed by the EoLC group, chaired by a palliative care consultant, and with a review of DNAR orders and appropriateness of escalation of care decisions. Results are to be reported back to HMG on a regular basis.
- Surgical admission clerking/differential diagnosis is now a taught session as part of FY1 education – usually delivered by the Trust Medical Director. Notes will be reaudited during 2021/22.
- VTE assessments have achieved the national standard of 95% within 24 hours of admission during the year overall. The Trust's Thromboembolism Group has been reconfigured with a dedicated consultant lead since May 2021.

51 case record reviews and 0 investigations completed after 31/03/2021 which related to deaths which took place before the start of the reporting period.

Mortality Outcomes Data - Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

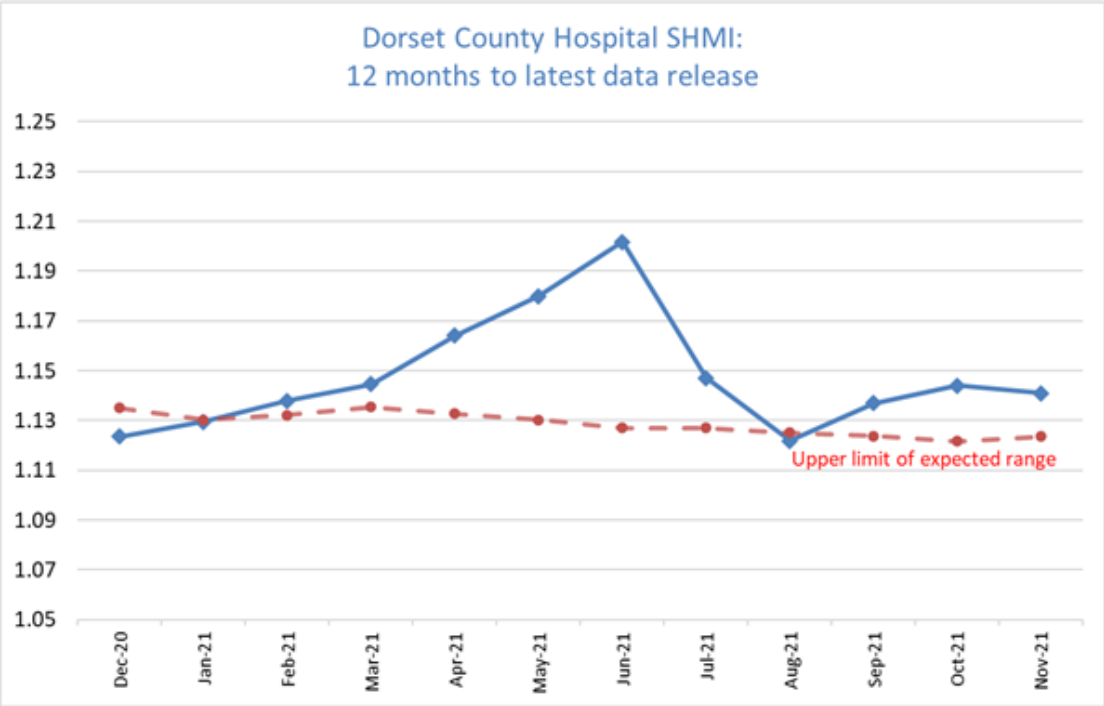
It covers all deaths of patients who were admitted to non-specialist acute trusts in England, and who either died in hospital or within 30 days of discharge.

A lower score indicates better performance. In addition to individual scores, trusts are categorised into one of three bandings: 1 (SHMI higher than expected); 2 (SHMI as expected); 3 (SHMI lower than expected).

	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021
DCH SHMI 2021	1.124	1.130	1.138	1.145	1.164	1.180	1.202	1.147	1.122	1.137	1.144	1.141
DCH SHMI Banding	2	2	1	1	1	1	1	1	2	1	1	1
% Deaths with palliative	44	45	44	42	38	36	37	40	40	38	38	38

care coded												

Latest published data prior to submission November 2021. For further information about the fluctuation in SHMI during 2021 please see the Q2 Learning from Deaths report published on the Trust internet site.



Summary Hospital-level Mortality Indicator	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	Trend
Banding	**2**	**2**	**2**	**1**	**2**	**1**	**1**	**2**	**1**	**N/A**	
Value	**1.07**	**1.11**	**1.10**	**1.16**	**1.12**	**1.17**	**1.19**	**1.13**	**1.14**	**N/A**	
% of patient deaths with palliative care coded at either diagnosis or speciality level	**12.0%**	**13.5%**	**15.7%**	**24.9%**	**35.6%**	**32.3%**	**33.0%**	**39.0%**	**42.0%**	**N/A**	
National Average	*19.9%*	*23.6%*	*25.7%*	*28.5%*	*30.7%*	*32.5%*	*35.0%*	*37.0%*	*38.0%*	*N/A*	
Lowest	*0.1%*	*0.0%*	*0.0%*	*0.6%*	*11.1%*	*12.6%*	*12.0%*	*9.0%*	*8.0%*	*N/A*	
Highest	*44.0%*	*48.5%*	*50.9%*	*54.6%*	*56.9%*	*59.0%*	*60.0%*	*58.0%*	*63.0%*	*N/A*	

Latest publication up to November 2021. Full year 2021/22 data published August 2022

The England average SHMI is 1.0 by definition, and this corresponds to a SHMI banding of 'as expected'. For the SHMI, a comparison should not be made with the highest and lowest trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, **it is inappropriate to rank trusts according to their SHMI**.

Source

Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation - NHS Digital

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

Patient Reported Outcome Measures (PROMs)	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18^	2018/19	2019/20	2020/21*	2021/22*	Trend
Groin Hernia											
Dorset County Hospital	**0.076**	**0.076**	**0.066**	**N/A**	**0.068**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	
National Average	*0.085*	*0.085*	*0.084*	*0.088*	*0.086*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest											
Highest											
Hip replacement											
Dorset County Hospital	**0.461**	**0.445**	**0.466**	**0.471**	**0.462**	**0.506**	**0.501**	**0.453**	**N/A**	**N/A**	
National average	*0.438*	*0.436*	*0.437*	*0.438*	*0.445*	*0.458*	*0.457*	*0.453*	*0.467*	*N/A*	
Lowest											
Highest											
Knee replacement											
Dorset County Hospital	**0.304**	**0.297**	**0.305**	**0.341**	**0.299**	**0.356**	**0.361**	**0.35**	**N/A**	**N/A**	
National average	*0.318*	*0.323*	*0.315*	*0.320*	*0.324*	*0.337*	*0.337*	*0.334*	*0.317*	*N/A*	
Lowest											
Highest											
Varicose Vein											
Dorset County Hospital	**N/A**	**N/A**	**0.099**	**0.127**	**0.043**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	
National average	*N/A*	*0.093*	*0.095*	*0.096*	*0.092*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	
Lowest											
Highest											

Provisional publication for 2020/21, 2021/22 data currently not published

In order to respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In addition it is possible that behaviours around activities relating to the completion, return and processing of pre and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place

^NHS England discontinued the mandatory varicose vein surgery and groin-hernia surgery national PROM collections from October 2017

Source
https://digital.nhs.uk/patient-reported-outcome-measures

A higher number demonstrates that patients have experienced a greater improvement in their health.

Emergency Readmissions

The table below shows the percentage of emergency readmissions to the Trust within 28 days of a patient being discharged.

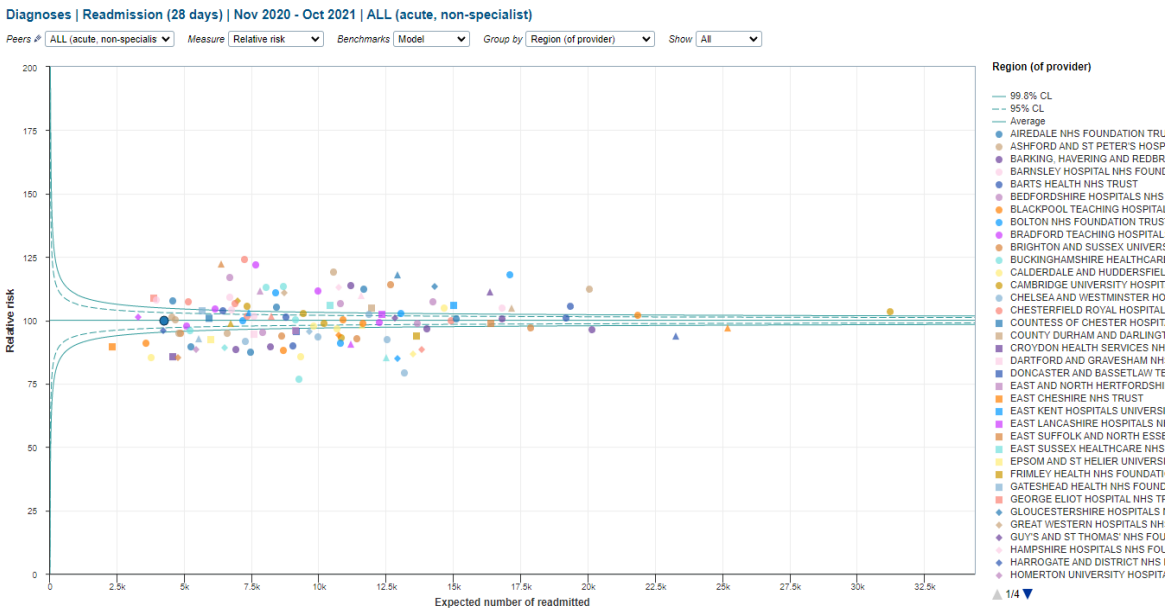
A readmission to hospital within 30 days may suggest either inadequate initial treatment or a poorly planned discharge process. The following funnel chart below shows number of readmissions within 28 days during 2021 for all acute, non-specialist Trusts. The large blue dot shows DCH's rate exactly on the average line (relative risk 100), demonstrating no increased risk of readmission within 30 days compared with other Trusts.

Readmissions within 28 days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Aged 0 to 15 years										
Total Spells	5,147	4,749	4,676	4,948	4,975	4,778	4,677	4,568	3,165	4,260
Of which, readmitted as an emergency within 28 days	456	393	442	471	488	478	508	573	372	527
Dorset County Hospital	**8.9%**	**8.3%**	**9.5%**	**9.5%**	**9.8%**	**10.0%**	**10.9%**	**12.5%**	**11.8%**	**12.4%**
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Aged 16 years and over										
Total Spells	16,832	16,103	17,567	18,263	18,837	17,957	17,920	18,196	14,439	17,081
Of which, readmitted as an emergency within 28 days	1,741	1,695	1,994	2,222	2,295	2,142	2,316	2,504	2,087	2,204
Dorset County Hospital	**10.3%**	**10.5%**	**11.4%**	**12.2%**	**12.2%**	**11.9%**	**12.9%**	**13.8%**	**14.5%**	**12.9%**
National average	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Lowest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Highest	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

Source Internal DCH report which follows the guidance as stated on p22 of:
https://improvement.nhs.uk/uploads/documents/Detailed_req_for_assurancefor__qual_repts_16-17_.pdf
NHS Digital has not published the recommended source reports since December 2013

Recommended Source (not available - see comment below)
https://indicators.hscic.gov.uk/webview/
Section Compendium of population health indicators > Hospital Care > Outcomes > Readmissions
To find the percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge: indi
To find the percentage of patients aged 16 or over readmitted to hospital within 28 days of being discharged, download "Emergency readmissions to hospital within 28 days of discharge
Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

S:\Information\ICS Clone\28 Day Re-Admissions\QA_Methodology_Emergency_Re_Admissions.mdb
Amend dates in append query and run macro



Responsiveness

The indicator is a composite, calculated as the average of five survey questions taken from the annual national inpatient survey.

Responsiveness to the personal needs of patients	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	Trend
Dorset County Hospital	**66.9**	**69.9**	**71.1**	**69.6**	**70.2**	**69.0**	**68.2**	**67.0**	**76.7**	**N/A**	
National average	*68.1*	*68.7*	*68.9*	*69.6*	*68.1*	*68.6*	*67.2*	*67.1*	*74.5*	*N/A*	
Lowest	*57.4*	*54.4*	*59.1*	*58.9*	*60.0*	*60.5*	*58.9*	*59.5*	*67.3*	*N/A*	
Highest	*84.4*	*84.2*	*86.1*	*86.2*	*85.2*	*85.0*	*85.0*	*84.2*	*85.4*	*N/A*	

2021/22 data to be published March 2023

As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding scoring regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years.

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.
NHS OF will be published on an annual basis from March 2022 onwards. The August 2021 release was the final quarterly publication.
Source
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/may-2020/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

The overall score can range from 0 to 100, a higher score indicating better performance. If all patients were to report all aspects of their care as 'very good' this would equate to an overall score of 80. A score of approximately 60 would indicate 'good' patient experience.

Staff Friends and Family Test (SFFT)

This test forms part of the national NHS Staff Survey undertaken in quarter 3 of each year. These figures are taken from the 2021 survey.

Results for 2021 survey shows a drop in completion locally and nationally. This is as a direct result of the Covid Pandemic

Staff survey feedback - staff who would recommend the Trust as a place to receive treatment to family or friends	2017	2018	2019	2020	2021

Dorset County Hospital	76%	**80%**	**78%**	**80%**	**66%**
National Average (median)	71%	**71%**	**69%**	**74%**	**58%**

Venous thromboembolism (VTE)

Venous thromboembolism (VTE) is an international patient safety issue and a clinical priority for the NHS in England.

VTE is a collective term for deep vein thrombosis (DVT) – a blood clot that forms in the veins of the leg; and pulmonary embolism (PE) – a blood clot in the lungs. It affects approximately 1 in every 1000 of the UK population and is a significant cause of mortality, long term disability and chronic ill-health problems.

There is no year end data since 2019/20 as collection and publication was suspended in line with national guidance to release capacity within providers to support and manage the Covid-19 pandemic

Rate of admitted patients assessed for VTE	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20*	2020/21*	2021/22*	Trend
Admissions	24,026	87,426	91,462	96,063	96,797	98,692	99,443	59,516	N/A	N/A	
Of which, VTE risk assessed	22,077	85,211	87,371	92,847	92,813	94,793	94,133	52,933	N/A	N/A	
% VTE risk assessed	**91.9%**	**97.5%**	**95.5%**	**96.7%**	**95.9%**	**96.0%**	**94.7%**	**88.9%**	**N/A**	**N/A**	
NHS Standard	*92.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*N/A*	*N/A*	
National Average	*94.0%*	*95.8%*	*96.1%*	*95.8%*	*95.6%*	*95.3%*	*95.6%*	*95.5%*	*N/A*	*N/A*	
Lowest	*80.2%*	*66.7%*	*88.6%*	*76.9%*	*0.0%*	*75.1%*	*0.0%*	*71.8%*	***N/A***	***N/A***	
Highest	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*N/A*	*N/A*	

2019/20 nationally published data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic

Source
https://www.england.nhs.uk/statistics/statistical-work-areas/vte/
https://improvement.nhs.uk/resources/vte/

Clostridium difficile C-Diff

Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea. People who become infected with C. difficile are usually those who have taken antibiotics, particularly the elderly and people whose immune systems are compromised. For each HOHA – hospital onset healthcare acquired care (stool sample taken after day 2 of admission, day one being day of admission) and COHA -community onset hospital associated case (inpatient in previous 28 days prior to sample being taken) a full route cause analysis is performed to identify any learning or lapses in care with particular attention on sampling in a timely manner, isolating patients with new onset of diarrhoea and justification of prior antibiotic use.

Due to COVID-19 there has been a delay in formal review of these cases by the CCG and several PIR (post incident review) have been cancelled. As a result of this, not all the cases have yet been formally reviewed to agree if they can be removed from trajectory (learning identified). Of the cases reported for 2021/2022 to date there have been 55 HOHA and COHA cases 24 of these cases have been agreed as non-trajectory (no lapses in care or learning) 10 cases agreed as trajectory and 21 cases pending PIR via the CCG.

C-difficile rates per 100,000 bed-days	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	Trend
Bed-days	101,156	102,674	98,654	105,719	99,883	98,908	98,845	100,903	77,905	N/A	
C-difficile cases	22	27	15	24	13	10	10	10	15	N/A	
C-difficile rate	**21.7**	**26.3**	**15.2**	**22.7**	**13.0**	**10.1**	**10.1**	**9.9**	**19.3**	N/A	
National Average	*17.4*	*14.7*	*15.0*	*14.9*	*13.2*	*13.6*	*12.2*	*13.6*	*15.4*	*N/A*	
Lowest	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*N/A*	
Highest	*31.2*	*37.1*	*62.6*	*67.2*	*82.7*	*91.0*	*79.7*	*51.0*	*80.6*	*N/A*	

2021/22 data currently not published
Source
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

Incidents

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

The trust actively encourages staff to report incidents and 'near-miss episodes. Incident reporting is a positive culture of open transparency on safety within The Trust. All reporting is disseminated to ensure that key learning points are shared throughout the organisation.

Patient safety incidents reported	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22*	Trend
Number of patient safety incidents reported to NRLS	2,945	1,736	2,116	4,609	4,493	4,838	4,997	5,542	5,552	N/A	
Admissions	51,184	50,530	98,666	105,413	99,883	99,491	98,845	100,903	77905	N/A	
Incident rate per 100 admissions	**5.8**	**3.4**	**2.1**	**4.4**	**4.5**	**4.9**	**5.1**	**5.5**	**7.1**	**N/A**	
National Average	*7.1*	*7.7*	*3.6*	*3.9*	*4.1*	*4.3*	*4.5*	*4.9*	*5.8*	*N/A*	
Lowest	*2.5*	*3.0*	*1.7*	*1.6*	*1.9*	*1.6*	*2.1*	*2.1*	*1.5*	*N/A*	
Highest	*27.8*	*30.4*	*10.2*	*13.0*	*14.8*	*16.7*	*14.2*	*18.1*	*18.5*	*N/A*	
Incidents resulting in severe harm or death	25	3	19	25	24	22	25	28	23	N/A	
Percentage of incidents resulting in severe harm or death	**0.85%**	**0.17%**	**0.90%**	**0.54%**	**0.53%**	**0.45%**	**0.50%**	**0.51%**	**0.41%**	**N/A**	
National Average	*0.65%*	*0.55%*	*0.49%*	*0.41%*	*0.37%*	*0.34%*	*0.32%*	*0.30%*	*0.44%*	*N/A*	
Lowest	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*N/A*	
Highest	*3.34%*	*3.90%*	*4.18%*	*1.74%*	*1.58%*	*1.76%*	*1.35%*	*1.31%*	*2.80%*	*N/A*	

2021/22 data currently not published
NHS OF will be published on an annual basis from March 2022 onwards. The August 2021 release was the final quarterly publication
Source
NHS Outcomes Framework (NHS OF) - NHS Digital

Part 3 – Other Information

This section of the report provides further detail on the quality of services provided or subcontracted by the Trust in the period 2020/21.

Patient Safety – Reducing avoidable harms from Hospital Falls

The Trust is committed to preventing slips, trips, and falls wherever possible and minimising risk to patients in their care. Staff have specific duties in relation to assessing and managing the risk of falls in patients in order that preventative measures can be taken wherever possible.

The number of falls within the Trust has remained unchanged over time. As part of the Patient Safety Strategy, falls have been identified as one of the priority work streams to be taken forward within the Trust. The work will be led by a newly formed frailty group. This will

involve multi-professional membership to include pharmacy, dietetics, and physiotherapy alongside clinical staff. It is recognized that falls are a multifactorial problem and cannot be addressed by one group of staff alone. It is envisaged that the frailty group will be overseen and report to the Clinical Safety Group.

Patient safety – All Cause Deterioration

The Trust have moved forward with a number of initiatives over the last year. The national emphasis has moved from the identification and management of sepsis to that of all cause deterioration, of which sepsis is a part. The Trust sepsis group has therefore been decommissioned, as it had achieved its objectives. This has been replaced by a Deteriorating Patients Group (DPG). This has a multi-professional membership and wider work plan.

The Commissioning for Quality and Innovation (CQUIN) scheme was paused during the pandemic but has been reintroduced this year, 2022 -2023. There are 15 indicator specifications, one of which is CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. This does not currently look at the quality of the patient management but the timing of any escalation. It is thought that this may be expanded next year. Monitoring of compliance with the CQUIN will be overseen by the DPG.

The All-Cause Deterioration Pathway and the Clinical Deterioration Episode (CDE) proforma have now been fully introduced and audit is underway to measure improvement in practice. Use of the CDE form will also allow collection of data to contribute to the CQUIN.

A Patient Safety Specialist has been appointed, as recommended in the National Patient Safety Strategy. They will oversee the workstreams set out above whilst taking forward the nine national priorities for the role. As there is much overlap between some of these priorities and the Trust risk management strategy, the two departments will join to form the Paient Safety and Risk department.

Improving Mortality Surveillance and reducing Variation

To reduce duplication as per the guidance for writing a Quality Account, the Information regarding this metric is enclosed within Part 2

Clinical Effectiveness – Promoting the Health and Wellbeing of staff

Goal 2021-2022: Staff can access quality information to look after their health and wellbeing and can get support when they need it.

Why is the Health and Wellbeing of staff important to delivery of outstanding care?

The health and wellbeing of staff continues to be a high priority and is imperative for ensuring safe, high-quality care for Trust patients. In order that DCH can support care quality and mitigate risk, reduce waiting lists, and support elective recovery, they must support people recovery.
The evidence shows that when the staff feel well and satisfied with their work, the experiences of patients improve. It makes sound business sense to ensure all staff can access timely, relevant, and evidence-based support to maintain and improve their health and wellbeing.

How did DCH perform?

The Trust offers the current initiatives and support:

Wellbeing Guardian

The introduction of a Wellbeing Guardian within the Trust aligns with the current work to implement elements of the NHS Health and Wellbeing Framework. The Wellbeing Guardian role will support further development of a compassionate and inclusive wellbeing culture by independently challenging senior leaders and championing the messaging of the Trust's People Plan.

Staff Intranet

A Clinical Psychologist has been working directly with the Organisational Development (OD) Team to develop evidence-based approaches to health and wellbeing. These approaches have informed development of a 'wellbeing continuum' and assessment tools to help with self-assessment and triage approaches for more efficient signposting to appropriate support.
A new staff portal on the staff intranet has been developed where staff can access the assessment tools and be directed to relevant resources and a range of support options.

Internal courses and self-directed learning

The Trust's refreshed Health and Wellbeing (HWB) offer encourages both preventative and proactive elements, underpinned by a programme of internal courses and self-directed learning to help staff manage stress and anxiety. Self-directed learning comes in the form of workbooks, written by Clinical Psychologists. NICE guidelines clearly assert that self-help is very effective for people with mild to moderate anxiety levels.

Health and Wellbeing Coaches

A network of staff Health & Wellbeing Coaches (HWCs) has been launched to help signpost colleagues to appropriate support. The HWCs have volunteered to support and publicise events and initiatives which benefit the health and wellbeing of staff and provide a way for staff to feedback their experiences. This network is a rebranding and strengthening of Wellbeing Champions which had previously only been partially implemented across the Trust. The HWCs form an internal Community of Practice, with opportunities to join system-wide Networks and further development opportunities including Mental Health First Aid and Suicide Awareness.

Mental Health First Aiders

The Trust has 2 in-house Mental Health First Aid (MHFA) Instructors qualified to deliver Mental Health First Aider (MHFA) 2-day, 1 day Champion and half-day Awareness sessions to staff and partners. DCH currently has 75 MH First Aiders and continue to recruit from all teams, targeting particularly vulnerable groups such as junior doctors. Many MH First Aiders have opted to become Health & Wellbeing Coaches to develop wider awareness and skills to enhance the HWB support they can provide to colleagues.

Wellbeing Conversations

Throughout the last year the appraisal process has primarily focused on wellbeing conversations. From May 2022, managers will be offered the NHS Safe & Effective Wellbeing Conversations course to develop skills and approaches to further support staff.

Occupational Health & Wellbeing

The role of the Occupational Health (OH) and Wellbeing Service is to act in an advisory capacity to both staff and managers to promote and maintain the highest possible levels of health and wellbeing in the workplace. The OH and Wellbeing service is both confidential and impartial.

Employee Assistance Programme (EAP) – Vivup

Vivup are a leading provider of professional counselling, information and advice offering support for issues arising from home or work. They employ professionally qualified Counsellors and Information Specialists, who are experienced in helping people to deal with all kinds of practical and emotional issues.
All staff can access Vivup confidentially on the phone 24 hours a day. They provide additional support in both work and non-work related matters. From work-life balance to childcare information, relationships to workplace issues, health & wellbeing. Topics include (but are not limited to) Debt, disability & illness, bereavement & loss, stress, elder care information, life events, anxiety & depression, family issues, education, and consumer rights.
Vivup offer all the benefits listed above with the addition of a full benefits package including Cycle to Work, Travel & Leisure and access to a huge range of discounts across UK's major retailers.

On-site counselling service

The on-site counselling service has received guaranteed funding for the next 12 months. To ensure the service is sustainable and appropriately used, sessions will be capped, and usage monitored.
The on-site counselling service is available over 7 days. Staff with urgent needs are usually offered an appointment within 48 hours of contacting the service.

Trauma Response

Staff are supported by trauma response network across the Trust. TRiM (Trauma Risk Management) is a peer delivered assessment tool, used to determine by what degree, if any, a colleague has been affected by a potentially traumatic incident, and to ascertain whether they would benefit from further support. The network of trained TRiM practitioners will increase during 22/23, to strengthen the trauma response capacity.
Staff also have access to a 60-minute session focusing on self-care and peer support, particularly how to look for signs of psychological distress and potential trauma in self and others. This been delivered by a Clinical Psychologist to several teams across the Trust and received excellent feedback.

Physiotherapy

All staff can access physiotherapy services via self-referral or through their line manager.

Wellbeing Walkarounds

The Wellbeing Walkaround process has been refreshed following an escalation from the People Recovery Steering Group (PRSG) to the Incident Management Team. The Walkaround timetable will prioritise areas based on known 'hot spots', People Pulse feedback and discussion with leaders within divisions and departments. The Wellbeing Walkarounds are supported by members of Senior Leadership Group (SLG), the Executive Management Team (EMT) and senior members of the People Division. The refreshed Wellbeing Walkarounds will provide visibility and accessibility to leaders as a platform for the staff voice and to show compassion and support, whilst providing targeted HWB interventions for individuals and teams.

Financial Wellbeing

Salary Finance, a financial wellbeing service (previously called Neyber) has been available to staff since February 2019, with a financial wellbeing portal offering free financial planning tools.

Pre-Retirement Planning

The Trust offers Pre-Retirement sessions for staff thinking about retiring in the next 3-5 years. These are delivered by Affinity Connect and offer the opportunity to start looking at all the various options

available and planning. This session also includes information from Livewell Dorset on the importance of remaining active in the retirement years and the health benefits of doing so.

Chaplaincy Service

Chaplains are employed by the Trust to provide confidential support and pastoral care to patients, carers, and staff. This support is completely confidential and available to people of all faiths and none.
The Prayer Room is also available at all times of the night and day as a place of quiet reflection and prayer.

Here for Each Other (Dorset ICS Wellbeing Hub)

The Here for Each Other service complements and enhances the on-site counselling and staff wellbeing support that is in place at DCH. The service has a variety of advice and guidance from trusted sources to help staff manage their own wellbeing. There is a link to this service on the Staff Intranet Wellbeing pages.

Covid and Flu Vaccinations

The Trust has successfully undertaken Covid and Flu vaccination campaigns. The Trust's Vaccination Hub and pop-up centres continue to offer staff easy access to vaccinations and boosters as required. The 2021/22 Flu vaccination campaign highlighted the Trust as one of the best performing for the year.

Clinical Effectiveness - Improving the identification, assessment, and referral for patients with Dementia

Dementia screening has improved since the appointment of 1.4WTE Dementia/Delirium support workers (Started in October 2021). Previously dementia assessments, in their old format have been variable and therefore the Trust welcomes a re-newed focus on all cause delirium.
They have been undertaking delirium screening of patients and following patients through their inpatient stay which enables the team, to assess, diagnose where appropriate, treat and discharge with onward care and support.
The support workers also visit every patient on the inpatient wards with a known diagnosis of Dementia to ensure that a support bundle in placed in the notes which signposts staff for additional support.
The Trust has been working with the digital team to ensure that 4AT delirium screening starts from ED and so have been part of the Agyle project*.
ANP for Dementia/Frailty continues to deliver education on Dementia, Delirium and behaviours that challenge to preceptorship students, medical training and offers bespoke training to ward teams.
Continued work on a frailty strategy with the wider MDT to provide an equitable service across the trust for patients living with Dementia.
ANP for Dementia/Frailty is engaged with the research department and is currently undertaking some research related activity funded by NIHR ARC Wessex looking at the link between Covid-19 and cognitive impairment

* *Argyle is a digital patient record solution which facilitates real time clinical documentation, clinical process management, and operational management functionality. It forms part of the Trust's Digital Patient Record, and when fully implemented will be used in the Emergency Department and Inpatient areas.*

Patient Experience – Improved Learning from Complaints

Goal 2021-22:

The Trust will ensure that they learn when patients tell us they have not had a good experience with us.

Following on from the national pause of NHS Complaints during 2020, DCH have continued with a 40 working day response timeframe which was agreed by both Divisions. As the hospital has continued to experience high demand, this enabled the Trust to respond to complaints in a realistic timeframe due to the demands on the clinical staff during the past year. This timescale will continue to be monitored via the Patient Experience Group quarterly reports.

Why is learning from complaint important?

A complaint is an expression of dissatisfaction made to or about an organisation, related to its products, services or staff. Complaints are an important way for the organisation to continual learn and improve and ensure an organisation remains accountable to the public. They also provide valuable feedback to identify areas to celebrate good practice and areas where practice or services need to improve. The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints for the organisation to learn from what has happened to them. The Trust considers this feedback invaluable.

Ideally DCH would like to address any dissatified service user experience at the time, however when this has not been possible a complaint is an invaluable way to resolve concerns, acknowledge and apologise for errors and be open to learning for improvement.
For the complainants to be assured that the Trust has taken their complaint seriously and DCH have taken the opportunity to learn from their complaint, the learning points are included in the complaint response.
The actions from learning points are monitored at Divisional and Care Groups meetings.

How did DCH perform?

Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings and support is provided by the Patient Experience Team which enables them to understand the emotional experience from the complainant and staff perspective and reflect upon improvements in relation to aspects of care.
Patients have continued assisted in making videos narrating their experience of the care that they received, and their feelings about the complaints process. These videos are shown to the relevant divisional leads and are available for presentation at Board when required.

Trust wide Performance

Learning and actions from complaints are monitored through the Divisions and Care Groups and where appropriate learning is shared across the organisation. Examples of learning from complaints are included in the quarterly Patient Experience report and reviewed by the Quality Committee.
Although the Trust have made progress in learning from complaints, using the digital system to help capture this, there is still more that could be achieved to fully embed and monitor learning from complaints in the Trust and across the system. As the Integrated Care System develops the shared learning will be DCH focus for the next year.

Patient Experience – Volunteer Report 2021/22

Goals for 2021/22

Reimagining, remaining flexible and responding have been the key themes for the volunteer service over the last 12 months. These themes have shaped key goals for the service which are:

Young Volunteer Programme

To sustain and develop the Young Volunteer Programme (YVP) in line with the Pears #iWill Fund beacon area commitments, focusing on both volunteer opportunities within the Trust and community engagement projects.

Volunteer Service Development

To continue to develop the volunteer service with focus on development of the Response Volunteer Team.

Volunteer Experience

To continue to collaborate with volunteers to ensure the volunteer experience at DCH is positive and that the volunteer roles and opportunities DCH offer are meaningful, safe, and support the Trust. This report focuses on what has been achieved over the last 12 months and how they have expanded the service to support changes within the Trust.

How did DCH perform?

Young Volunteer Programme

DCH have continued to recruit a steady stream of Young Volunteers over the last 12 months but have struggled to continue to develop the programme in the ways they had planned. This is partly due to ongoing COVID restrictions and partly due to unforeseen demands on the service which has limited capacity. Despite this, DCH were able to deliver a Summer Activity Programme in August 2021 which saw Young Volunteers take part in workshops looking at the future Emergency Department plans from a young person's perspective, a research workshop and dementia awareness training. One of the young volunteers was also given the opportunity to volunteer in the Maternity unit during the summer holidays.

DCH have been able to support Weymouth college Health and Social Care students offering them volunteer placements. They have been able to count their volunteer experience towards meeting the requirements of their college course. DCH have reengaged with both Blandford Sixth Form and Weymouth College attending their volunteer fairs which they have been able to hold face to face again. The Trust will continue to reengage with local schools and colleges into the 2022/23 year.

After agreement from the Trust Senior Leadership Group, DCH signed a MOU with St Johns Ambulance (SJA) in September 21 to open an NHS Cadet unit linked to the Trust. This is due to start running in May 2022 following recruitment of cadets and a project lead. The project is funded by NHSEI and run by SJA and gives opportunities for young people aged 14 to 18 to take part in a programme which will see them complete training ranging from learning first aid skills to developing leadership skills. As part of this programme, DCH will offer those on the foundation programme (14 to 16 years) opportunities to visit the hospital and learn more about different services and careers. The

young people on the Advanced programme (16-18) will be offered volunteer placements in the hospital.

The Trust has also re-established discussions with the Dorset Youth Association and hope to collaborate with them and other youth groups in the next 12 months to establish a Youth Voice across Dorset. This will link to the #iWill theme of 'Having your Say' promoting Youth Social Action.

Volunteer Service Development

The focus over the last year has very much been on building theTrust Response Volunteer Team and that is quantified in part by the increase in requests for volunteers to support on Wards. The role is divided into two key areas:

- Healthy Stay: Supporting Inpatients on Wards with key tasks, for example hydration rounds, meal-time support, and PPE replenishment.
- Healthy Visit: Supporting in Main entrances and Outpatient departments.

Whilst the demand for support on wards from the Trust's healthy stay team has been evident through the requests received, the role of the healthy visit team is of equal importance. Alongside ongoing support to the Dialysis Unit and Medical / Surgical Outpatients, the team support main entrances, meeting and greeting and directing. They have also increased support where numbers allow in ED Triage and most recently have started to provide regular support one morning per week in the Robert White centre. Along with the healthy stay team they also continue to ensure the daily distribution of surgical masks to departments across the hospital. They support areas which are not necessarily staffed (i.e., South 1 main entrance) so they do not receive requests for their help. However, when these areas are covered by volunteers supporting patients and visitors coming into the hospital, it makes an enormous difference to patient experience.

Six volunteers in the Response Volunteer Team completed Sitting Companion training in September 2021 with the Palliative Care team. They now 'check in' with the team as part of their shift and provide support for patients at End of Life.

Funding from NHS England in the 2019/20 financial year has also enabled us to plan a project to support patient activity. Planning continued throughout last year and equipment to deliver this service has now been purchased. The Trust will be conducting training with volunteers starting in June 2022 to enable them to support staff on wards with patient activity.

The Trust took on the volunteer service at South Walks House, (SWH) Outpatient Assessment Centre just before it opened in November 2021. 60 volunteers were inducted in the first two weeks of opening enabling the volunteers to support the new centre. This was no easy task and supporting this with no additional resource has meant the reprioritisation of other projects. This is a new volunteer service

operating in a new service for the Trust and has inevitably seen challenges. The Volunteer team are collaborating with the team at SWH to overcome these challenges and with the volunteer team to develop and shape the role. As part of the development plans at SWH, the Trust are also working with the Live Well / Active Dorset team to develop the Wellbeing Champion branch to the SWH volunteer role.

The last 12 months has also seen us working with a team from the CCG and the voluntary teams at UHD and DHC to deliver the new Better Impact - data base software. The system already used successfully in other NHS trusts will see us migrate volunteer recruitment, training, and management into one system which is designed for volunteers. It has also given us a chance across the three Trusts to align the volunteer processes and share best practice. DCH are on target now to go live with the recruitment element of the system from June 2022.

Alongside the roles mentioned above the volunteer team have also continued to support other roles in the hospital including the Chaplaincy Assistants, Patient Research Ambassadors, the Friends of DCH and the YFW Blood Bikes. Figure 1 below shows the breakdown of volunteers per role at the end of March 2022.

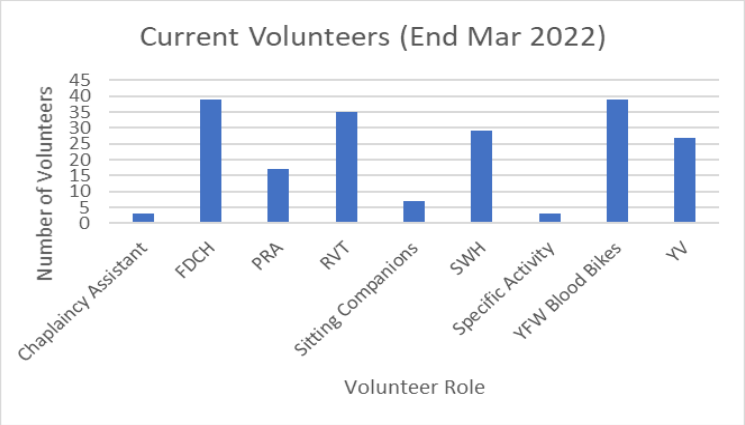


Figure 1 – Active Volunteer Role Numbers

COVID restrictions have continued to affect some roles returning to normal, this includes the Chaplaincy Assistants and also DCH PAT dog and Music volunteers, some of which have completed the returning to volunteering COVID risk assessment but who are now just waiting for the green light to resume their volutneer role in the hospital.

Volunteer Experience

DCH were delighted that as the end of September 2021 approached, the volunteers moved into the new and permanent volunteer hub. The new hub is located has been vital to supporting volunteers in

the Response role giving them a base from which to operate and support effectively. This has in turn contributed to improving their experience.

Whilst COVID restrictions have prevented us from holding the Trusts annual 'thank you' events during the Summer and at Christmas, DCH has made sure it has acknowledged their contribution by providing thank you gestures in the hub and recognising their achievements through nominations at the Trust annual GEM awards, where DCH was delighted to see three of the team win the volunteer of the year award.

Volunteer health and wellbeing has been a priority for the service over the last year and continue to monitor closely the health and wellbeing of the volunteers. The support team make it a priority to be present so they can offload to us when they need too. They are also taking positive steps as a team to make sure the Trust is better equipped to support the health and wellbeing of volunteers. This has included a volunteer co-ordinator taking part in the first Health and Wellbeing Champion training course at the Trust. The support they provide for one another also continues to grow and the team ethos between themselves and the growing positive response they receive from staff and patients they help, is helping and providing a more positive atmosphere and volunteer experience.

Summary and the Year ahead

The focus over the last 12 months has largely been to continue to respond to changes and work with a small team of volunteers to shape the service provided. The next 12 months will see DCH build that team so that it can provide more effectiveness and opportunity both on the main hospital site and at South Walks House. To enable additional capacity to achieve this and to expand the voluntary services team, DCH are thankful for the funding from NHS England Voluntary Partnerships Winter funding programme. The funding supports anew post that will assist the team in their aspirations and the impact of this will be monitored as part of the overall delivering of volunteer support.

As part of the partnership approach of DCH the Trust will continue to work with the NHS England voluntary partnerships team, other NHS Voluntary teams and the wider voluntary sector is a key part of ongoing development of the service and will continue to contribute to the network and work with them on various projects. This is helping DCH to look ahead and understand better how volunteering will look in the future. This will be vital in looking at how DCH develop and recruit into volunteer roles which support the Trust, and which are safe, but which also offer flexibility, meaningfulness opportunities to use and develop individual skills and experience, as part of the social value pledge to the local communities.

As DCH head into another 12 months it will certainly continue to be busy, will see the projects come to fruition and hopefully offer opportunity to do more. Whilst DCH will need to remain flexible to changes, it will continue to build on what it has already achieved and continue the work to ensure it can provide a consistent volunteer service and positive volunteer experience.

Speaking Up Disclosure

It is a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian (FTSUG). The Guardian's key role is to support the creation of a positive, open learning culture where people feel listened to, and feedback is welcomed, and acted on. The Trust have designated FTSU roles including the FTSU Guardian, Senior Independent Officer who holds a Non-Executive Director position on the Trust Board, and FTSU Champions across the Trust. The holders of these roles ensure all methods of raising concerns are promoted, including Line Managers/Supervisors and colleagues, the Human Resources (HR) Team, Patient Safety & Risk Team, Trade Unions, Occupational Health and Chaplaincy Services, Professional Regulars, and the National Guardian Office. Staff are encouraged to Speak Up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust.

At DCH the FTSUG role is as a facilitator and enabler rather than 'fixer' of issues, following up with line managers on progress in resolution and identification of trends to support organisation learning. There are several enabling factors that support 'speaking up' throughout the Trust, including a visible leadership culture that supports and encourages the raising concerns at all levels in all parts of the organisation. DCH ensures that those raising concerns are listened to, feel valued and that their concerns receive the appropriate level of review and response. The FTSUG feeds back directly to those who raise concerns or ensures feedback is provided by others involved in cases such as HR Managers and Line Managers. Where staff are concerned, they will suffer detriment for speaking up, their confidentiality is protected (unless required to disclose it by law) and there are options to raise concerns anonymously.

The FTSUG provides six-monthly updates to the Trust Board, as recommended by the National Guardian's office, and meets bi-monthly with the Non-Executive Director responsible for FTSU and the Chief People Officer.

Rota Gaps

The Trust has processes in place to monitor and act on Rota Gaps.

Trainees are encouraged to exception report, and these are used to drive changes including recruitment to fill such gaps. The hospital departments, education team and Guardian work cooperatively to review exception reporting, liaising with doctors in training via the Junior Doctor Forum and aim to tackle problems proactively.

The current GMC survey is active, and the previous results (covering 2020-21 – Covid period) is available from DME presentations contained within the Trust Board papers which are available through the Trust Website.

Risk Assessment Framework and Single Oversight Framework Indicators

The following indicators are a pre-requisite of the Risk Assessment Framework and the Single Oversight Framework to be included by Acute Trusts. More up-to-date data and fuller analysis and narrative is available on the Trust website in the Trust Board papers.

RTT - In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.

ED 4 hour target - A four-hour target in emergency departments was introduced by the Department of Health for National Health Service acute hospitals in England to state that at least 95% of patients attending an A&E department must be seen, treated, and admitted or discharged in under four hours.

62 days wait - All patients who have been referred by their GP or by a dentist on a suspected cancer pathway should receive their first definitive treatment within 62 days of referral receipt or a maximum 62-day wait from referral from an NHS cancer screening service to the first definitive treatment for cancer.

Indicator	Standard	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Trend
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	92%	95.5%	94.9%	93.7%	92.1%	87.6%	85.3%	81.6%	70.6%	47.9%	55.9%	
Maximum ED waiting time of 4 hours from arrival to admission/transfer/discharge (ED Only)	95%	96.5%	94.7%	94.9%	94.1%	93.2%	95.0%	90.5%	82.9%	87.6%	64.1%	
Maximum ED waiting time of 4 hours from arrival to admission/transfer/discharge (Including MIU/UCC from November 2016)	95%	96.5%	94.7%	94.9%	94.1%	95.2%	97.6%	95.5%	91.8%	92.8%	75.2%	
62 day wait for first treatment from an urgent GP referral for suspected cancer	85%	93.4%	88.4%	85.5%	81.7%	86.2%	80.5%	77.9%	78.4%	72.9%	72.2%	
62 day wait for first treatment following a NHS Cancer Screening Service referral	90%	96.8%	96.0%	98.2%	94.9%	83.2%	96.2%	93.8%	72.8%	64.1%	70.3%	
C-Difficile infections^	16	22	27	8	10	7	8	3	13	22	47	
SHMI	1.00	1.07	1.11	1.10	1.16	1.12	1.17	1.19	1.13	1.14	N/A	
Maximum 6 week wait for diagnostic procedures	99%	99.3%	93.9%	94.8%	98.8%	93.0%	91.2%	86.2%	91.5%	64.7%	86.9%	
VTE Risk assessment~	95%	91.9%	97.5%	95.5%	96.7%	95.9%	96.0%	94.7%	88.9%	N/A	N/A	

Target achieved
Target not met

^pre 2019/20 criteria based on hospital acquired cases (post 72 hours) due to lapses in care, from 2019/20 onwards hospital onset healthcare associated cases defined as those detected in hospital three or more days after admission
~2019/20 nationally published VTE data upto December 2019 - VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic

Annex 1 Statement from Commissioners, Local Healthwatch and Overview and Scrutiny Committees

HealthWatch

No requirement for a statement from Healthwatch Dorset is required as per National Guidance.

DCH Lead Governor Commentary on the Trust Quality Report 2019-2020

No commentary required as per national guidance

Statement from CCG

Draft statement has been sent to the CCG and DCH await a response

Statement from Health and overview Scrutiny Committee

No statement required as per National Guidance

Annex 2 Statement of Directors' Responsibility for the Quality Report

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the board:

Mark Addison
Chairman

Nicholas Johnson
Interim Chief Executive

Meeting Title:	**Board of Directors**
Date of Meeting:	**25th May 2022**
Document Title:	**Annual License Condition Declarations:** • **Continuity of Services Condition 7 and General License Condition 6 of the NHS Provider Licence – Availability of Resources** • **License Condition FT 4 – Corporate Governance Statement,** • **Training of Governors**
Responsible Director:	**Nick Johnson, Interim Chief Executive**
Author:	**Trevor Hughes, Head of Corporate Governance**

Confidentiality:	*If Confidential please state rationale:*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Risk and Audit Committee	May 22	Recommended to Board to approve publication

Purpose of the Paper	The purpose of this paper is to detail the Board's self-assessment and declarations of compliance against: • Continuity of Services Condition 7 and General Condition 6 of the NHS Provider Licence **Appendix 1** • License Condition FT 4 – Corporate Governance Statement and Training of Governors - **Appendix 2**						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	It is a statutory requirement for foundation trusts to review their arrangements for effective governance and use and availability of resources and to make a public declaration, approved by the Board of Directors, within two months of the financial year ending. -							
Action recommended	The **Trust Board** is asked to a) **Approve** the Continuity of Service (CoS7) self-certification declaration statement 3b, that over the course of the following 12 months, and subject to the explanation provided, the Board of Directors reasonably expects to have the required resources to deliver Commissioner Requested Services; b) **Approve** the self-certification declaration to confirm compliance with General License Condition 6; c) **Approve** the self-certification declaration to confirm compliance with license condition FT4 and Governor training; d) **Delegate** authority to the Trust Chair and Chief Executive to sign these declarations; e) **Publish** the approved declarations within one month.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Failure to comply would have regulatory and reputational impact.
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	Y/N	
Decision to be made?	Y	To approve the Annual Declarations prior to publication on the Trust Website.
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Appendix 1

Title of Meeting	**Board Of Directors**
Date of Meeting	**26th May 2021**
Report Title	**Continuity of Services Condition 7 of the NHS Provider Licence – Availability of Resources**
Author	Trevor Hughes, Head of Corporate Governance

Introduction

This declaration pertains to condition CoS 7 of the NHS Provider Licence and relates to having the resources required to continue to deliver services designated as being 'Commissioner Requested' over the next 12 months. Commissioner Requested Services (CRS) are services Commissioners consider should continue to be provided locally, even if a provider is at risk of failing financially, and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:.

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

The terms of license condition CoS 7 state:

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the required resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the required resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the required resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the required resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the required resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be

declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

(c) "In the opinion of the Directors of the Licensee, the Licensee will not have the required resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to NHS Improvement with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS Improvement in accordance with paragraph 4 shall be approved by a resolution of the Board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS Improvement immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

3. Self-Assessment

Foundation trusts are required to confirm one of three declarations about the resources required to provide CRS designated services summarised as:

a. the required resources will be available over the next financial year
b. the required resources will be available over the next financial year but specific factors may cast doubt on this
c. the required resources will not be available over the next financial year.

and to explain the reasons for the chosen declaration.

Required resources include: management resources, financial resources and facilities, personnel, physical and other assets.

The Trust considers the services that it is commissioned to provide are 'commissioner requested' services and has confidence that it operates a robust programme of performance management against a number of key quality, performance and finance indicators that are monitored via the performance Score Card and scrutinised via respective Board subcommittees.

The Board also receives the following information on a regular basis:

- Quality and Performance Report including;
  - Quality performance
  - Use of resources
  - Financial performance and rating scores in line with regulatory guidance
- Board Assurance Framework
- Annual Plan and progress reports
- Interim Reports and Minutes from Board sub-committees

Additionally, the Board of Directors meet with the Council of Governors and has regard to their views and is able to be assured about the effective deployment and availability of resources.

The COVID-19 pandemic significantly impacted NHS providers throughout 2021/22 and financing arrangements were radically amended nationally in order to address the crisis. The Operating Plan for 2022/23 has been developed in the context of significant financial challenges ahead and the Board of Directors is therefore requested to approve the declaration **3b**.

The following rationale is recommended to the Board:

The Trust have reviewed the consequences contained within the planning guidance for 2022/23 and submitted an operational plan that does not meet the break-even requirement, despite including the assumption of 2.5% Cost Improvement. The Trust and the wider health system are working on several workstreams that should improve the financial position of the Trust in year, but the current plan anticipates a degree of external borrowing to ensure liquidity can be maintained until the end of the fiscal year.

It is no longer a requirement to submit this declaration to NHS Improvement. However, audits will be undertaken by NHSI to ensure that Trusts complete a self-assessment and approve the subsequent declaration.

4. Recommendation

The Trust Board is asked to:

- **note** the assessment of factors considered in respect of CoS7 licence requirements
- **approve** confirmation of declaration 3b and;
- **approve** delegated authority to the Chief Executive Officer and Chairman to sign the declaration on behalf of the Board of Directors.

Signed

Trust Chair	**Chief Executive**
Date	**Date**

Appendix 1

Title of Meeting	**Board Of Directors**
Date of Meeting	**25th May 2022**
Report Title	**General License Condition 6 of the NHS Provider Licence**
Author	Trevor Hughes, Head of Corporate Governance

Introduction

The NHS Provider Licence sets out the conditions the Trust must comply with to operate as an NHS foundation trust. NHS Improvement may take action against an NHS foundation trust if it is found to be in breach of its Licence conditions. Therefore it is a requirement of an NHS Foundation Trust Board of Directors to make prescribed declarations in regard to the Trust's on-going compliance with the terms of its Provider Licence and Constitution.

This declaration pertains to General Condition 6 of the NHS Provider Licence and relates to having systems for compliance with licence conditions and related obligations in place. The terms of this condition are as follows:

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

(a) the Conditions of this Licence,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are / or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate for the purpose of this Condition within one month of its approval in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Declarations Required by General Condition 6 of the NHS Provider Licence

The Board of Directors is required to either “Confirm" or "Not Confirm" the following statements:

General Condition 6 - systems for compliance with licence conditions
1. Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution;

and

2. The Board of Directors declares that the Licensee continues to meet the criteria for holding a licence. The declaration requires the signature of two Board members to sign on behalf of the Board of Directors and for the Board to have had regard to the views of the Governors.

3. Recommendation

The Board has received the Annual Governance Statement for the 2021/22 Financial Year period. This statement provides assurance of sound corporate and quality governance, risk management and control systems in place to ensure the Trust has met its requirements over this period. Further, the Head of Internal Audit Opinion provided for moderate assurance on the Trust’s internal risk management and control systems.

The **Trust Board** is asked to

- **confirm** compliance with G6 licence requirements and;
- **approve** delegated authority to the Chief Executive Officer and Trust Chair to sign the declaration on behalf of the Board of Directors.

Signed

Trust Chair	**Chief Executive**
Date	**Date**

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Dorset County Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust have reviewed the consequences contained within the planning guidance for 2022/23 and submitted an operational plan that does not meet the break-even requirement, despite including the assumption of 2.5% Cost Improvement. The Trust and the wider health system are working on several workstreams that should improve the financial position of the Trust in year, but the current plan anticipates a degree of external borrowing to ensure liquidity can be maintained until the end of the fiscal year.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Appendix 2

Title of Meeting	**Board Of Directors**
Date of Meeting	**25th May 2022**
Report Title	**License Condition FT 4 – Corporate Governance Statement and Training of Governors**
Author	Trevor Hughes, Head of Corporate Governance

NHS Foundation Trusts are required to make two self-certificated declarations regarding the robustness of corporate governance arrangements and compliance with the NHS Provider License annually. Additional declarations are required concerning governance arrangements and consideration of the impact on the Trust's governance and finance arrangements of partnership working where the Trust is part of a major Joint Venture.

The attached paper comprises declarations requiring approval by the Board of Directors in relation to the following two areas as follows;

- Corporate Governance Statement
- Training of Governors

A brief rationale of compliance is outlined against each statement. No risks to compliance with the Provider License conditions or mitigating actions have been identified against each required declaration and the Board of Directors is making a positive declaration.

4. Recommendation

The Trust Board is asked to:

- **Approve** the enclosed declarations and rationales
- **delegate** the signing of these declarations on behalf of the Board of Directors to the Trust Chair and Chief Executive Officer
- **Publish** the signed declarations.

Signed

Trust Chair **Chief Executive**

Date **Date**

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Dorset County Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed		Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed		Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed		Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed		Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed		Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board has maintained an appropriate membership and effective balance between Executive and Non-Executive members throughout the reporting period ensuring a diversity od skills and qualifications.	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name _____ **Name** _____

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity		**Capacity**	
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25/05/2022
Document Title:	**Nurse Staffing Review**
Responsible Director:	Nicola Lucey – Chief Nursing Officer/ DIPC/ Interim Deputy CEO
Author:	Emma Hoyle – Deputy Chief Nursing Officer

Confidentiality:	*No*
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Finance and Performance Committee	16th May 2022	

Purpose of the Paper	To discuss the findings on Ward based safe staffing review, gain assurance on the robust approach as per the methodology et out in guidance and approve the recommendations							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	Francis Report (2013) prompted the National Quality Board to publish standards on ward based safe staffing and the production of NICE guidance for the requirement and methodology of ward based safe staffing in hospital, built upon evidence and research. Like the recent maternity review (Ockenden), the review found that decisions on ward-based safe staffing based on finances alone meant poor safe staffing impacting upon care, outcomes and staff morale. Therefore, the Safer Nursing Care Toolkit has was developed and is the recognised tool for reviewing safe staffing at ward level, using a triangulation of metrics to assist decision making and recommendations. The tool is not prescriptive and should be applied alongside the application of professional clinical judgement to finalise the recommendations (for example knowledge of infrastructure and environment applied). There is a requirement for NHS providers and Trust Boards to regular review ward based safe staffing, which during the height of the pandemic emergency response was paused. As per most trusts DCHFT delayed the review and re-introduced the audit in October 2021, when there was less covid admissions and a more reflective position of case mix. Trust Boards are required, along with maternity safe staffing, to share in public Boards the safe staffing requirements and decisions. DCHFT findings of the review concludes the requirements to meet safe staffing and outlines the compliance with NICE guidance that suggests that there is '*increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts'*. NHS Improvement have also concluded that there is '*no new evidence to inform a change to this statement'.* DCHFT is compliant with this recommendation. The original report was reviewed by People and Culture Committee (April 2022) with a request that further financial analysis was completed for submission to							

	FPC (reviewing what could be explored from the run rate that was in the Trust position). Finance and HR Business Partners have assisted in this paper to ensure the robustness of the data. This paper outlines the details of the review for assurance on the robustness, the outcome and recommends the proportion of the additional spend over in run rate (above current budgeted establishment on e-roster) is converted into substantive (able to recruit to and put into the roster). The recommendation of this report is to allow for the investment, advertising and recruitment of: • 13.32 WTE additional RNs • 4.29 WTE additional HCSWs Total cost 696,925 which is within the 2021/2022 run rate Conversion and recruitment to fill safe staffing gaps substantively is intended to reduce agency spend which has been £3.9 million in 21/22 across the divisions This will meet the patient care and safety needs that the Trust is providing. This will be reviewed again in line with NICE requirements. Other run rate temporary staffing costs would still be part of the work of the agency reduction programme in the Trust, continuing to the financial plan.
Action recommended	The Board is asked to : 1. Receive assurance the review has been completed in line with evidenced based methodology agreed by the Board 2. To note the outcomes of the 2021 Acuity and Dependency Review and accept the areas identified as in highest need of investment 3. To agree the adjustment within the run rate of the FYE of this investment for 2022/2023 (£696,925). 4. To agree the investment

Governance and Compliance Obligations

Legal / Regulatory	Y	Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience. Aligned to CQC regulation
Financial	Y	There are costs and financial benefits associated with the recommendations of the full establishment review.
Impacts Strategic Objectives?	Y	People are key to our Trust strategy. The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objective one and our ambition to provide outstanding care. Incorrect ward-based staffing levels could have a significant effect on patient experience, care received, clinical outcomes and length of stay. There is a requirement from NHS England for Trust Boards to receive assurance regarding this information and determine if further analysis is required. Staffing levels are reviewed daily, along with a review of the patient needs. If there are staffing gaps, then a clinical review and effective distribution of staffing resources is applied.

		The National shortage of both Nursing and Midwifery registered staff continues to cause concern. Staffing shortages could lead to patient safety and experience incidents and negative reputational impact as well as regulatory action.
Risk?	Y	*People Board risk, top risk in the corporate risk register is workforce.*
Decision to be made?	Y	To agree recommendations
Impacts CQC Standards?	Y	This information is monitored by the CQC as part of the Safe, Responsive, Effective and Well-Led domains. Safe nursing staffing is a regulatory requirement outlined in: - Regulation 18: Staffing - Regulation 9: Person centred-care - Regulation 12: Safe care and treatment
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

May 2022 Safe Staffing Review: Urgent and Integrated Care and

Family Services & Surgical Divisions

1. INTRODUCTION

1.1 This report outlines proposals to implement the conclusions of the audit of Safe staffing for adult ward-based nursing, incorporating the acuity and dependency audit conducted in October 2021 (see Appendix 1). The last review was completed in March 2019 (see Appendix 3), with the subsequent reviews deferred due to the Coronavirus pandemic.

1.2 The review has included all adult inpatient wards at Dorset County Hospital. Critical Care, Theatres, Emergency Department, Paediatrics, Maternity and Special Care Baby Unit are not included in this report.

1.3 As part of the agency reduction project, further work will be done to consider ongoing requirement for substantive staffing of Evershot (currently running with no funded staffing establishment, ensuring consistency in built in cover and how sickness and maternity gaps are budgeted for and managed as part of examining ways to reduce agency reliance and costs.

1.4 This report does not cover other programmes such as agency, recruitment and retentions, sickness absence and financial forecast

1.5 The Board have approved this methodology as part of the safe staffing workforce planning. The methodology includes use of the evidence-based tool (The Association of UK University Hospitals (AUKUH) Acuity and Dependency Tool); alongside any relevant benchmarking, (such as model Hospital or other acute similar ward service in another provider), and professional judgement.

1.6 AUKUH tool is made up of two key elements, acuity, and dependency. “Acuity” is defined as a measurement of higher skill nursing interventions (e.g., Vital signs, cardiac monitoring, high level of clinical judgement oversight) based upon the level of patient illness. “Dependency” is defined as the amount of care/time needed for basic level care for a patient (e.g.: eating, drinking, hygiene, mobilisation) (Barr, Moores, & Rhys Hearn, 1973). It is measured by the time spent by nurses at the bedside as well as the related workload.

The below outlines the scoring groups:

- **Level 1a** scoring measures acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate.

- **Level 1b** scoring measures patients who are in a stable condition but have an increased dependence on nursing support

1.7 Safe staffing reviews are expected as part of the regulatory framework in meeting the needs of the patients that use services. Lesson learnt from various national

reviews expressed the need for safe staffing reviews to be overseen by Trust Boards (Francis Report (2013) and Keogh Review (2013))

1.8 As part of safe staffing the skill mix, leadership, and any supporting roles are key to the professional judgement applied to the audit. Having the right number of nurses, with the right mix of skills and experience, is essential to support safe, high-quality care for patients. National Institute for Health Research (NICE 2019) notes that determining the right number of staff on the wards and mix of education and skills is not a precise science and depends on a risk assessment based on the best available evidence

1.9 The Royal College of Nursing had set out detailed expectations for employers, national organisations, and regulators to support patient safety and enable the UK's nursing workforce to deliver safe and effective care. The fourteen workforce standards, launched by the college in May 2021 are intended to bring the entire nursing community in the UK, under one set of standards for the benefit of staff and patient safety.

1.10 This report highlights:

- the difference between current establishment and recommendations following the audit
- how the current gaps in safe staffing areas being covered and resourced
- any changes speciality changes impacting on the ward case mix and therefore potential changes to the required nursing establishment
- the evidence of triangulation between the use of tools and professional judgement and scrutiny
- relevant other workforce metrics that may impact upon the ward establishment for this review. E.g.: vacancies (short and long-term); sickness; staff turnover/retention
- the details of the outcome and any recommendations, including the financial implications

2. METHODOLOGY

2.1 Full engagement of the ward leaders was achieved to ensure the audit was as accurate as possible, with the Matrons holding responsibility for ensuring that the data was collected and that the tool was being applied effectively and consistently across their inpatient wards.

2.2 All inpatient wards were required to collect data using the AUKUH the same time, to ensure consistency and allow benchmarking across the Trust. The audit period was between October and November 2021.

2.3 Paediatrics use a different evidence-based tool; and the case for additional substantive staffing has been considered within Divisional business planning prioritisation.

2.4 Triangulation was applied to ensure validation of information from the following sources.

- Patient Acuity
- Professional Judgement
- Quality indicators

2.5 Information regarding staffing vacancies, turnover and sickness rates were also used to inform the recommendations made within this paper

2.6 Divisional analysis and additional information regarding the financial implications were applied.

2.7 Current uplift for ward staffing is 20.5% (for training and annual leave and sickness of which 2.5% is kept centrally for sickness absence cover through temporary staffing.

2.8 Application of maximum bed base in ward area has been applied to this review.

2.9 Review of annual run rate has been acknowledged and incorporated into the recommendations noting that within the divisional arrangements there may need to be adjustments within the run rate to support the bottom line.

2.10 The paper has been agreed at People and Culture Committee (April 2022). Further to Executive review it was agreed to review the report and recommendations in the context of analysing what is currently being spent with the target in place to reduce overall spend.

2.11 The request to FPC is that a proportion of the additional spend over and above current budgeted establishment but within the current the run rate is converted into substantive 'recruit to' staffing establishment i.e., a request to convert some of the spend on temporary staffing into additional substantive staffing to meet updated safer staffing requirements in adult wards. This is expected to result in an overall reduction in run rate and a reduction in high-cost agency spend.

2.12 The recommendations have been further reviewed by the Chief Nursing Officer, Deputy Chief Nursing Officer, Heads of Nursing and Quality for both Divisions, Finance Officers for both Divisions and Workforce Business Partners.

2.13 It is noted that any gap that is not in the run rate needs to be managed within the Division. This means that any asks for cover over and above safe staffing levels needs to be managed within the divisions as part of careful rostering and roster management.

3. REVIEW RESULTS AND RECOMMENDATIONS

3.1 Full details of the review are included in the Supporting Information paper at Appendix 3. Appendix 1 outlines a summary of the outcome of each ward review. Professional judgement was applied to interpreting the results of the audit and the ultimate recommendations for safe staffing for each ward.

3.2 The total ward establishment budget for adult wards is £18,010,662 for 21/22. Safer staffing additions increase this to £18,697,587. The run rate (actual spend on staffing) in these wards for the financial year 21/22 was £21,495,305 of which £3,996,917 was incurred using agency staff. Therefore, the proposed investment in an increase to substantive staffing of 13.32 wte registered nurses and 4.29wte Health Care Assistants which adds £686,925 to the cost of substantive staff will offset some of the current agency expenditure.

3.3 It is recognised that the current run rate is high due to COVID-19 related and short-term notice sickness so agency use higher. It is also likely that there will be further

waves of COVID-19 related absence and so this will be managed separately via the Divisions.

3.4 Recruitment to the gap in trained nurses must be the priority to drive up care standards and reduce stress related absences. Whilst it is understood that recruitment into trained band 5 posts can be challenging a targeted recruitment drive will be considered with an emphasis on all bands including higher bands looking to relocate.

3.5 The Trust's ambition to invest in the nursing associate post and the 6:4:2 model requires further exploration and embedding. Professional judgement was applied to interpreting the results of the audit and the ultimate recommendations for safe staffing for each ward are expressed as RN and HCA although some RN roles could be Nursing Associate roles as part of a future staffing model as more trained Nursing Associates come into the workforce through an internal training programme and external recruitment.

3.6 Divisional Heads of Nursing and Quality have confirmed that recommendations made by this safer staffing review are already in the run rate.

3.7 The safer staffing review highlighted a recommendation to consider an uplift in the additional % cover included in the 'recruit to' substantive staffing establishment and bank budget additions to cover annual leave, training, and sickness gaps with an initial recommendation that this should rise from a 20.5% to a 22% uplift. This recommendation will be further reviewed as part of the agency reduction project alongside any workforce planning aligned to activity within the Divisions. This will be alongside any Workforce Business Partner and finance reviews with divisions on substantive staffing and capacity.

3.8 This review does not take into account any changes any other requirements such as COVID-19 or waiting list initiative related activity.

4. RECOMMENDATIONS

4.1 As per Appendix 1 the review has occurred and this is the recommendation the following a re-review of finance and Workforce Business Partners calculations of the 'Requirement.

4.2 Total requested uplift to substantive Nursing and HCA staffing establishment for Family Services and Surgical Division

4.7wte RN and 4.29HCA = £298.123 Conversion of temporary staffing costs within the 21/22 run rate to substantive staffing spend. Refer to Appendix 3 for cost breakdown.

4.3 Total requested uplift to substantive Nursing and HCA staffing establishment for Urgent and Integrated Care Division

8.62wte RN = £388,802 Conversion of temporary staffing costs within the 21/22 run rate to substantive staffing spend. Refer to Appendix 3 for cost breakdown.

Combined requested uplift to substantive nursing and HCA recruit to 13.32 wte RN and 4.29 wte HCA. Cost shift of £696,925 is well within 21/22 run rate and

conversion and recruitment to fill safe staffing gaps substantively is intended to reduce agency spend which has been £3.9 million in 21/22 across the divisions

5. SUMMARY

There is a requirement by NHS England to submit information relating to Ward based Nursing Dependency and Acuity audits, recommended twice yearly. DCHFT has undertaken the audit once a year to inform business planning on any changes, alongside operational reviews of safer staffing. This audit has been delayed due to COVID 19, as the normal case mix was impacted upon, and re-introduced October 2021.

The Safer Nursing Care Toolkit is the recognised method for reviewing safe staffing at ward level and uses a triangulation of metrics to assist decision making and recommendations. The tool is not prescriptive and should be applied alongside the application of professional clinical judgement. Safer staffing is a key component of quality and safety ensuring the right level of staff to the patient case mix and falls under CCC regulation 12. FPC is remined the evidence behind the tools are the quality metrics e.g. Pressure ulcer, falls

In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed three time as day at the internal bed/operational flow meetings. Daily Safe Staffing meetings are in place to support the Divisions with immediate staffing requirements. Staff are requested to move area of work to ensure safe and effective care of our patients. This review was undertaken in conjunction with the Ward Sister, Matron and Divisional Head of Nursing and Quality responsible for that area.

The Trust has reviewed the acuity and dependency audits results for the inpatient ward areas and has identified that uplift in substantive establishment is required in certain areas. The Trust also remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

The costings and WTE were reviewed due to finance calculation therefore this is an updated paper to the report which was initially presented to People and Culture Committee in April 2022.

The recommendation of this report is to allow for the conversion of some expenditure on temporary staffing which is already in the 2021/22 run rate to enable the advertising, and recruitment of the following additional substantive staff numbers into adult ward nurse staffing:

- 13.32 WTE additional substantive RNs
- 4.29 WTE additional substantive HCSWs

It is noted that some recruitment will tie into the planned international recruitment programme for 22/23. This will meet the patient care and safety needs that the Trust is providing. This will be reviewed again in line with NICE requirements. It is recognised that it is unlikely that recruitment to these posts will be immediate and support within the Divisions required to avoid agency usage by conducting timely managed rotas.

The detail of the audit conducted in October 2021 is covered in the additional Supporting Evidence document **(Appendix 3)**.

- Further qualitative recommendations from the scoping exercise relating to the report
- information relating to individual ward areas
- Summary of recommendations following 2019 audit **(Appendix 2)**
- Metrics relating to report
- Business planning for Divisions accounting for areas not covered in report

Appendix 2 is a summary of the financial impact of the recommendations and shows that
the request is for a revised approach to convert expenditure already being incurred within the current ward establishment run rates for 2021/22.

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Appendix 1: Staffing recommendations

Family Services and Surgical Division

Ward	Previous template 2019	Audit results 2021	Current Staffing	Professional judgement	Recommendation
Abbotsbury (29 Beds)	34.51wte	40.80wte	Day: 4RN, 4E/3L HCA Night: 3RN, 2 HCA M- F (Reduced staff at weekends 3 HCA E/L) **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week and Ward Administrator 0.5 wte Band 3	Bed base change from 2020 (23 beds) to 29 beds in 2022. Gastro patients moved into ward specialty since last audit. Agreed to prioritise investment in area this year. *Disparity at weekends. Increase staffing ratio in line with weekday Reviewed above and care needs against roster.	Increase recruit to establishment by: HCA increase by 4.29 wte RN increase by 2 wte **New proposed skills mix – 7 days** **Day** 5 RN + 4 HCA **Night** 3RN and 3 HCA
Lulworth (31 Beds)	38.87wte	38.87wte	Day: RN 4 (plus 1Twilight) and HCA 4 Night: 3RN 3, HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week and Ward Administrator 0.5 wte Band 3	Gastro moved off ward specialty (allocated into Abbotsbury) therefore professional judgement revise staffing need for acuity and dependency. Funding did not follow the speciality move so professional judgement made to remain at current template but change twilight RN shift to early shift .	**No increase in wte.** **Skill mix remains** **Day** 5RN (E) 4RN (L) +4 HCA **Night** 3RN + 3 HCA

Purbeck (27 beds)	34.92 wte	37.62 wte	Day: RN 4, HCA 4 Night: 2RN, HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week and Ward Administrator 0.5 wte Band 3	The ward bed base has not changed since the last acuity audit. Staffing ratio to remain with RN and HCA 50/50. Required changes are: • additional RN ND shifts	Increase recruit to establishment by: RN 2.7 wte. **New proposed skills mix – 7 days** **Day** 4RN + 4HCA **Night** 3 RN + 3 HCA
Ridgeway (30 beds)	42.41wte	42.41 wte	RN 4, HCA 6 N 3/3 **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week and Ward Administrator 0.5 wte Band 3	HCA uplifted by 5.4 wte in 2019/20 No increase of establishment recommended – noted over established and for Division to absorb this within safe staffing review outcome to support Purbeck's requirements	**No increase in wte.** **Skill mix remains** **Day** 4 RN + 6HCA **Night** 3 RN + 3 HCA

Urgent and Integrated Care

Ward	Current establishment 2019	Audit results 2021	Current Staffing	Professional judgement	Recommendation
Fortuneswell (17 Beds)	26.01 wte	28.71 wte	Day: 2RN, 3 HCA Night; 2RN, 2 HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	Disparity in RNs at weekends. Uplift in RN weekends required Required changes are: • additional RN LD Weekend	**Increase establishment by:** RN 2.7 wte **New proposed skill mix - 7 days** **Day** 3RN +3 HCA **Night** 2 RN + 2 HCA
Cardiac Care (18 Beds)	32 24 wte	34.24 wte	Day:4 RN , 3 HCA reduced to 2 HCA at weekends Night: 4RN, 2 HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	Lower staffing levels at weekend due to catheter lab not being open. Current staffing levels supports service.	**No increase in wte.** **Skill mix remains** **Day** 4RN + 3 HCA (2 HCA at weekends) **Night** 4RN + 2 HCA
Ilchester (33 Beds)	57.82 wte	57.82 wte	Day: 6 RN, 5HCA LD plus 1E and 1 TW Night 5 RN and 5HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	The ward bed base has not changed since the last acuity audit. Agreed no change to current template except conversion of 1 Twilight HCA shift to 1 Late HCA shift over 7 days	**No increase in wte.** **Skill mix remains** **Day** 6RN +5 HCA **Night** 5RN + 5 HCA

Moreton (26 Beds)	35.25 wte	38.21 wte	Day: 3RN, 4HCA (Mon-F 2 x B3 Day shifts) Night: 2RN, 3HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week Ward administrator 0.6 wte 3 days a week	Currently running at 4/4 days and nights funded from the COVID budget. This was to support the ward from 2020. Recovery model now in place so levels of infection significantly reduced so staffing model to revert to pre-COVID with additional RN night with bpap and high flow recognised adjustment of additional *ND trained shift* *Required change is:* *additional RN ND shift*	Increase establishment by: RN 2.96 wte New proposed skill mix **Day** 3RN +4 HCA (+ 2 x B3 Days M-F) **Night** 3 RN and 3 HCA
Stroke (24 beds)	34.84 wte Excludes outreach	37.8 wte Excludes outreach	Day: 3RN plus 1E, 4HCA Night: 2RN, 3 HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	Bed base fluctuates between 23-26 beds so staffing additional trained to safely manage this need to be included. Required changes are: • additional RN ND shifts	Increase establishment by: RN 2.96 wte **New proposed skills mix – 7 days** **Day** 3RN (+1E)+ 4 HCA **Night** 3 RN + 3 HCA
Day Lewis (23 Beds)	30.78 wte	30.78 wte	Day: 3RN (plus 1E), 3HCA Night: 2RN, 2HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	Changes made as part of work toward – centre of excellence	**No increase in wte.** **Skill mix remains** **Day** 3RN (+1E) + 3 HCA **Night** 2 RN + 2 HCA
Barnes (23 Beds)	33.16 wte	33.16 wte	Day: 3 RN,, 4HCA, Night: 2 RN, 3 HCA **Plus** supervisory Sister/Charge Nurse 1.0wte		

					No increase in wte. **Skill mix remains** **Day** 3RN + 4 HCA **Night** 2 RN + 3 HCA
Evershot (14 Beds)	-	-	Day: 3RN, 3 HCA Night: 2 RN, 2 HCA **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	Minimum required for size and lay out of ward	**25.66 wte recruit to is required to run this ward. No substantive staffing establishment exists.** **Skill mix for running the ward - 7 days** **Day** 3 RN + 3 HCA **Night** 2 RN + 2 HCA
Prince of Wales (13 Beds)	31.81 wte	31.81 wte	LD 4/3 +B3 N 2/2 **Plus,** supervisory Sister/Charge Nurse 1.0wte 5 days a week	Staffing adequate for specialty	**No increase in wte.** **Skill mix remains** **Day** 4 RN/NA + 4 B3/2 HCA (On Sundays B3 is early not LD) **Night** 2RN + 2 HCA

Appendix 2 – Adult Wards Safer Staffing Changes and 21/22 Run Rates

Ward	Grade	Current 22/23 Establishment (WTE) includes sick cover in bank budget	Proposed increase (WTE)	Proposed establishment (WTE)	Current 22/23 Establishment (£)	Proposed increase (£)	Proposed establishment (£)	21/22 Total actual cost (£)	Of which Agency (£)
Abbotsbury	RN	20.14	2.00	22.14	£994,226	£85,934	£1,080,160	£1,170,459	£436,221
	HCA	15.68	4.29	19.97	£479,138	£136,346	£615,484	£698,761	£25,403
Lulworth	RN	22.33		22.33	£1,133,470		£1,133,470	£1,134,935	£204,543
	HCA	18.75		18.75	£597,523		£597,523	£640,543	£19,375
Purbeck	RN	17.09	2.70	19.79	£796,977	£75,842	£872,819	£937,821	£275,490
	HCA	20.31		20.31	£657,505		£657,505	£744,360	£14,616
Ridgeway	RN	19.44		19.44	£862,852		£862,852	£977,523	£281,395
	HCA	24.28		24.28	£743,306		£743,306	£701,916	£18,205
Moreton	RN	15.14	2.96	17.60	£827,190	£140,272	£967,462	£1,168,859	£375,354
	HCA	20.77		20.77	£640,044		£640,044	£802,100	£13,657
Barnes	RN	14.72	0.00	14.72	£674,443		£674,443	£788,534	£266,863
	HCA	19.12	0.00	19.12	£607,419		£607,419	£690,239	£7,803
Day Lewis	RN	17.25	0.00	17.25	£802,894		£802,894	£1,310,815	£733,944
	HCA	14.12	0.00	14.12	£440,699		£440,699	£562,285	£53,218
POW	RN	14.95	0.00	14.95	£756,758		£756,758	£934,803	£133,716
	HCA	17.50	0.00	17.50	£540,036		£540,036	£418,689	£8,168
Evershot	RN	0.00	0.00	0.00	£0		£0	£205,908	£0
	HCA	0.00	0.00	0.00	£0		£0	£361,291	£1,143
Ilchester	RN	30.22	0.00	30.22	£1,637,825		£1,637,825	£1,649,408	£393,619
	HCA	28.88	0.00	28.88	£892,553		£892,553	£1,026,770	£37,310
Fortuneswell	RN	12.75	2.70	15.45	£626,240	£108,257	£734,497	£711,682	£154,928

	HCA	13.79	0.00	13.79	£431,320		£431,320	£438,992	£4,110
Stroke	RN	16.05	2.96	19.01	£768,830	£140,272	£909,102	£1,093,224	£352,439
	HCA	19.50		19.50	£625,935		£625,935	£808,885	£14,437
Cardiac care	RN	22.61	0.00	22.61	£1,067,059		£1,067,059	£1,097,976	£164,733
	HCA	12.31	0.00	12.31	£406,420		£406,420	£418,528	£6,227
Total	**RN**	**222.69**	**13.32**	**235.51**	**£10,948,764**	**£550,579**	**£11,499,343**	**£13,181,947**	**£3,773,244**
	HCA	**225.02**	**4.29**	**229.30**	**£7,061,898**	**£136,346**	**£7,198,244**	**£8,313,358**	**£223,673**

Grand Total	**447.71**	**17.61**	**464.81**	**£18,010,662**	**£686,925**	**£18,697,587**	**£21,495,305**	**£3,996,917**

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25th May 2022
Document Title:	Ockenden Final Report - emerging findings and recommendations
Responsible Director:	Nicky Lucey, Chief Nursing Officer
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**

Purpose of the Paper								
	Note (✓)		*Discuss (✓)*	**x**	*Recommend (✓)*		*Approve (✓)*	**x**
Summary of Key Issues	• Presentation of the Final Ockenden Report with a link to the full report • Final report of the Ockenden review - GOV.UK (www.gov.uk) • Historical background to the report • Essential actions relating to both Ockenden 1 and the final report • National next steps • Regional next steps • Next steps for the system – oversight from the LMNS • Next steps for providers • Reflections and opportunities • Reported compliance against actions from Ockenden 1 – one action partially compliant - *risk assessment embedded into digital maternity system and clinical practice. Awaiting repeat audit results for assurance before declaring full compliance* • LMNS Ockenden and Patient Safety Strategy Actions (recent meeting) • Example of shared learning							
Action recommended	The Board of Directors is recommended to: Consider the summary of the final Ockenden report and the progress made with the I&E actions for Ockenden 1							

Governance and Compliance Obligations

Legal / Regulatory	Y/N	Compliance with Ockenden action from the first report are mandated.
Financial	Y	There are financial implication for several of the actions including increased consultant time, possible increase in maternity staffing and a commitment to invest the CNST rebate into maternity services
Impacts Strategic Objectives?	Y	**C**ollaborative – ensuring the voce of the patient (the woman) is central to care provision and to safety **O**utstanding – Ockenden provides a framework in which to provide outstanding care to women and their families **S**ustainable – the BR+ safe staffing audit will underpin the sustainability of the maternity service. **I**ntegrated – the safety and quality of the maternity service must be integrated into the Board, the LMNS and the ICS **E**nabling – Completing all the actions will ensure the workforce feel confident and proud of the maternity service they represent and the care they provide
Risk?	Y	The Ockenden actions require a commitment from the Board. Any actions not completed will directly affect the way in which the maternity service is viewed and evaluated locally, regionally and nationally.
Decision to be made?	Y/N	If yes, please summarise how the decision recommendation is consistent with the Trust Risk Appetite Statement
Impacts CQC Standards?	Y	The report links to all five domains
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

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Final report of the Ockenden review - GOV.UK (www.gov.uk)

Ockenden Final Report - emerging findings and recommendations

presented to The DCH NHS FT Board, 25th May 2022 by Jo Hartley Associate Director of Midwifery & Neonatal Services

NHS England and NHS Improvement

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Before Ockenden

- 2014, Secretary of State for Health announced a new ambition to reduce the rate of stillbirths by 50 per cent in England by 2025. The Saving Babies Lives Care Bundle continues to be the cornerstone to this initiative
- 2015 Morecombe Bay Report into Maternity Services led by Bill Kirkup highlighted many concerns about maternity care in the Trust
- 2016 Better Births - This report sets a vision for the planning, design and safe delivery of maternity services; how women, babies and families will be able to get the type of care they want; and how staff will be supported to deliver such care.
- NHSE request all CCGs had a LMS (local maternity system) set up by Oct 2017
- Dorset STP (as was then) through the One Acute Vanguard (which developed into One Acute Network) oversaw the Better Births implementation and transformation programme, managed through the LMS
- Dec 2021 Ockenden 1 published. LMS to lead on and support providers in the completion of the Immediate and Essential Actions
- Neonatal services incorporated and LMS became LMNS
- 2022 Ockenden 2: LMNS asked to continue transformation and oversee the delivery of actions associated with Ockenden 2

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Background

In 2017 Donna Ockenden was asked to review Maternity Services in the Shrewsbury and Telford Hospital Trust by the Secretary of State.

The inquiry covered 1,592 clinical incidents involving 1,486 families between 2000 and 2019.

The final report follows on from the first report which was published in December 2020. In addition to the seven Immediate and Essential Actions (IEAs) first identified, the final report identifies 15 new themes with a series of further recommendations. It contains 66 for local trust, 15 for the wider NHS and 3 for the Secretary of State.

Immediate and Essential Actions - first report

- Enhanced Safety
- Listening to women and families
- Staff Training and Working Together
- Managing Complex Pregnancy
- Risk Assessment Throughout Pregnancy
- Monitoring Fetal Wellbeing
- Informed Consent
- Workforce

Essential Actions - final report

- Workforce planning and Sustainability
- Safe Staffing
- Escalation and Accountability
- Clinical Governance – Leadership
- Clinical Governance - Incident investigation and Complaints
- Learning from Maternal Deaths
- Multidisciplinary Training
- Complex Antenatal Care
- Preterm Birth
- Labour and Birth
- Obstetric Anaesthesia
- Postnatal Care
- Bereavement Care
- Neonatal Care
- Supporting Families

Secretary of State for Health and Social Care

In his statement to Parliament on the 30th March 2022, the Secretary of State for Health and Social Care the Rt Hon Sajid Javid stated:

- It's vital that across maternity services that we focus on safe, personalised care where the voice of the mother is heard throughout.
- The ongoing active police investigation (Operation Lincoln) which is looking at around 600 cases.
- The Shrewsbury and Telford Hospital Trust, NHS England, and the Department of Health and Social Care will be accepting all 84 recommendations.
- NHS England to write to all trusts, instructing them to assess themselves against these actions and NHS England will be setting out a renewed delivery plan that reflects these recommendations.
- The need to further expand the maternity workforce, the NHS recently announced a £127 million funding boost for maternity services across England.
- The recommendation to create a working group independent of the Maternity Transformation Programme with joint leadership from the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.
- Create a special health authority to continue the Maternity Investigation Programme that is currently run by the Healthcare Safety Investigation Branch. Again, that will start its work from April next year.

Proposed Next Steps National

NHSE/I National Team

- **Letter sent 1st April , to NHS Trust and Foundation Trust: Chief Executives, Chairs, Chief Nurses, Chief Midwives, Medical Directors. ICS leads and Chairs. LMNS/LMS Leads. CCG Accountable Officers. Regional Chief Nurses, Regional Chief Midwives, Regional Medical Directors and Regional Obstetricians**
- **Meeting with each region in early June to take stock of performance, reflect on the report, and inform national plans**
- **Consolidate actions from Ockenden report, East Kent and other reviews underway to develop a refreshed coherent National delivery plan in the Autumn**
- **Publish by trust the Ockenden first report IEA compliance at the May 19th Public Board meeting – this will reflect returns from Trusts to regions by 15th April 2022**
- **Publish a revised national policy and guidance on speaking up**

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Proposed Next Steps Regional

- ❖Review the report and identify learning for the SW Region
- ❖Set up a Regional Task and Finish Group to undertake coproduction of actions (If consensus gained that this would be useful and a productive way to collaborate on actions that could be approached SW wide)
- ❖Identify through SW LMNS where support is required
- ❖Receive Ockenden one Trust assurance by 15th April
- ❖There is a Commitment to aligning Maternity and Neonatal at region in relation to Ockenden implementation.
- ❖The neonatal ODN have committed to lead on actions for neonates and regional progress will be reported to Neonatal Implementation Board
- ❖Health Education England have committed to collaborating on workforce elements
- ❖ The Ockenden Governance and assurance process at South West region will be monitored through PQSSG

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Proposed Next Steps System

Local Maternity & Perinatal System

- Review the report and identify learning for the LMNS/ICS and reports to Board
- Governance arrangements for support and assurance on progress for Provider Trusts
- Consider how to maintain the confidence of local families in maternity services – local communications on safe services in coproduction with MVPs
- Identify an Ockenden Lead to participate in the Regional Task and Finish Group. (If consensus gained that this would be useful and a productive way to collaborate on actions that could be approached SW wide)

Proposed Next Steps Provider

SW Provider Trusts

- ❖ Present the Full Ockenden report to next Public Board and share with all staff
- Review the report and take action to mitigate any risks identified, and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:
  1. Safe staffing levels
  2. A well-trained workforce
  3. Learning from incidents
  4. Listening to families
- Immediately assess staffing position and make one of the recommended decisions regarding Continuity of Carer provision (as per 1st April letter).
- Ensure robust governance routes in place to report to Trust Board and LMNS
- Ensure robust training on Freedom to Speak Up for all managers and leaders and a regular series of listening event.
- ❖ Consider how to maintain the confidence of local families in maternity services – local communications on safe services in coproduction with MVPs
- ❖ Wider implications for services beyond Maternity & neonatal – especially given reflections on governance, learning from incidents, culture, complaints, listening to patients & families and Freedom to Speak Up
- ❖ Identify an Ockenden Lead to feed in to system level

Reflections

- This is a watershed moment for maternity and perinatal services
- Has had a profound effect on staff working across the services at every level
- Potential impact in attracting people into the speciality – obstetrics and midwifery
- Potential further attrition due to the impact and public profile of the report
- In some places real change needs cultural change which takes time and a complete shift

However ....

- This is an opportunity to really transform maternity services
- Significant actions that the SoS has accepted – leadership support, education and training, strengthened governance, bereavement care
- Significant funding already confirmed – workforce, digital and retention
- Real opportunity to build on existing collaboration and system working
- Opportunity to build on actions and develop outcome-based measures

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Compliance against Ockenden 1 actions

1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	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
	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
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	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
	Confirmation that funding allocated for maternity staff training is ringfenced	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
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	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
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.	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.	Compliant

risk assessment embedded into digital maternity system and clinical practice. Awaiting repeat audit results for assurance before declaring full compliance

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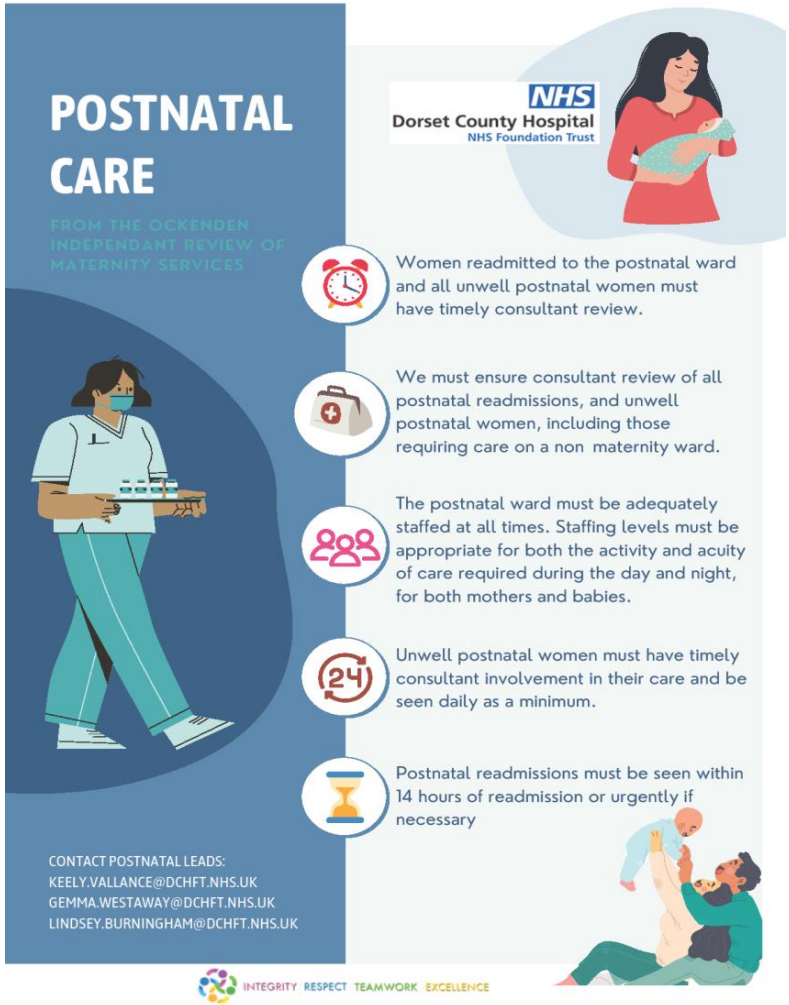
LMNS Ockenden and Patient Safety Strategy Actions

Aligning Maternity Risk and Safety Leads across the LMNS (DCH and UHD). There are some areas that can be supported from our Patient Safety Strategy priorities and PSIRF (patient safety incident response framework) planning that we are due to embark on in the coming months.

- **Safe staffing** – standardised triggers for reporting and responding to incidents where staff numbers fall below the minimum numbers, across the system
- **Patient Safety Specialist dedicated to maternity services** –strengthening connection and giving access to the PSS resources and training may be useful for the Safety Lead Midwives
- **Human factors training** – scoping what is required, where it is provided and how this can be delivered across the system
- **Management of serious incidents (SIs)** There is a robust and relatively standard approach to SIs in both Trusts with HSIB conducting the larger number of investigations. Assurance required that changes in practice are in place within 6 months.
- **PSIRF** – develop a TOR for convening a specific panel for Maternal deaths
- **Just culture** – work on emotional, psychological support for staff involved in incidents and around encouraging civility is something being worked on across the system with links to freedom to speak up

Sharing the learning



Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25 May 2022
Document Title:	**Mortality Report: Learning from deaths Qtr 3 2021/22**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	16th Feb 2022	None specific
Quality Committee	19th April 2022	

Purpose of the Paper	To inform the Quality Committee of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The Trust's SHMI reported during Q3 (5 months in arrears - rolling years to Jun, Jul and Aug 2021) rose initially to a peak of 1.20 in June but then fell rapidly to 1.15 and back into the normal range at 1.12 in August. This continues to be influenced by delays in coding (reasons for this are explained in the previous Q2 report)). No other local or national indicators suggest that excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are being used to examine the care of an appropriate sample of people who died whilst in-patients, 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.
Action recommended	The Quality Committee is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website 3. **Not publish** appendices 1 and 2 which are for internal discussion only

Governance and Compliance Obligations

Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor

Decision to be made?	N	
Impacts CQC Standards?	Y	An elevated SHMI will raise concerns with NHS E&I and the CQC. NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019 and is complete, but work continues. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 has adversely influenced coding and therefore recent SHMI figures are inaccurate.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports.

1.1 Family Services and Surgical Division Report - Quarter 3 Report

Structured Judgement Review Results:
The Family Services & Surgical Division had 70 deaths in quarter 3, of which 60 required SJR's to be completed. Of these 13 have had an SJR completed. Between October to December, an additional 22 SJR's have also been completed from previous months.

SJR Backlog:
The outstanding SJR's for the Division as at 11/01/2022 is 57:

May	July	August	September	October	November	December
3	3	3	1	13	12	22

The available notes have been allocated to Clinical staff to ensure these are completed.

Feedback from SJR's completed in quarter 3:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	1	6	10	24	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	2	0	0	0	0	1
3 Adequate	8	4	7	2	7	8
4 Good	14	15	10	7	16	16
5 Excellent	10	10	8	2	9	10

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
1	0	2	7	17	8

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	2	1	4	28

Report completed by:
Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care Q3 Report

Structured Judgement Review Results:

The Urgent and Integrated Care Division had 224 deaths in quarter 3, 61 SJR's were requested and 39 were completed. Year to date (01/04/2021 – 31/12/2021) 75 SJR's have been completed.

*Due to an influx of SJR's requested July – November, it was agreed at Hospital Mortality Group (15/12/2021) that 1/3 of the back log could be returned incomplete and so 16 SJR's were returned at the end of December.

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	13	16	36	38	15	14
1 Very Poor	0	0	0	0	0	0
2 Poor	0	1	0	0	0	0
3 Adequate	2	2	0	0	3	4
4 Good	19	19	0	0	12	18
5 Excellent	5	1	3	1	9	3

Overall Quality of Patient Record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
13	0	0	5	18	3

Avoidability of Death Judgement Score

Blank	Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
*10	1	2	2	2	2	20

SJR Backlog

The outstanding SJR's for the Division as at 26/01/2022: 41

October	November	December
38	19	4

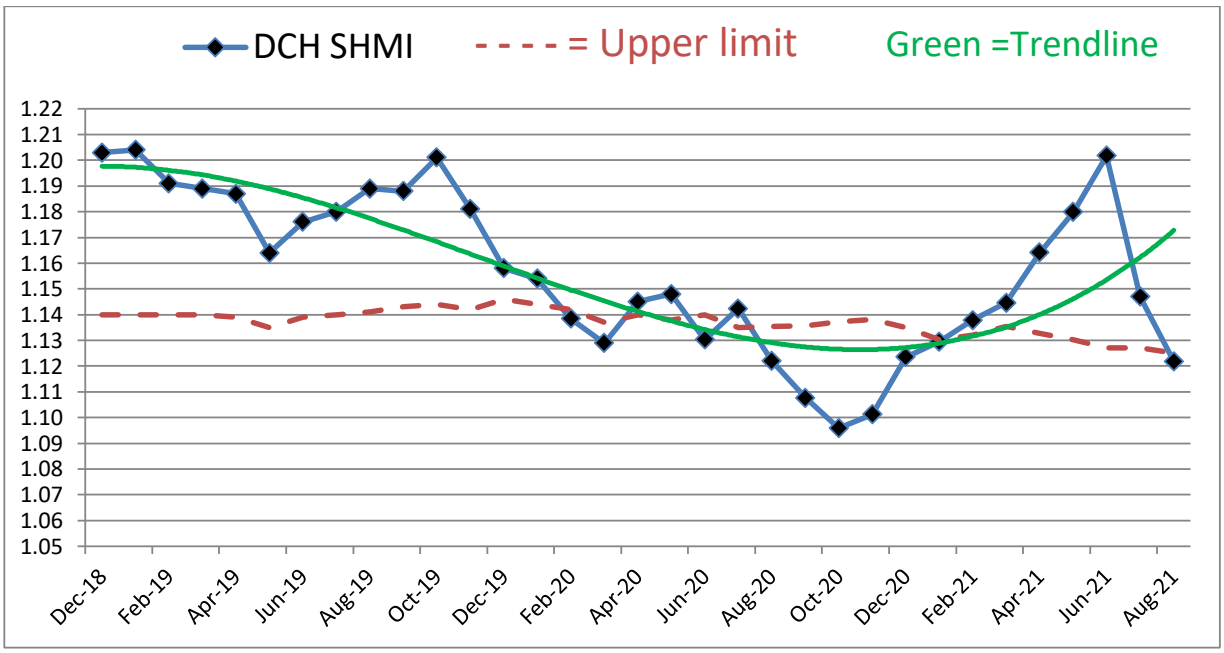
8 Nosocomial COVID 19 deaths required review.

Jemma Newman, Quality Manager
Sonia Gamblen, Divisional Head of Nursing & Quality
James Metcalfe, Divisional Director

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and those occurring within 30 days of discharge. The SHMI for the rolling years from October 2020 to June 2021 shows a clear reversal of the previous trend to improvement, but data for July and August has improved again as result of additional input to coding. However, staff absences and continued working from home using scanned records suggest that timeliness of coding remains uncertain. A coding action plan has been produced and enacted by Sue Eve-Jones and Stephen Slough.



SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady improvement in DCH's SHMI as a result of investment in the coding department which resulted in more accurate and timely coding returns to NHS Digital.

For a full explanation of recent coding difficulties please see the previous Q2 report published on the DCHFT intranet site.

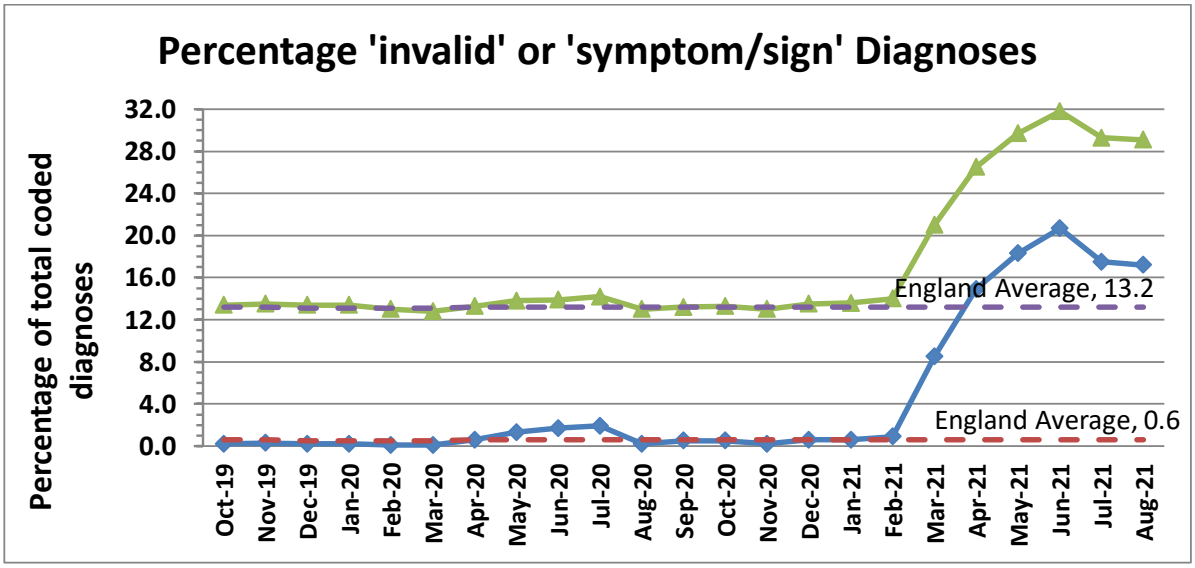
2.2 Percentage of provider spells with a primary diagnosis which is a symptom or sign: NHS Digital states "*This indicator presents the percentage of finished provider spells with a primary diagnosis which is a symptom or sign (identified by ICD-10 codes beginning with the letter 'R'). A high percentage of provider spells with a primary diagnosis which is a symptom or sign compared to other similar trusts may indicate problems with data quality or timely diagnosis of patients*".

DCH has a very high, but reducing number of spells with a primary diagnosis which is a symptom or sign – for example 'chest pain' rather than 'myocardial infarction' – at 29.3% of 25,770 admissions in Aug 2021 versus 13.3% Oct 2020. This percentage is from 25,770 admissions. Such uncoded spells are attributed a low risk of death since a symptom or sign only, does not suggest a life-threatening illness. This significantly reduces our expected number of deaths.

2.3 Percentage of provider spells with an invalid primary diagnosis code: NHS Digital states "*This indicator presents the percentage of finished provider spells with an invalid primary diagnosis code (identified as those spells where the primary diagnosis is given by the ICD-10 code R69X). A high*

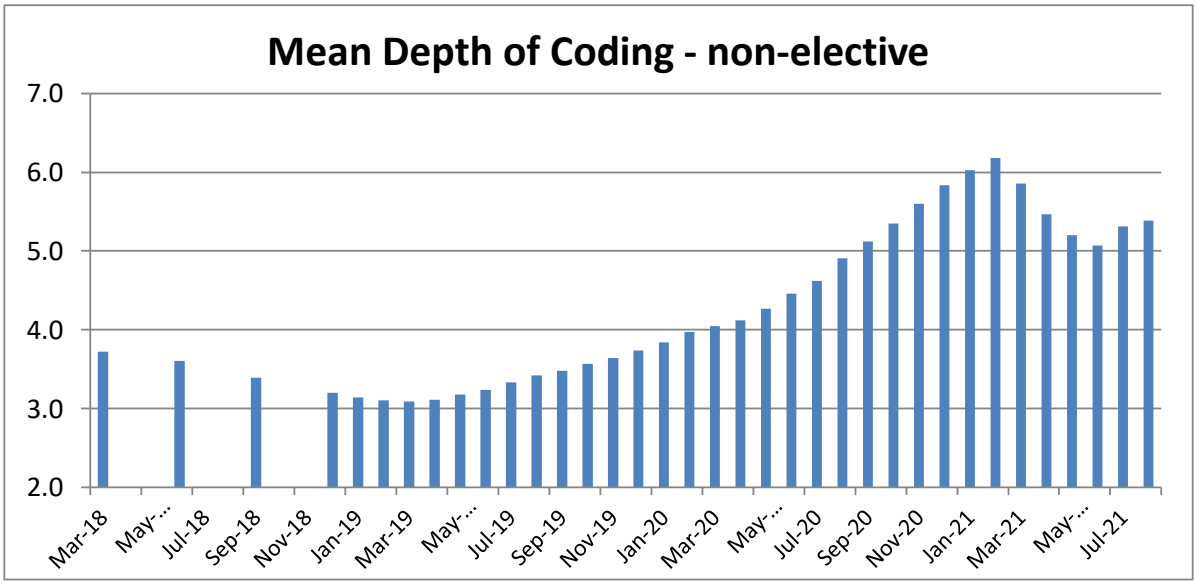
percentage of provider spells with an invalid primary diagnosis code compared to other trusts may indicate a data quality problem."

This metric is a subgroup of 2.2 above. A 'spell' is a continuous period of in-patient care. The graph below shows the change in these two metrics of coding accuracy over the past 30 months:



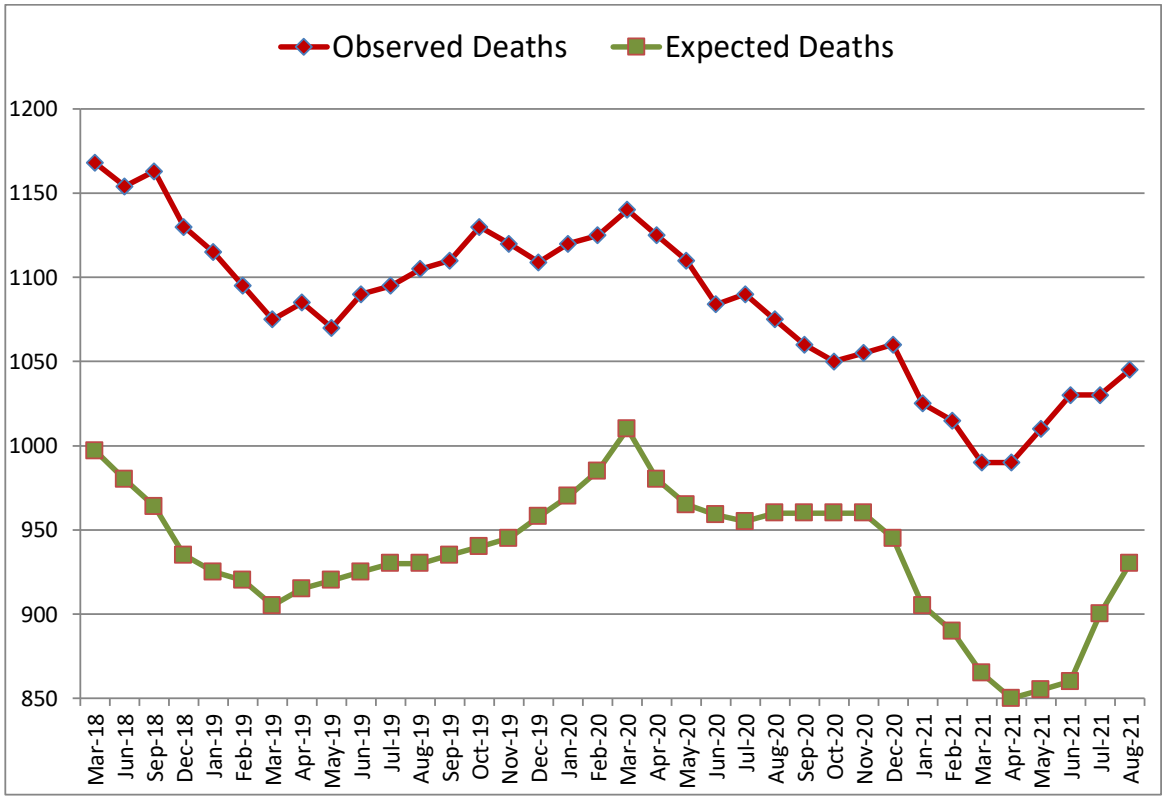
2.4 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts*."

DCH's depth of coding had been improving steadily up to February 2021 (see graph below), but is now fluctuating and this almost certainly reflects the same backlog problem in the coding department.



2.5 Expected Deaths (based on diagnoses across all admissions per rolling 12 months):

The chart below shows observed and expected deaths over the past 3 years (rolling years from March 18 to April 21), and whilst both observed (actual) and expected deaths have increased (as total number of in-patients increases post-covid-19), the expected deaths have increased faster as a result of partial recovery of coding practice, thereby improving the SHMI ratio.



2.6 Communication with NHS Digital:

From: "CLINICAL INDICATORS, Hscic (NHS DIGITAL)" <clinical.indicators@nhs.net>
Date: 27 January 2022 at 08:11:32 GMT
To: "Hutchison, Alastair" <Alastair.Hutchison@dchft.nhs.uk>

Hi Alistair,
Thank you for raising the issue of Dorset County Hospital Trust's high percentage of invalid diagnosis codes with us. We can see that the percentage of invalid codes is about 16% and that you have a "higher than expected" SHMI which may be a result of this. It is good to get some context for this from the trust and it sounds as though you are taking the correct steps with HES to amend this problem before the 2021/22 APC data is finalised.
Please get back to us if you need any further information.
Kind Regards,

David Keighley (he/him)
Senior Information Analyst, Analytical Services Team
Pronouns: he/him
d.keighley@nhs.net
07592 399251

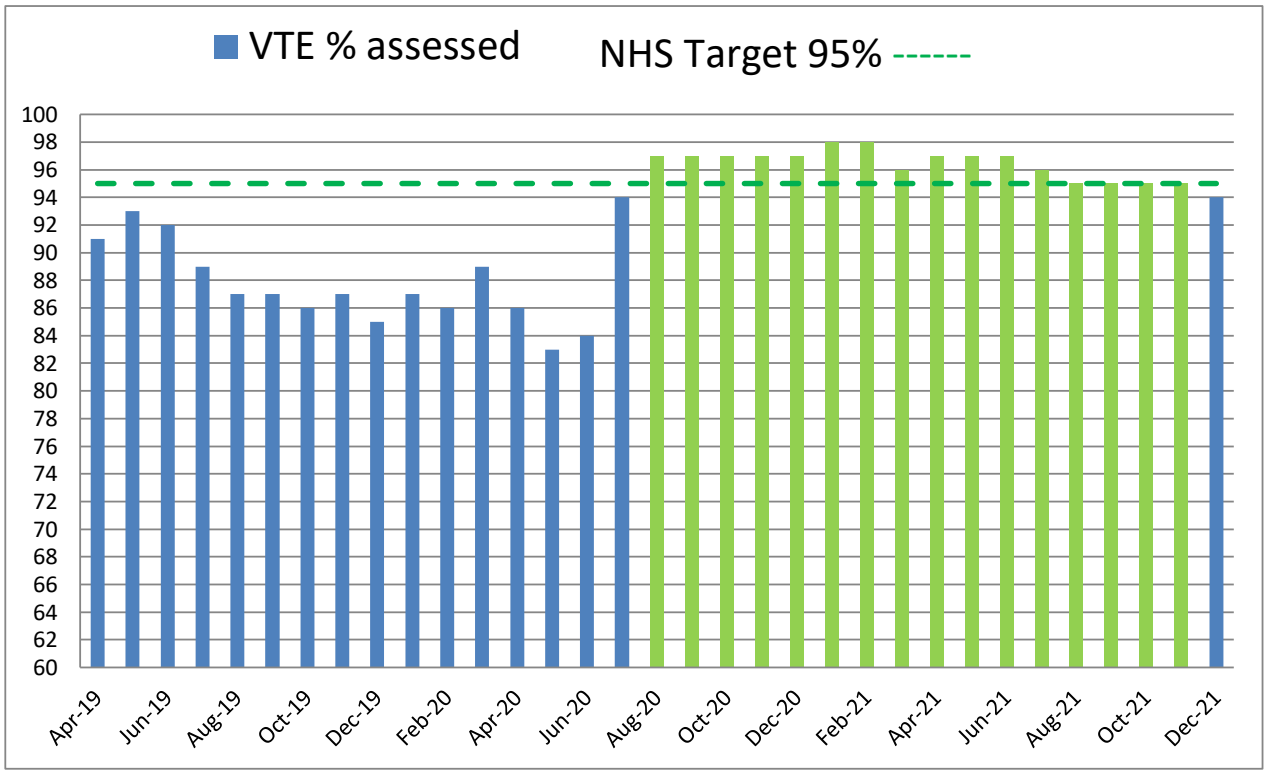
NHS Digital

3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care, and has continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies who report on individual Trusts' performance.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing.

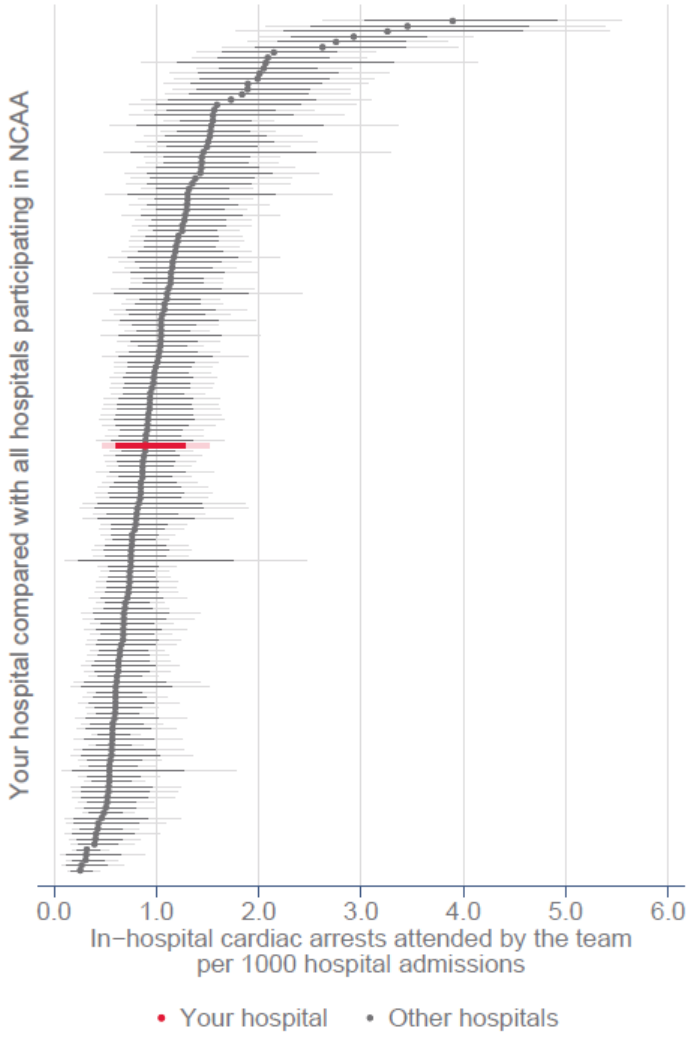
DCH VTE risk assessments reached 97% in August 2020 with the introduction of a more accurate reporting system, and have attained the 95% target for every month except December 2021 (94%). This graph has been circulated to all junior staff.



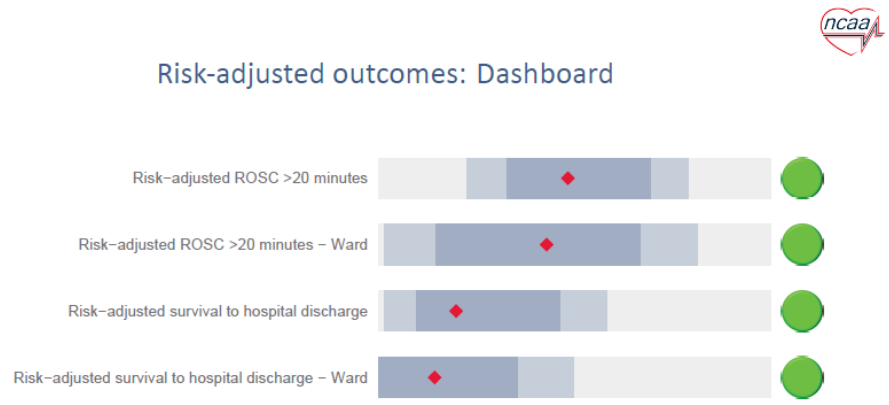
3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH April 2021 to September 2021 was published on 3/12/2021. A total of 33 cardiac arrest calls were recorded for this time period. The format and reporting period for this report (Q1 + Q2) has changed from previous editions so that some of the graphs are not directly comparable to previous versions. The report was also published alongside a more detailed summary of the previous year's results - 2020/21. This is available on request from Richard Jee

The graph below represents the number of in-hospital cardiac arrests attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower is better.


Your hospital compared with all hospitals participating in NCAA
0.0
1.0
2.0
3.0
4.0
5.0
6.0
In−hospital cardiac arrests attended by the team per 1000 hospital admissions
Your hospital
Other hospitals

The graph below shows two outcome measures:
a) Return of Spontaneous Circulation and b) Survival to Discharge. These and all other measures in the report get a 'green' indicator for the 6 month period (Q1 and Q2 2021/22).



3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019, and not undertaken for either 2019/20 or 2020/21

Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

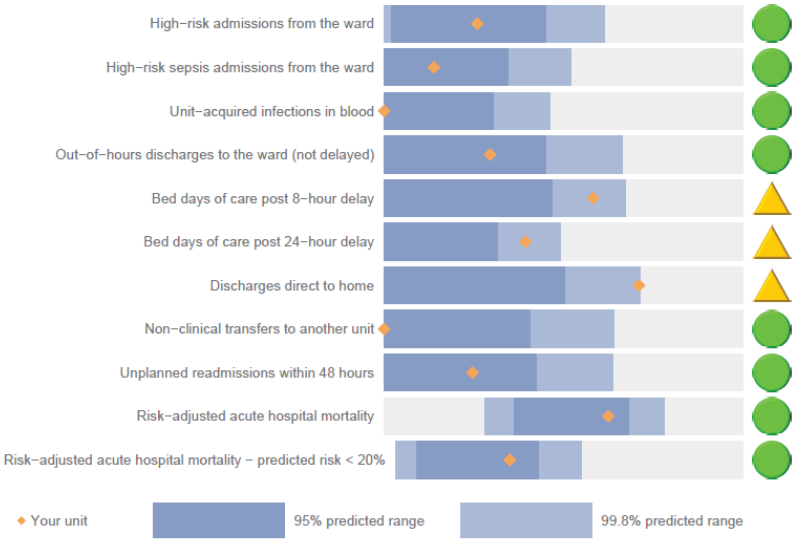
The results suggest that patients admitted to DCH 2018/19 tended to be more ill than the national average, but had a lower death rate and shorter length of stay, with fewer readmissions.

3.3 ICNARC Intensive Care survival latest data published 10 August 2021
The amber indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home

Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2021 to 30 September 2021

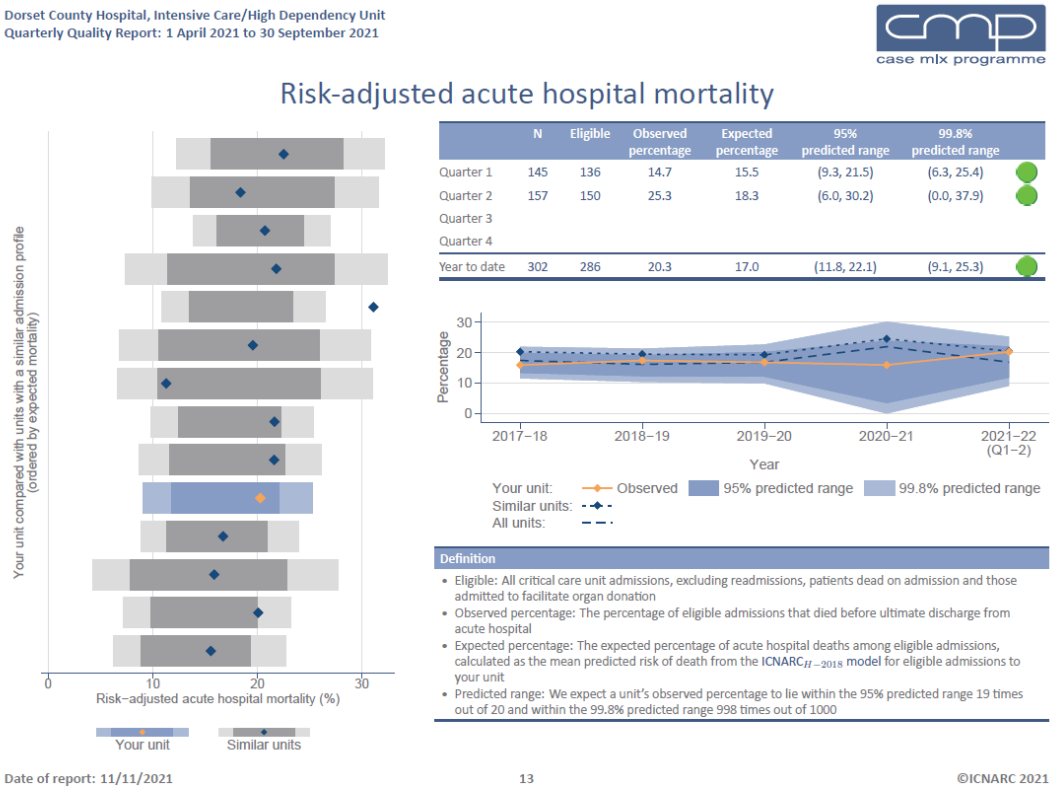
case mix programme

Quality indicator dashboard



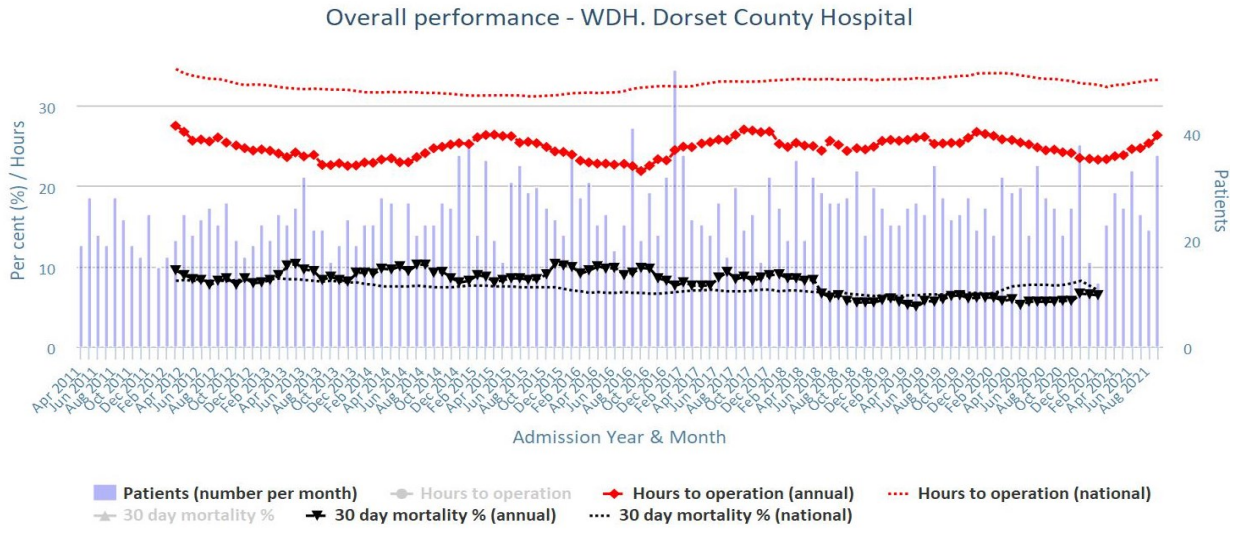
Date of report: 11/11/2021 3 ©ICNARC 2021

The charts below show the "risk adjusted acute hospital mortality" following admission to the DCH Critical Care Unit. They compare observed and expected death rates in a similar fashion to SHMI.



These results are comfortably within the expected range.

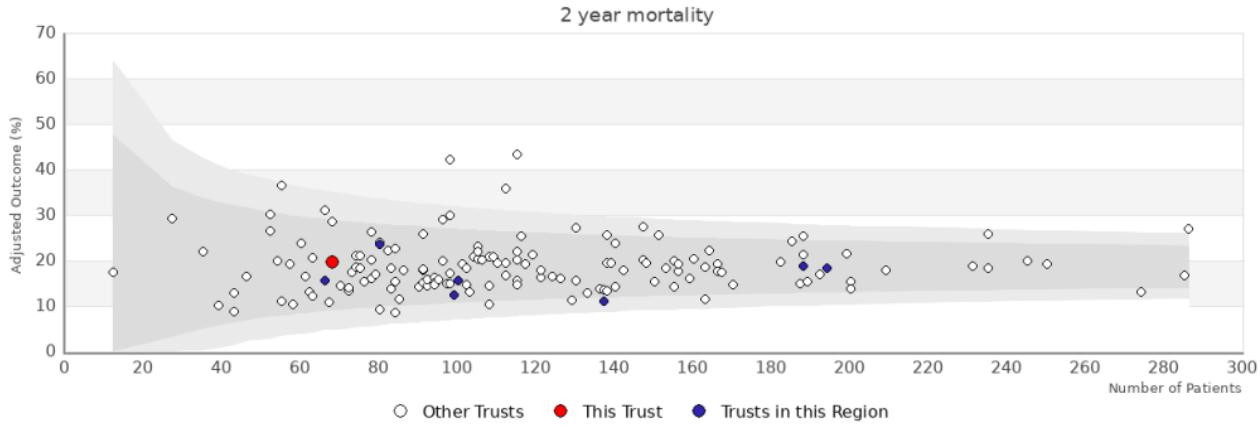
3.5 National Hip Fracture database to December 2021. Mortality data has apparently been delayed by contract negotiations with NHS Digital, and it therefore unchanged from the previous report.



The latest national average annualised mortality for hip fracture is 7.0%, with DCH's annualised mortality at 6.4% to February 2021 (latest available data).

3.6 National Bowel Cancer Annual audit

No new data as yet this year - graph below shows latest available 2 year survival data for patients admitted in financial year 2018/19, compared to all other NHS Trusts, with other Wessex Trusts in dark blue.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	68	19.7%	19.3%

3.7 Getting it Right First Time; reviews in Q3

No GIRFT reviews have taken place during this quarter.

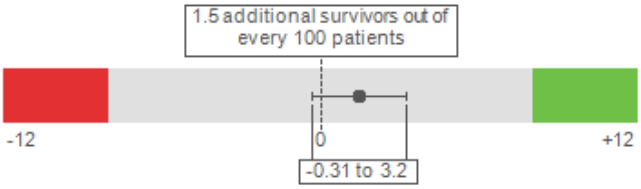
Full reports from all previous GIRFT visits are available, and feedback from each review has generally been very positive. Action plans have been developed and are being worked through at present.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. Data for the period 1/1/18 to 31/5/21 is shown below, but data specific to Q1, Q2 or Q3 s not available at present:

Rate of Survival at this Hospital

Between January 1st 2018 and May 31st 2021



Rate of Survival Breakdown at this Hospital

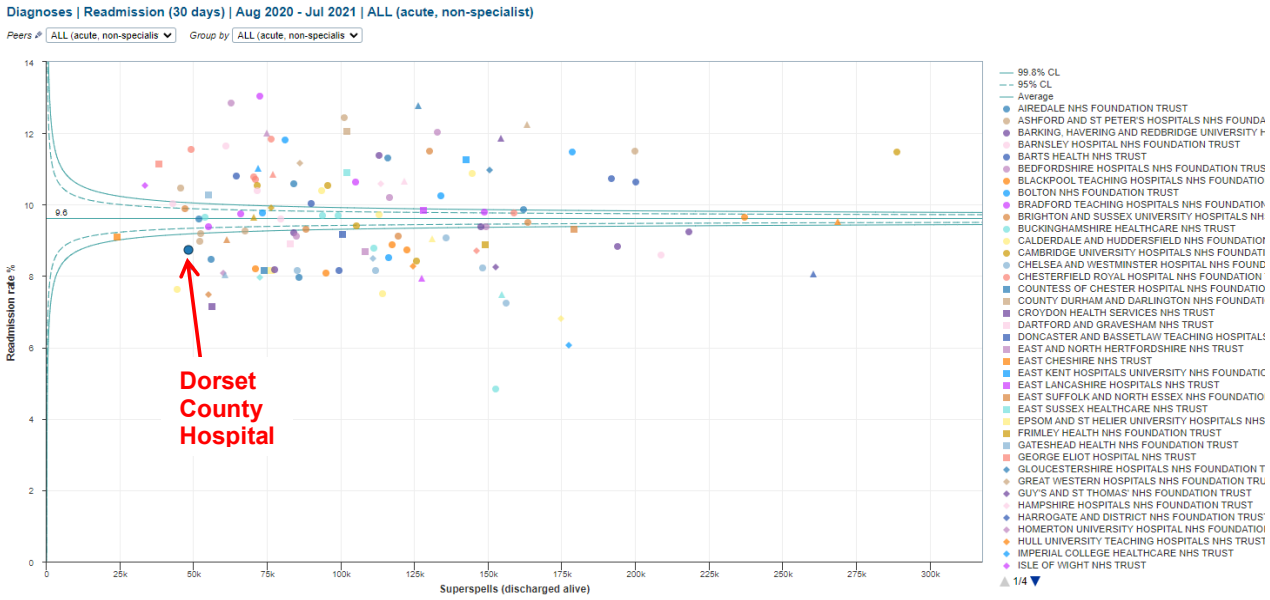
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	429	420	425	1.0	0.6
90 - 95	155	144	142	-1.3	-0.2
80 - 90	95	81	85	3.8	0.3
65 - 80	34	25	23	-6.3	-0.2
45 - 65	13	7	12	33.1	0.7
25 - 45	3	1	2	28.7	0.5
0 - 25	3	0	0	-16.0	-0.2
Total	**732**	**680**	**689**	**1.1**	**1.5**

Unexpected deaths in minor/moderate injury
Usually due to poor management of co-morbidity and/or complications

Unexpected survivors with more serious injury
Usually indicates good initial resusitation and the treatment of head injury in Neurological Centres

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors. In this data there were 9 more survivors than expected.

3.9 Readmission to hospital within 30 days, latest available data (Dr Foster); lower is better



A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However DCH's latest readmission rate is lower than the majority of other acute Trusts.

3.10 Dr Foster Safety Dashboard

This dashboard has been temporarily withdrawn by Dr. Foster, but will apparently be reinstated later this year. Below is last published version – now 12 months out of date.

Patient Safety Indicators

Period: 12 months (Feb 20 to Jan 21) | Data lag: No lag

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk	Compare
Accidental puncture or laceration	28524	53	45.3	1.9	1.6	116.9	
Deaths after surgery	195	9	14.7	46.2	75.2	61.3	
Deaths in low-risk diagnosis groups	12626	24	44.2	1.9	3.5	54.3	
Decubitus ulcer	3785	264	225.9	69.7	59.7	116.9	
Infections associated with central line	5431	0	0.3	0	0.1	0.0	
Obstetric trauma - caesarean delivery	383	2	1.7	5.2	4.5	115.4	
Obstetric trauma - vaginal delivery with instrument	108	8	7.3	74.1	67.9	109.0	
Obstetric trauma - vaginal delivery without instrument	678	21	19.9	31.0	29.3	105.7	
Postoperative haemorrhage or haematoma	10920	4	4.1	0.4	0.4	98.1	
Postoperative physiologic and metabolic derangement	9377	0	1.7	0	0.2	0.0	
Postoperative pulmonary embolism or deep vein thrombosis	11005	33	30.3	3.0	2.8	109.0	
Postoperative respiratory failure	8572	5	8.8	0.6	1.0	56.6	
Postoperative sepsis	110	1	1.7	9.1	15.6	58.2	
Postoperative wound dehiscence	375	0	0.3	0	0.8	0.0	

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:

a) Poor quality of some admission clerking notes, particularly in surgery

- The hospital clerking proforma has been revised, and the continuation note paper has had reminder watermarks added to remind staff to date, time, print name/GMC no.

b) Morbidity and Mortality meetings - standardization and governance (see next item)

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers.

Specialty	Contact	April	May	June	July	August
Cardiology	Helen Dell,	13.04.21	11.5.21	8.06.21	13.07.21	10.08.21
Renal	Kathleen O'Neill	05.05.21	02.06.21	30.06.21	28.07.21	28.08.21
Vascular	James Metcalfe	Weekly	Weekly	Weekly	Weekly	Weekly
Oncology	Abi Orchard				16.07.21	tbc
ED &Acute Medicine	Tamsin Ribbons & James Ewer	15.04.21	----------	Cancelled	----------	19.08.21
Respiratory	Marianne Docherty	27.4.21	25.5.21	Cancelled	27.07.21	24.08.21
Elderly Care & Stroke	James Richards Harold Proeschel	21.04.21	----------	----------	21.07.21	----------

6.0 LEARNING FROM CORONER'S INQUESTS Q3

DCH has been notified of 21 new Coroner's inquests being opened in the period October 2021 – December 2021.

12 inquests were held during Quarter 3. 3 inquests were heard as Documentary hearings, not requiring DCH attendance. 0 required the clinician to attend Court in person. 9 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 70 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 6 pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings, a significant number of which will be attended virtually. The virtual court room set up within Trust Headquarters is working well, and Ms Mandy Ford (DCH) liaises with the coroner's officer to improve the technology and its use.

7.0 LEARNING FROM CLAIMS Q3

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs.

Claims pattern this Quarter:

New potential claims	14
Disclosed patient records	15
Formal claims	9 clinical negligence, 1 employee claim
Settled claims	7 clinical negligence, 0 employee claim
Closed - no damages	0

8.0 SUMMARY

SHMI has improved to within the expected range over the past few months. However difficulties remain within the coding department as evidenced by the increased uncoded 'Primary Diagnoses' at 29%. No other metrics of in-patient care suggest that excess mortality is occurring at DCH, and much of the national data suggests better than average mortality, although several previously regular national reports are themselves having difficulty in producing timely data. This appears to be related to recent data quality problems experienced with NHS Digital's HES M04 release.

Nevertheless, the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25th May 2022
Document Title:	**Mortality Report: Learning from deaths Qtr 4 2021/22**
Responsible Director:	Prof. Alastair Hutchison, Medical Director
Author:	Prof. Alastair Hutchison, Medical Director

Confidentiality:	Public
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Hospital Mortality Group	11th May 2022	None specific
Quality Committee	17th May 2022	

Purpose of the Paper	To inform the Quality Committee of the learning that has occurred as a result of deaths being reported, investigated and appropriate findings disseminated throughout the Trust.
Summary of Key Issues	The Trust's SHMI reported during Q4 (5 months in arrears - rolling years to Sep, Oct and Nov 2021) remained relatively stable at around 1.14 throughout this quarter. This figure continues to be influenced by delays in coding (reasons for this are explained in the previous Q2 report). No other local or national indicators suggest that excess unexpected deaths are occurring at DCH. Structured Judgement Reviews are being used to examine the care of an appropriate sample of people who died whilst in-patients, 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. DCH is about to take on the ME function for community deaths, and has recruited 5 additional MEs for this work, with NHSE funding.
Action recommended	The Quality Committee is recommended to: 1. **NOTE** the report 2. **APPROVE** the report for publication on the DCH internet website 3. **Not publish** appendices 1 and 2 which contain patient data

Governance and Compliance Obligations

Legal / Regulatory	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement.
Financial	Y	Failure to learn from deaths could have financial implications in terms of the Trust's claim management and CNST status.
Impacts Strategic Objectives?	Y	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Ensuring that an elevated SHMI is not a result of lapses in care requires regular scrutiny of a variety of data and careful explanation to staff and the public. An elevated SHMI can have a negative impact on the Trust's reputation both locally and nationally.
Risk?	Y	• Reputational risk due to higher than expected SHMI • Poor data quality can result in poor engagement from clinicians, impairing the Trust's ability to undertake quality improvement • Clinical coding data quality is improving, but previously adversely affected the Trust's ability to assess quality of care • Clinical safety issues may be reported erroneously or go unnoticed if data quality is poor

Decision to be made?	N	
Impacts CQC Standards?	Y	An elevated SHMI will raise concerns with NHS E&I and the CQC. NHS-I undertook a review in March 2019 and produced a report which has resulted in an action plan. This plan was presented to Trust Board in July 2019 and is complete, but work continues. The previous reduction in SHMI and improvements in coding are acknowledged, but Covid-19 and elective tariff incentivisation targets have adversely influenced coding and therefore recent SHMI figures are inaccurate.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

CONTENTS

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning. See appendix 1 and 2 for full reports.

1.1 Family Services and Surgical Division Report - Quarter 4 Report

Structured Judgement Review Results: The Division had 59 deaths in quarter 4, of which 47 require SJR's to be completed. Of these 12 have had an SJR completed. Between January to March, an additional 35 SJR's have also been completed from previous months.

SJR Backlog: The outstanding SJR's for the Division as at 25/04/2022 is 52:

May	July	October	November	December	January	February	March
2	2	4	7	6	7	6	18

The available notes have been allocated to Clinical staff to ensure these are completed.

	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	9	26	32	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	2	0	0	0	2
3 Adequate	12	5	6	4	9	6
4 Good	20	22	9	7	27	27
5 Excellent	15	9	6	4	9	12

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
1	0	3	4	28	11

- Generally excellent documentation. 1 entry from ITU Consultant very difficult to read.
- Notes all loose in file and some in wrong order.
- Generally good documentation, especially by palliative care team. Case notes not all in correct order.
- Scanned to DPR so very difficult to navigate but documentation otherwise OK.
- Some entries not timed and/or illegible.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	1	0	8	38

Report completed by:
Richard Jee – Divisional Mortality Lead
Laura Symes – Quality Manager

1.2 Division of Urgent & Integrated Care Q4 Report

Structured Judgement Reviews

Quarter 4: 170 deaths, 33 SJR's were requested and 16 were completed.

Year to date (01/04/2021 – 31/03/2022): 622 deaths, 156 SJR'S requested and 96 have been completed.

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	2	15	16	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	3	0	0	0	2
3 Adequate	2	3	0	0	2	4
4 Good	12	7	1	0	6	8
5 Excellent	2	1	0	0	5	2

Overall Quality of Patient Record

Blank	Score 1 Very Poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	6	9	0

Avoidability of Death Judgement Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (> 50:50)	Score 4 Possibly avoidable but not very likely (<50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	2	2	12

SJR Backlog

The outstanding SJR's for the Division as at 07/04/2022 is 59, 24 of which have been allocated but not yet completed.

January	February	March
10	11	12

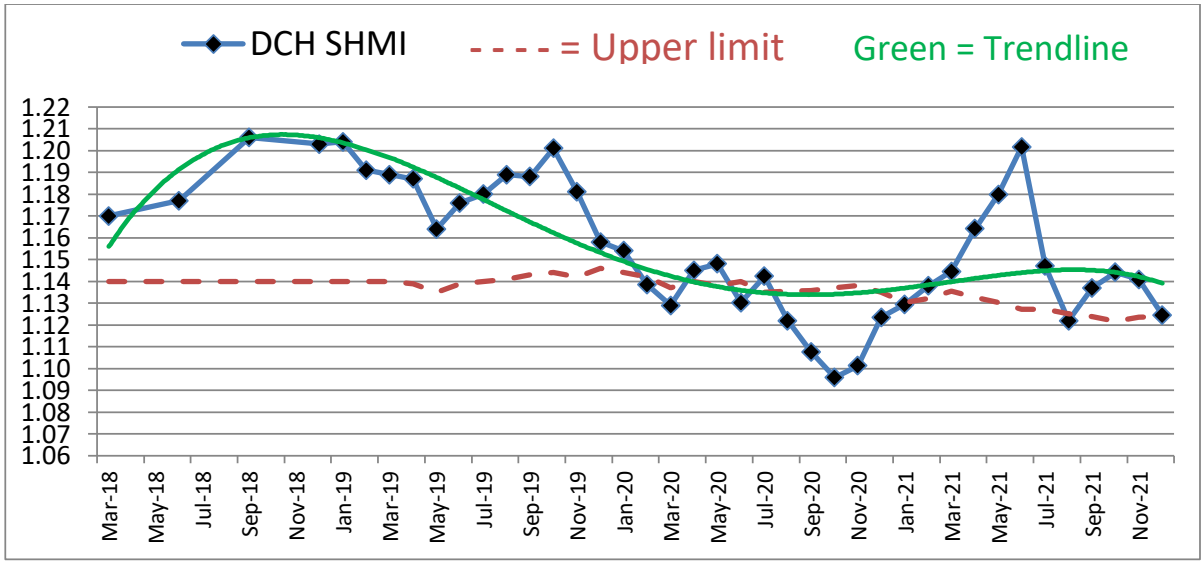
7 Nosocomial COVID 19 deaths required review.

Report completed by:
Jemma Newman, Quality Manager,
Sonia Gamblen, Divisional Head of Nursing & Quality
James Metcalfe, Divisional Director

2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES

2.1 Summary Hospital-level Mortality Indicator (SHMI)

SHMI is published by NHS Digital for a 12 month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. The SHMI for the rolling years from October 2020 to June 2021 showed a clear reversal of the previous trend to improvement, but the latest data has stabilised around a SHMI of 1.14 or less and we know that this has been adversely influenced by difficulties in the Coding Department – see below. Staff absences and continued working from home using scanned records suggest that timeliness of coding was poor during Sep/Oct/Nov 2021 (latest published data). A coding action plan has been produced and enacted by Sue Eve-Jones and Stephen Slough which is on course to correct the data prior to the validation deadline of 19/05/2022.



SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12 month period to the expected deaths (predicted from coding of all admissions). From October 2019 onwards there had been a steady improvement in DCH's SHMI as a result of investment in the coding department which resulted in more accurate and timely coding returns to NHS Digital.

For a full explanation of recent coding difficulties please see the previous Q2 2022 report published on the DCHFT internet site.

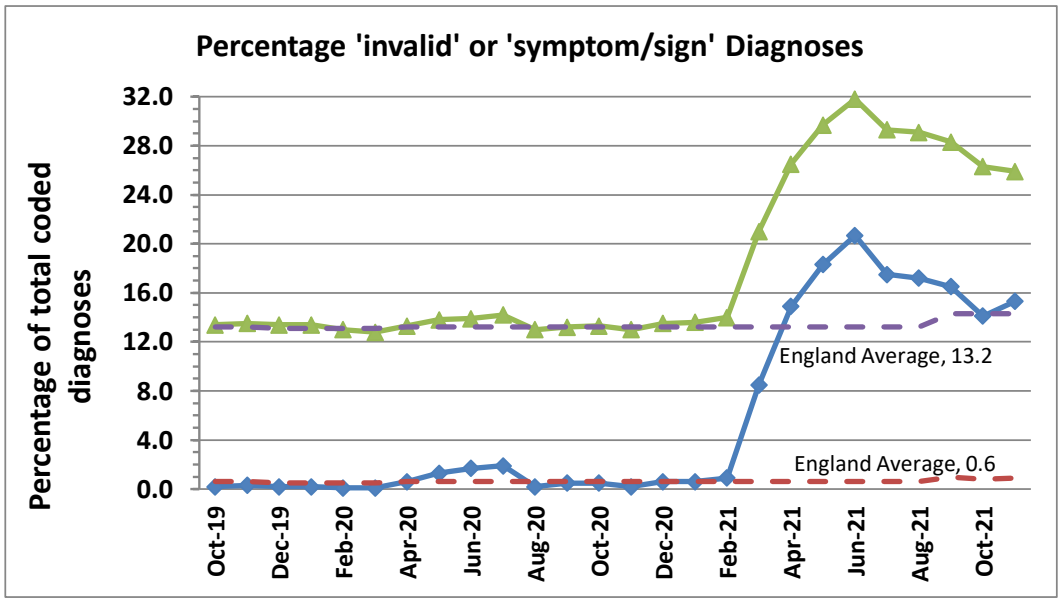
2.2 Percentage of provider spells with a primary diagnosis which is a symptom or sign: NHS Digital states "*This indicator presents the percentage of finished provider spells with a primary diagnosis which is a symptom or sign (identified by ICD-10 codes beginning with the letter 'R'). A high percentage of provider spells with a primary diagnosis which is a symptom or sign compared to other similar trusts may indicate problems with data quality or timely diagnosis of patients*".

DCH has recently had a very high but reducing number of spells with a primary diagnosis which is a symptom or sign – for example either no entry at all (uncoded), or 'chest pain' rather than 'myocardial infarction' – at 31.8% for June 2021 but improving progressively since then to a latest figure of 25.9% for November 2021. The England average is around 13%, and the increase seen in DCH data is largely due to uncoded cases which therefore have no recorded diagnosis. Such uncoded in-patient 'spells' are attributed a very low risk of death, since a symptom or sign only, does not suggest a life-threatening illness. This significantly reduces our expected number of deaths and hence increases the SHMI value.

2.3 Percentage of provider spells with an invalid primary diagnosis code: NHS Digital states "*This indicator presents the percentage of finished provider spells with an invalid primary diagnosis code*

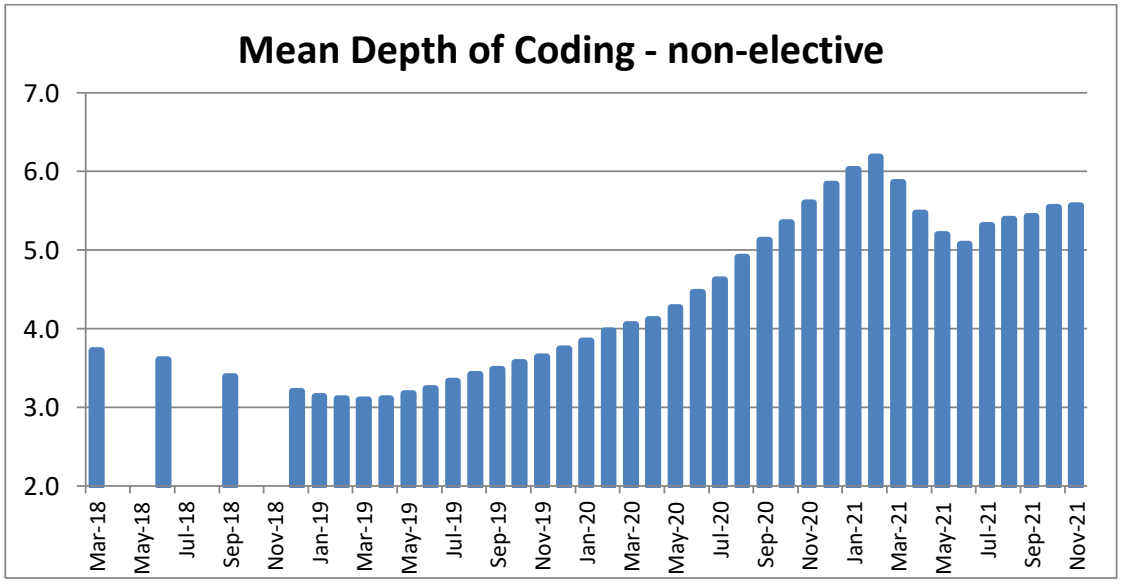
(identified as those spells where the primary diagnosis is given by the ICD-10 code R69X). A high percentage of provider spells with an invalid primary diagnosis code compared to other trusts may indicate a data quality problem."

This metric is a subgroup of 2.2 above. A 'spell' is a continuous period of in-patient care. The graph below shows the change in these two metrics of coding accuracy over the past 30 months:



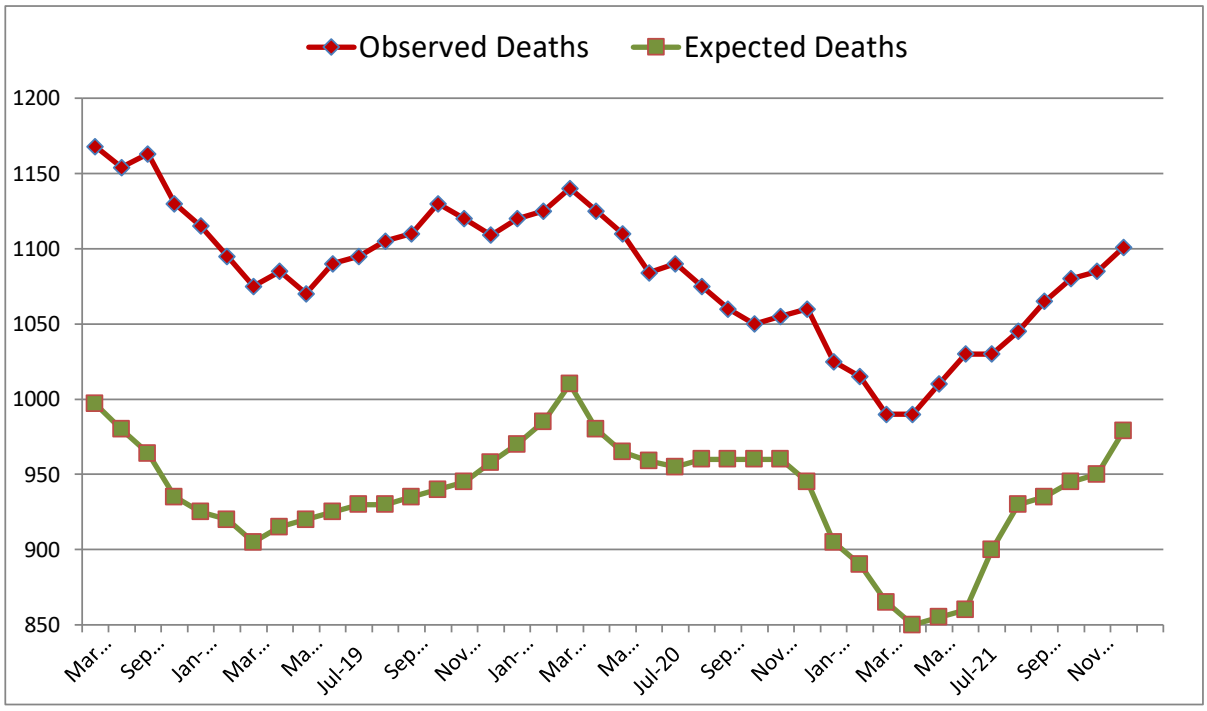
2.4 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts.*"

DCH's depth of coding had been improving steadily up to February 2021 (see graph below), the fell but is now improving and this almost certainly reflects the same backlog problem in the coding department.



2.5 Expected Deaths (based on diagnoses across all admissions per rolling 12 months):

The chart below shows observed and expected deaths over the past 3 years (rolling years from March 18 to December 21), and whilst both observed (actual) and expected deaths have increased (as total number of in-patients increases post covid-19), the expected deaths have increased faster as a result of partial recovery of coding practice, thereby improving the SHMI ratio.



2.6 Communication with NHS Digital:

From: "CLINICAL INDICATORS, Hscic (NHS DIGITAL)" <clinical.indicators@nhs.net>
Date: 27 January 2022 at 08:11:32 GMT
To: "Hutchison, Alastair" <Alastair.Hutchison@dchft.nhs.uk>

Hi Alastair,
Thank you for raising the issue of Dorset County Hospital Trust's high percentage of invalid diagnosis codes with us. We can see that the percentage of invalid codes is about 16% and that you have a "higher than expected" SHMI which may be a result of this. It is good to get some context for this from the Trust and it sounds as though you are taking the correct steps with HES to amend this problem before the 2021/22 APC data is finalised.
Please get back to us if you need any further information.
Kind Regards,

David Keighley (he/him)
Senior Information Analyst, Analytical Services Team
Pronouns: he/him
d.keighley@nhs.net
07592 399251

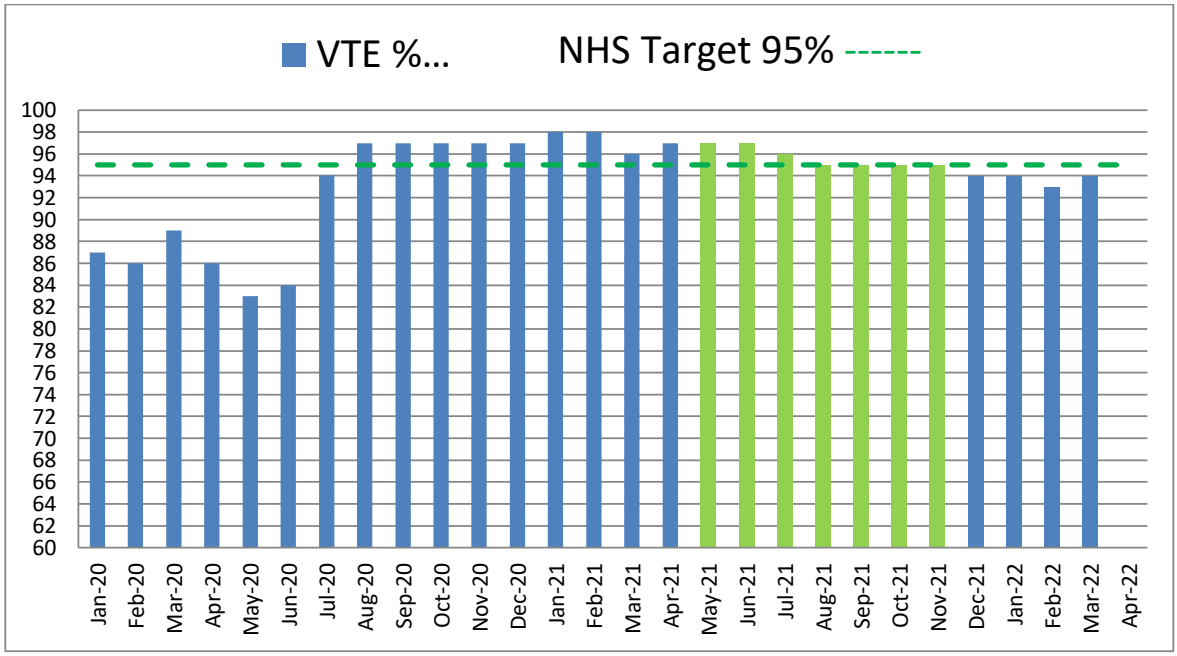
NHS Digital

3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Learning from Deaths Mortality Group regularly examines any other data which might indicate changes in standards of care and continued to meet on a monthly basis throughout the COVID-19 crisis. The following sections report data available from various national bodies which report on Trusts' individual performance. However much of this data has also been interrupted by covid-19 and has not yet caught up again.

For other metrics of care including complaints responses, sepsis data (on screening and 1 hour for antibiotic administration), AKI, patient deterioration and DNACPR data, please see the Quality Report presented on a monthly basis to Quality Committee by the Director of Nursing.

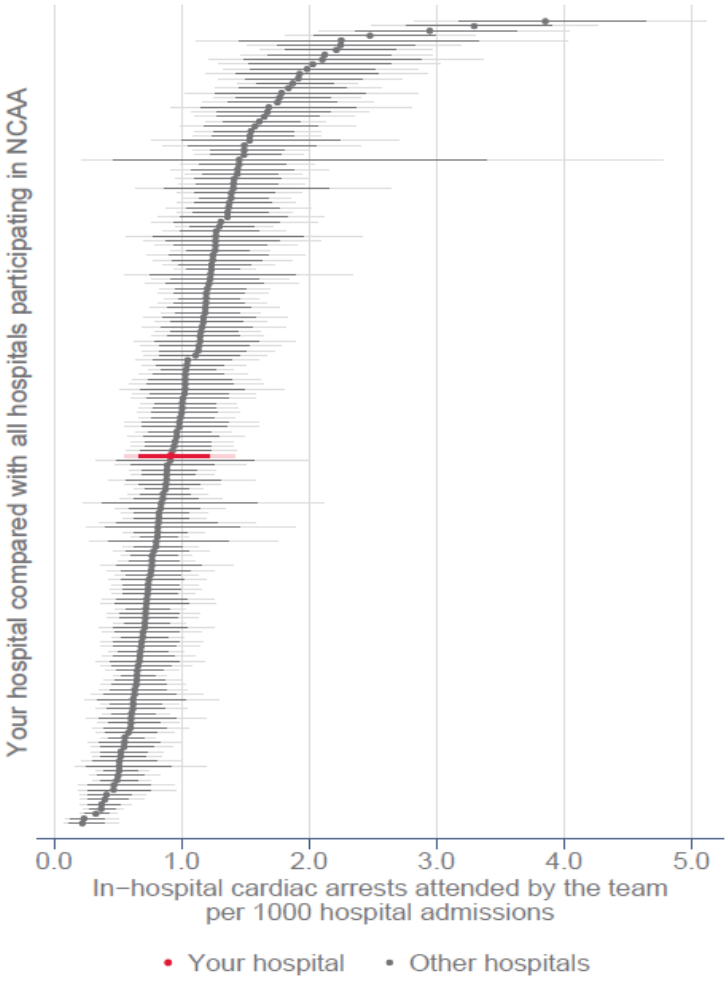
DCH VTE risk assessment recording reached 97% in August 2020 with the introduction of a more accurate reporting system, but in the last 4 months has reduced to 94%. This graph has been circulated to all junior staff and ward nursing teams. Dr Aruna Arjunan has taken over as chair of the VTE Group and is auditing compliance with the VTE prophylaxis policy which has been recently revised.



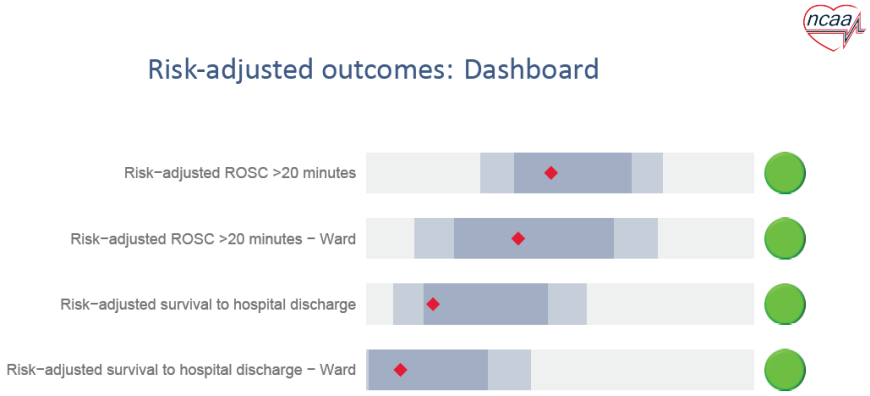
3.1 NCAA Cardiac Arrest data

The national Cardiac Arrest audit for DCH April 2021 to December 2021 was published on 12/04/2021. A total of 46 cardiac arrest calls were recorded for this period. The format and reporting period for this report (Q1+Q2+Q3) has changed from previous editions so that some of the graphs are not directly comparable to previous versions. The report was also published alongside a more detailed summary of the previous year's results - 2020/21. This is available on request from Dr. Richard Jee

The graph below represents the number of in-hospital cardiac arrests attended by the team per 1,000 admissions for all adult, acute care hospitals in the NCA Audit. DCH is indicated in red, and lower is better.


Your hospital compared with all hospitals participating in NCAA
0.0
1.0
2.0
3.0
4.0
5.0
In−hospital cardiac arrests attended by the team per 1000 hospital admissions
Your hospital
Other hospitals

The graph below shows two outcome measures:
a) Return of Spontaneous Circulation and b) Survival to Discharge. These and all other measures in the report get a 'green' indicator for the 9 month period (Q1 to Q3 2021/22).

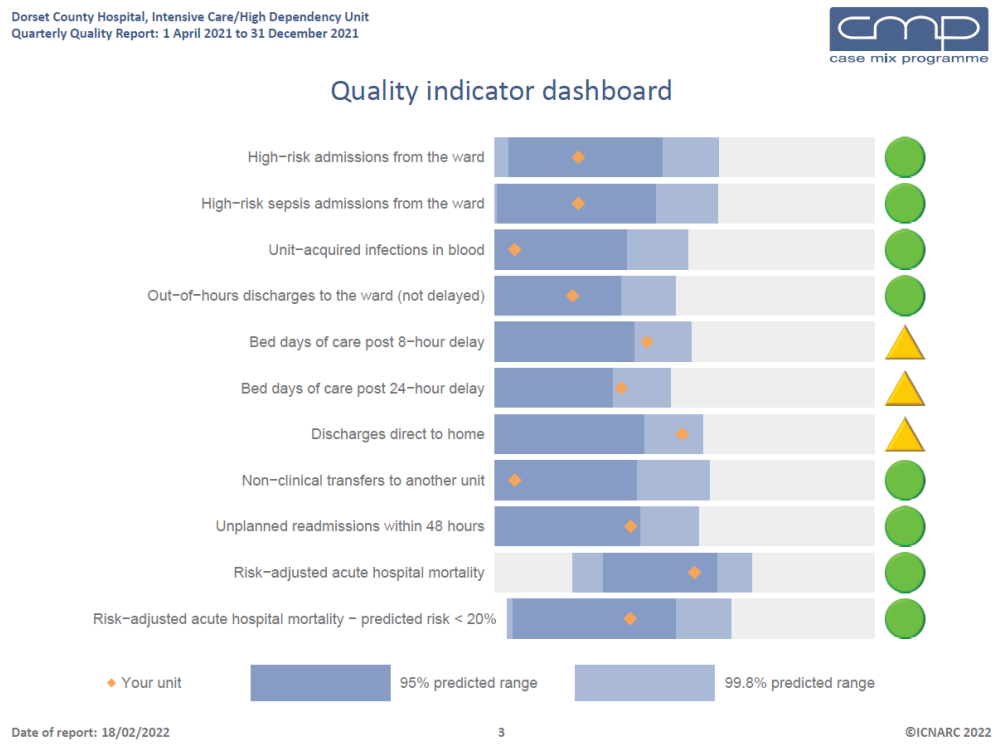


3.2 National Adult Community Acquired Pneumonia Audit latest data – last published Nov 2019 (see below), and not undertaken for either 2019/20 or 2020/21. However it has been announced that data collection will restart in Spring 2022 for publication in Summer 2023.

Results Summary		Dorset County Hospital	National results
Patient Characteristics and Diagnosis		**n = 88**	**n = 10174**
Gender	Male Female	43% 57%	48% 52%
Age	Median (IQR)	78 (61-84)	75 (61-85)
Cohort Severity (CURB65 score)	0-1 2 3-5	42% 31% 27%	47% 29% 24%
Inpatient mortality	Proportion deceased	7%	10%
Length of stay (discharged patients)	Median in days	3	5
Critical care admission	Yes - proportion	2%	5%
Readmission	Yes - proportion	8%	13%

The results suggest that patients admitted to DCH 2018/19 tended to be more ill than the national average but had a lower death rate and shorter length of stay, with fewer readmissions.

3.3 ICNARC Intensive Care survival latest data published 18 February 2022; n = 480 patients.
The amber triangle indicators in the chart below indicate delays in being able to discharge patients from ICU, with some delays being long enough that the patient was discharged direct to home. This is an indicator of DCH bed pressures.

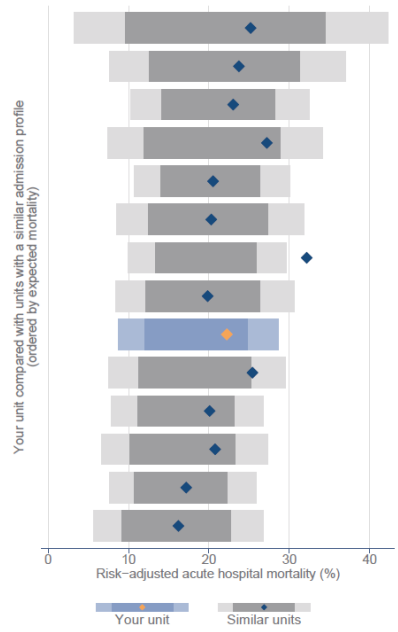


The charts below show the “risk adjusted acute hospital mortality” following admission to the DCH Critical Care Unit, Q1 to Q3. They compare observed and expected death rates in a similar fashion to SHMI.

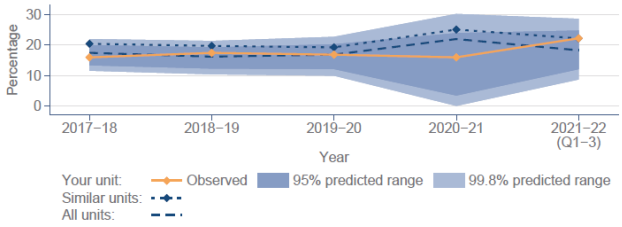
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2021 to 31 December 2021

case mix programme

Risk-adjusted acute hospital mortality



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	145	136	14.7	15.5	(9.3, 21.5)	(6.3, 25.4)	
Quarter 2	157	153	24.8	18.8	(7.5, 29.7)	(1.8, 36.7)	
Quarter 3	178	161	26.1	20.7	(9.2, 31.7)	(3.4, 38.7)	
Quarter 4							
Year to date	480	450	22.2	18.5	(12.1, 24.7)	(8.7, 28.6)	



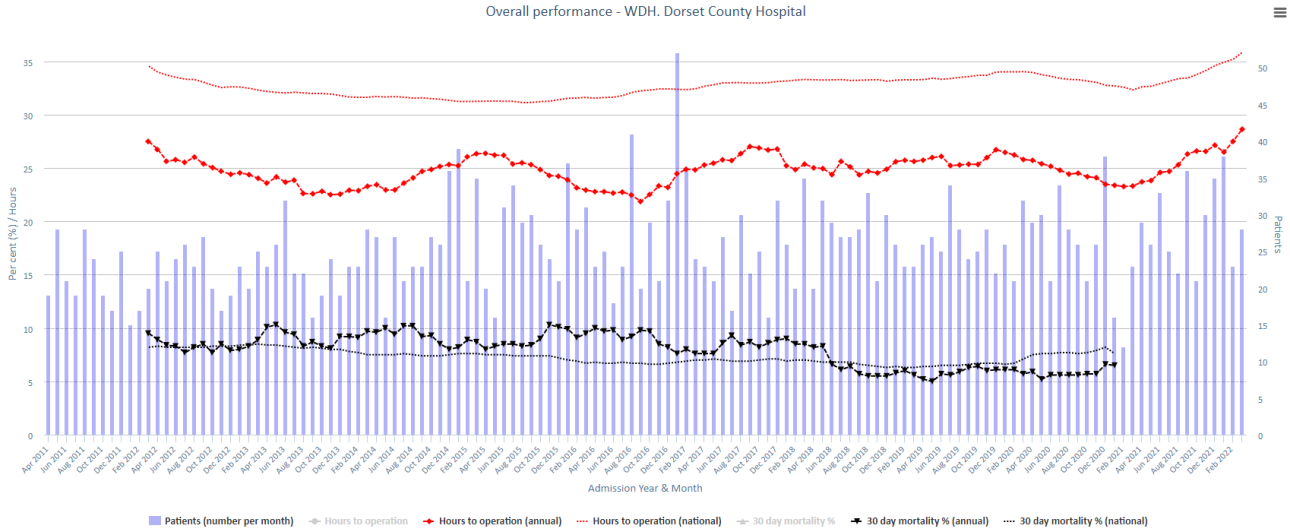
Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC$_{H-2018}$ model for eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Date of report: 18/02/2022 13 ©ICNARC 2022

These results are within the expected range, but somewhat higher than last quarter.

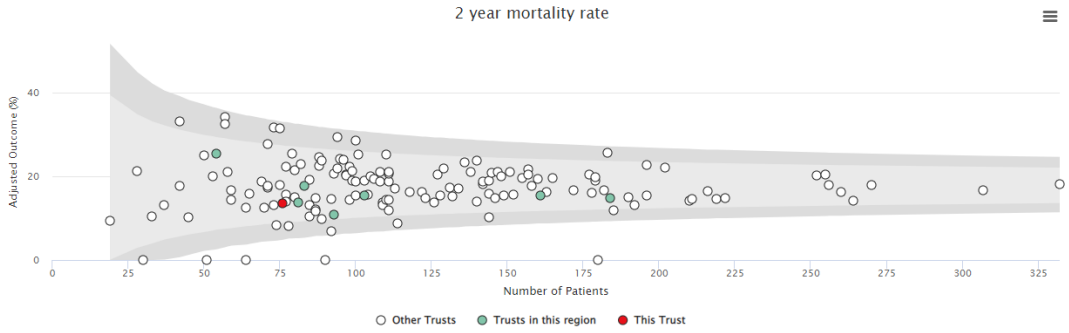
3.5 National Hip Fracture database to December 2021. Mortality data has apparently been delayed by contract negotiations with NHS Digital, and is therefore unchanged from the previous report.



The latest national average annualised mortality for hip fracture is 7.0%, with DCH's annualised mortality at 6.4% to February 2021 (latest available data). Hours to operation remains significantly better than the national average for Q3 (28.6 vs 36 hours).

3.6 National Bowel Cancer Annual audit

New data has been published for the year 2019/20. The graph below shows latest available 2 year survival data for patients admitted in financial year 2019/20, compared to all other NHS Trusts, with other Wessex Trusts in green.



Trust	Number	Adjusted	Observed
Dorset County Hospital NHS Foundation Trust	76	13.5%	15.9%
Other trusts within the region: Wessex			
Hampshire Hospitals NHS Foundation Trust - Basingstoke and North Hampshire Hospital	83	17.7%	14.2%
Hampshire Hospitals NHS Foundation Trust - Royal Hampshire County Hospital	81	13.7%	11.6%
Isle of Wight NHS Trust	54	25.5%	20.8%
Portsmouth Hospitals NHS Trust	184	14.7%	11.6%
University Hospital Southampton NHS Foundation Trust	161	15.4%	14.9%
Poole Hospital NHS Foundation Trust	93	10.8%	13.8%

3.7 Getting it Right First Time; reviews in Q4

One virtual GIRFT review was undertaken at DCH during this quarter relating to recovery of waiting lists post-covid-19. The full report is available on request. No other visits took place during Q4, and the next one is not scheduled until August 2022. Full reports from all previous GIRFT visits are available, and feedback from each review has generally been very positive. Action plans have been developed and are being worked through at present.

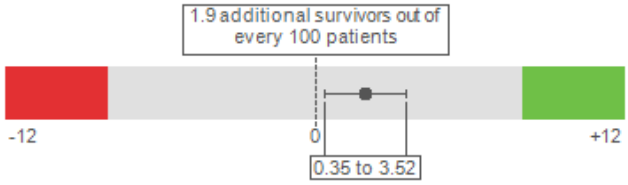
GIRFT have recently requested that all Trusts add a section to their quarterly Learning from Deaths report that explains learning from medico-legal claims and inquests - as DCH has done every 6 months for some years. Sections 6.0 and 7.0 of this report have been expanded to cover this request.

3.8 Trauma Audit and Research Network

DCH is a designated Trauma Unit (TU) providing care for most injured patients, and has an active, effective trauma Quality Improvement programme. It submits data on a regular basis to TARN which then enables comparison with other TUs. Cumulative data recently published for the 36 months from 1/1/19 to 31/12/21 is shown below, but data specific to Q1, Q2 or Q3 is not available at present:

Rate of Survival at this Hospital

Between January 1st 2019 and December 31st 2021



Rate of Survival Breakdown at this Hospital

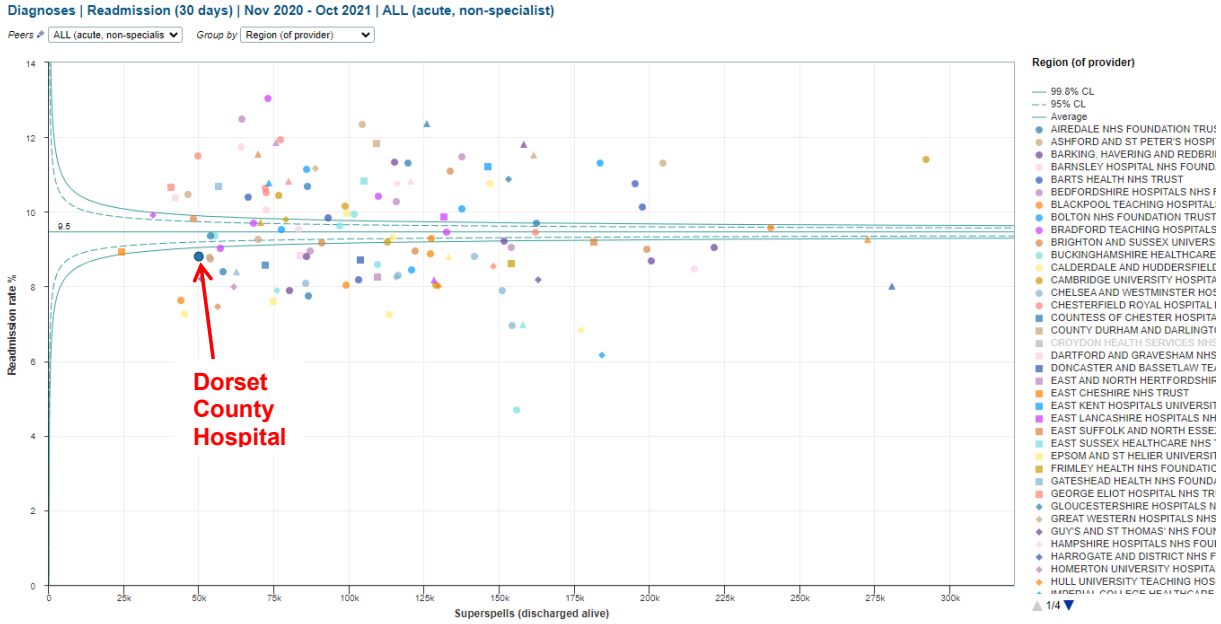
Survival band %	Number in group	Expected survivors	Actual survivors	Difference*	Adjusted difference**
95 - 100	518	508	514	1.1	0.8
90 - 95	190	176	177	0.4	0.1
80 - 90	112	95	102	5.4	0.5
65 - 80	46	34	33	-2.2	-0.1
45 - 65	15	8	14	34.3	0.8
25 - 45	4	1	2	10.4	0.2
0 - 25	4	0	0	-12.9	-0.2
Total	**889**	**825**	**842**	**1.9**	**1.9**

Unexpected deaths in minor/moderate injury
Usually due to poor management of co-morbidity and/or complications

Unexpected survivors with more serious injury
Usually indicates good initial resusitation and the treatment of head injury in Neurological Centres

The first column categorises patients by percentage likelihood of survival, followed by the total number of patients seen at DCH, the calculated likely number of survivors and then the actual number of survivors. In this data there were 17 more survivors than expected.

3.9 Readmission to hospital within 30 days, latest available data (Dr Foster); lower is better



A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process. However, DCH's readmission rate continues to be significantly lower than the majority of other acute Trusts.

3.10 Dr Foster Safety Dashboard
This dashboard has been temporarily withdrawn by Dr. Foster, but will apparently be reinstated later this year.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs

The following themes have been previously identified from SJRs and are being translated into quality improvement projects:
a) Poor quality of some admission clerking notes, particularly in surgery - the hospital clerking proforma has been revised, and the continuation note paper has had reminder watermarks added to remind staff to date, time, print name/GMC no. The introduction of the 'AGYLE' electronic patient record software occurred at the end of Q4 and as this is rolled out across the Trust it will be fully auditable and replace written records.

b) Morbidity and Mortality meetings - standardization and governance (see next item)

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers.

Specialty	Contact	Jan	Feb	Mar	April	May	Jun
Cardiology	Helen Dell,	18/01/22		01/03/22			
Renal	Kathleen O'Neill	12/01/22					
Vascular	James Metcalfe						
Diabetes			16/02/22				
Oncology	Abi Orchard	14/01/22		18/03/22		20/05/22	17/06/22
Haematology	Sarah Attfield, Jill McCormack						
ED &Acute Medicine	Andy Brett & James Ewer						
Respiratory	Marianne Docherty	25/01/22 (CG)	15/02/22 (CG)	29/03/22 (M+M)			
Elderly Care & Stroke	James Richards Harald Proschel		09/02/22	X			

Specialty	October	November	December	January	February	March
Anaesthetics	01/10/21	26/11/21	Scheduled 24/12/21 cancelled due to apologies	21/01/22	18/02/22	18/03/22
Breast Surgery	01/10/21 (hosted by YDH)	26/11/21 (hosted by YDH)	24/12/21 – cancelled due to lack of staff	21/01/22 (hosted by YDH)	18/02/22	Scheduled 18/03/22 cancelled due to Trust pressures
Gastroenterology	06/10/21	03/11/21	01/12/21	05/01/22	Scheduled 02/02/22 but no cases	Scheduled 02/03/22 but other priorities discussed
General Surgery + Colorectal	01/10/21	26/11/21	Scheduled 24/12/21 cancelled due to apologies	21/01/22	18/02/22	Scheduled 18/03/22 cancelled due to Trust pressures
Orthopaedics	08/10/21	Scheduled 05/11/21 no cases to discuss	03/12/21	28/01/22	25/02/22	Scheduled 25/03/22 cancelled due to Trust pressures
Perinatal	27/10/21	24/11/21	22/12/21	26/01/22	23/02/22	23/03/22
Urology	01/10/21	26/11/21	Scheduled 24/12/21 cancelled due to apologies	21/01/22	Scheduled 18/02/22 cancelled due to apologies	Scheduled 18/03/22 cancelled due to Trust pressures

6.0 LEARNING FROM CORONER'S INQUESTS Q4

DCH has been notified of 16 new Coroner's inquests being opened in the period Jan 2022 – March 2022.

10 inquests were held during Quarter 4. 7 inquests were heard as Documentary hearings, not requiring DCH attendance. 0 required the clinician to attend Court in person. 3 required attendance remotely from the DCH 'virtual courtroom' (in THQ) using Microsoft Teams.

We currently have 50 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. 3 pre-inquest reviews were listed during this period.

We continue to work with the Coroner's office, and will continue to support staff at these hearings. The coroner has requested from May 2022 that witnesses attend the court room at the Town Hall, Bournemouth in person. Authority will be required, if we wish the clinician to attend remotely.

7.0 LEARNING FROM CLAIMS Q4

Legal claims are dealt with by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs.

Claims pattern this Quarter:

New potential claims	9
Disclosed patient records	7
Formal claims	4 clinical negligence, 1 employee claim
Settled claims	4 clinical negligence, x employee claim
Closed - no damages	2 clinical negligence, 1 employee claim

8.0 SUMMARY

SHMI is expected to improve in the coming months since the backlog of uncoded notes has been cleared, and updated HES data for 2021/22 will be submitted to NHS Digital by the deadline of 19th May 2022. However this will not change previously published figures which will remain on record although they are known to be inaccurate. The 5 month SHMI publishing delay means that the DCH SHMI will not accurately reflect in-patient activity until early autumn 2022.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH and much of the national data suggests better than average mortality, although several previously regular national mortality reports are themselves having difficulty in producing timely data. In particular TARN, ICNARC and NCAA data continue to be reassuring since unexpected deaths would be likely to show up here, at least in part.

Nevertheless the Hospital Mortality Group remains vigilant and will continue to scrutinise and interrogate all available data to confirm or refute this statement on a month by month basis. At the same time internal processes around the completion and recording of SJRs, M&M meetings and Learning from Deaths are now well embedded and working effectively within the Divisional and Care Group Teams.

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**25th May 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)	16th May 2022	See committee escalations

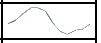
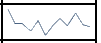
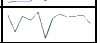
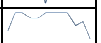
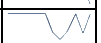
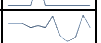
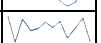
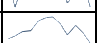
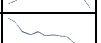
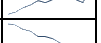
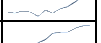
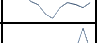
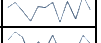
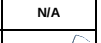
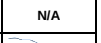
Purpose of the Paper	To provide the Board with details of the Trust's operating performance, and to escalation key issues from the Board Sub Committees to the Board of Directors.							
	Note (✓)	✓	*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	**Performance Scorecard** The reporting month of April 2022 continued to experience significant patient flow restrictions. The number of patients with no reason to reside did reduce, which resulted in a slight improvement against the 4-hour standard. The number of patients waiting in the ED department for more than 12 hours, also reduced. Ambulance handover delays improved slightly, but remain at high levels, putting pressure on the ambulance response times. Ambulance response times is now included in the performance paper. The impact of the continued high levels of no reason to reside is felt throughout the hospital. 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. Elective activity levels, as a percentage of 2019/20, have been low in April 2022, with inpatient activity at 60.67% of 2019/20 levels. Despite the flow challenges, the trust continues to perform well in cancer, of particular note is the achievement of the 28 day standard. T he trust has seen another short-term staffing gap in diagnostics, this is made up of sickness and a high vacancy rate. Waiting list performance has been mixed, with the 52+ week wait trajectory achieved, but the 78+ and 104+ week wait trajectory behind plan. **Escalation Reports** The May Board sub-committees met as follows: Monday 16th May: Finance and Performance Committee and People and Culture Committee Tuesday 17th May: Quality Committee Tuesday 24th May: 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	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	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)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	Contractual (National Quality Requirement) 2019/20	**6 (0.7)**	**6 (0.6)**	**4 (0.4)**	**3 (0.2)**	**4 (0.4)**	**2 (0.2)**	↑	
Never Events	**0**	Contractual (National Requirement)	**1**	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	For monitoring purposes only	0	1	0	0	1	0	**N/A**	
Duty of Candour - Cases completed	**N/A**	For monitoring purposes only	9	3	5	3	4	4	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	For monitoring purposes only	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	**3**	0	**2**	0	**4**	**2**	↑	
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)	↔	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	For monitoring purposes only	0 (0.0)	0 (0.0)	1 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Emergency caesarean section rate			15.9%	24.4%	23.1%	21.7%	19.3%	15.1%	↑	
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)	**87.5%**	**83.3%**	N/A	N/A	N/A	N/A	↓	
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)	**87.2%**	94.7%	100%	**82.4%**	92.3%	N/A	↑	
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)	**82.6%**	**81.0%**	N/A	N/A	N/A	N/A	↓	
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)	**87.1%**	**83.3%**	100%	**81.3%**	91.7%	N/A	↑	
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**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.10 (ratio between observed deaths and expected deaths)**	Contractual (Local Quality Requirement)	**1.14**	**1.12**	N/A	N/A	N/A	N/A	**N/A**	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	Contractual (Local Quality Requirement)	**102.0**	**103.2**	98.7	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)	**114.4**	**118.0**	**117.2**	N/A	N/A	N/A	**N/A**	
Stroke - Overall SSNAP score	**C or above**	Contractual (Local Quality Requirement)	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)	90.2%	**80.4%**	**83.4%**	**82.0%**	94.8%	75.7%	↓	
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%	↔	
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)	98.0%	94.7%	100.0%	97.0%	100.0%	100.0%	↔	
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	↔	
Complaints - Number of formal & complex complaints	**N/A**	For monitoring purposes only	36	19	24	29	35	28	↑	
Complaints - Percentage response timescale met	**Dec '18 = 95%**	Local Trajectory	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	Mar-18 National Average	**93.8%**	**93.5%**	**93.6%**	**91.6%**	**92.2%**	**93.1%**	↑	
Friends and Family - Emergency Department - Recommend	**84%**	Mar-18 National Average	86.8%	87.9%	87.4%	80.4%	82.9%	**82.8%**	↓	
Friends and Family - Outpatients - Recommend	**94%**	Mar-18 National Average	**93.8%**	**93.8%**	94.6%	**93.0%**	94.1%	**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	NA	

Metric	Threshold/ Standard	Type of Standard	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Movement on Previous Period	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)	**56.1%**	**55.6%**	**55.8%**	**56.8%**	**58.4%**	**58.1%**	↓	
RTT Incomplete Pathway Waiting List size	**Trajectory Mar-22 = 17700**		**17802**	17024	16727	17128	17195	17678	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	Contractual (National Operational Standard)	**52.9%**	**63.8%**	**52.5%**	**71.0%**	**53.6%**	**50.7%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	Contractual (National Operational Standard)	**52.2%**	**61.8%**	**65.2%**	**88.7%**	94.1%	**81.5%**	↓	
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	Contractual (National Operational Standard)	96.9%	97.9%	97.1%	97.3%	97.6%	**95.8%**	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	Contractual (National Operational Standard)	100.0%	100.0%	100.0%	**83.3%**	**88.9%**	**66.7%**	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	Contractual (National Operational Standard)	**97.4%**	**96.3%**	**97.5%**	100.0%	**97.2%**	100.0%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	Contractual (National Operational Standard)	-	-	-	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	Contractual (National Operational Standard)	**80.8%**	**63.1%**	**58.3%**	**62.0%**	**81.9%**	**70.1%**	↓	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	Contractual (National Operational Standard)	**71.4%**	**77.8%**	**61.3%**	**71.4%**	**81.3%**	**57.1%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	Contractual (National Operational Standard)	**95.7%**	**91.2%**	**82.9%**	**89.5%**	**84.3%**	**77.3%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	Contractual (National Operational Standard)	**61.5%**	**60.3%**	**59.8%**	**54.4%**	**54.2%**	**54.4%**	↑	
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)	**74.0%**	**72.0%**	**69.6%**	**64.7%**	**65.6%**	**67.4%**	↑	
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
Sickness rate (one month in arrears)	**3.3%**	Internal Standard reported to FPC	4.79%	4.85%	4.79%	4.36%	6.10%	N/A	↓	
Appraisal rate	**90%**	Internal Standard reported to FPC	**71%**	**69%**	**67%**	**67%**	**66%**	**65%**	↓	
Staff Turnover Rate	**8 -12%**	Internal Standard reported to FPC	8.1%	8.7%	9.0%	9.7%	10.5%	11.4%	↓	
Total Substantive Workforce Capacity		Internal Standard reported to FPC	2,875.4	2,881.0	2,881.6	2,908.1	2,922.3	2,916.8	**N/A**	
Vacancy Rate (substantive)	**<5%**	Internal Standard reported to FPC	**5.3%**	**6.3%**	**6.8%**	**6.6%**	**6.3%**	**6.8%**	↓	
Total Substantive Workforce Pay Cost		Internal Standard reported to FPC	**11,601.2**	**11,692.1**	**11,497.0**	**12,246.0**	**18,886.6**	**12,382.5**	↑	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	Internal Standard reported to FPC	0	0	0	0	0	0	**N/A**	
Essential Skill Rate	**90%**	Internal Standard reported to FPC	**89%**	90%	91%	91%	91%	91%	↔	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**		**2,284**	**1,924**	**2,312**	**1,993**	**2,409**	**2,157**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**		**£2,417,850**	**£2,080,224**	**£2,214,088**	**£2,074,581**	**£2,414,961**	**£2,246,834**	↓	
Surplus/(deficit) (year to date)	**2022/23 = £(16,868) YTD M1 = £(1,515)**	Local Plan	**(721)**	**(578)**	**(340)**	(125)	**(402)**	**(1,678)**	**N/A**	**N/A**
Cash Balance	**2021/22 - M11 = 14,365**		17,291	17,369	16,807	27,061	25,951	23,665	↓	
CIP - year to date (aggressive cost reduction plans)	**2022/23 target - £(5,744) M1 target £(239)k**	Local Plan	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	Yet to be decided	**(49)**	**N/A**	**N/A**
Agency spend YTD	**2022/23 = £9,230 YTD M1 = £872**		**8,207**	**9,032**	**9,995**	**10,959**	**12,086**	853	**N/A**	**N/A**
Agency % of pay expenditure			**7.8%**	**7.7%**	**7.6%**	**7.6%**	**7.3%**	**6.2%**	↑	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	Mar-22	Apr-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**	2 (0.2)	3 (0.3)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**22**	**4 (0.4)**	**2 (0.2)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)	**51 (4 per month)**	1	0
	SHMI - Rolling 12 months (**Nov-20 to Oct-21**)	**<1.10**	**1.12**	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Feb-21 **to Jan-22**)	**100**	**98.7**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**58.4%**	**58.1%**
	RTT Incomplete Pathway Waiting List size	**Trajectory Mar-22 = 17700**	17,195	17,678
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**81.9%**	**70.1%**
	Maximum 6 week wait for diagnostic tests	**99%**	**84.3%**	**77.3%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**65.6%**	**67.4%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,414,961**	**2,246,834**
	Surplus/(deficit) (year to date)	**2022/23 = £(16,868) YTD M1 = £(1,515)**	**(402)**	**(1,678)**
	CIP - year to date (aggressive cost reduction plans)	**2022/23 target - £(5,744) M1 target £(239)k**	Yet to be decided	**(49)**
	Agency spend YTD	**2022/23 = £9,230 YTD M1 = £872**	**12,086**	853

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 19th April 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Continued delivery of important training and educational opportunities in difficult circumstances • Workforce risks and triangulation with other data sources and reports.
Key issues / other matters discussed by the Committee	The committee received, discussed and noted the following reports: • People Performance Report and Dashboard noting the particular challenges in month arising from staff shortages • Family and Surgical Services Division Report • Deferral of the Health Informatics Report • Education, Training and Development Report • Ward Accreditation and Learning from Excellence Update • Workforce Risk Report • Quarterly Bank and Agency Report • Escalation Reports from the following subgroups: ○ People Recovery Steering Group
Decisions made by the Committee	• The Safe Staffing Return was approved and will be presented to Finance and Performance Committee and Board in May
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Workforce Risk Report was received
Items / issues for referral to other Committees	• None

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 16th May 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• Committee Priorities and Work Plan • Guardian of Safe Working Hours Report

Key issues / other matters discussed by the Committee	The committee received, discussed, and noted the following reports:
	• People Performance Report and Dashboard noting
	  ○ An increase in the numbers of staff testing positive for COVID in March and an improvement in staff absence in April
	  ○ A reduced number of disciplinary cases following implementation of the 'Just Culture' arrangements increased number of appointments from ethnic minority groups
	  ○ Learning from Excellence Dashboard
	  ○ Increased turnover to 11.5%
	  ○ Maintenance of Essential Skills training compliance
	• Urgent and Integrated Care Divisional Escalation Report noting
	  ○ Two medical Consultant appointments
	  ○ Pan Dorset Pathology appointment and system working arrangements
	  ○ Occupational Therapy staff shortages
	• Estates and Facilities Escalation Report noting
	  ○ Recruitment to the Facilities team structure
	  ○ Reintroduction of Listening events
	  ○ Achievement of the Five Star Hygiene Award by the Catering Team
	• Library Service Annual Report
	• Guardian of Safe Working Hours Report noting the limiting environmental factors affecting the Junior Doctors Forum
	• Freedom to Speak Up Report noting the progress, thanking outgoing Guardian, and recognising a focus of the next Guardian will be supporting managers to create environments for psychological safety.
	• Escalation Reports from the following subgroups:
	  ○ Equality, Diversity and Inclusion Steering Group

Decisions made by the Committee	The committee approved the following items which are recommended to the Board: • Committee Priorities and Work Plan
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: 19th April 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Soft intelligence information received regarding staffing pressures and the impact on level of care able to be delivered • New revised trajectories for quality and safety performance reporting • New pathway for non-elective patients • Q3 Learning from Deaths Report approved for publication, and assurances provided, noting the challenges in discharging patients from intensive care to other wards • Publication of the second Ockenden report

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Continued focus on ensuring quality and safety standards are upheld across the organisation
	  ○ Challenges include C. Difficile, patients with no reason to reside, and mixed-sex accommodation
	  ○ Revised trajectories for quality and safety performance reporting
	  ○ New pathway for non-elective patients
	• Maternity Safety Report noting
	  ○ Publication of the second Ockenden report and actions arising from the report. Impact of the Ockenden report on maternity staff
	  ○ Operational challenges with supporting smoking cessation
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division
	  ○ Family and Surgical Services Division noting anaesthetics clinical service accreditation and ongoing work to reduce >104 week waiting lists
	• Learning from Deaths Q3 Report
	• Supporting Healthy Living / Treating Tobacco Dependency Update
	• Safeguarding Section 11 Quality Assurance Audit, with agreement from the Committee to submit to CCQ

Decisions made by the Committee	• Learning from Deaths report approved for publication, not including the appendices
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 • Continued operational pressures across the Trust
Items / issues for referral to other Committees	• Nil new to note

Escalation Report

Committee: Quality Committee

Date of Meeting: 17th May 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Pressure ulcer deep dive due in July will provide further assurance to the committee • Unresolved concerns regarding the blood science and blood bank audit • Maternity safety report and good progress on actions from the Ockenden report • Reenergising of the quality improvement strategy and training, indicating a return to business as usual

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Overall sustained quality and safety metrics, including a reduction in mixed-sex accommodation
	  ○ Challenges included pressure ulcers and a dip in Family and Friends test and patient experience in the Emergency Department
	• Maternity Safety Report noting
	  ○ Good progress against Ockenden 1 actions
	  ○ One case likely to require a HSIB investigation
	  ○ Appropriate action being taken regarding incidents involving Clexane
	  ○ Improvements in K2 training
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division noting unresolved concerns regarding the blood science and blood bank audit by MHRA
	  ○ Family and Surgical Services Division
	• Fall Quality Improvements Report
	• Transformation Update
	• Learning from Deaths Q4 Report
	• Quality Account
	• Clinical Audit Team Summary of Trust Register of Audits
	• Committee Priorities and Work Plan
	• Escalation Reports from
	  ○ Medicines Committee
	  ○ Clinical Practice Group

Decisions made by the Committee	• Learning from Deaths report approved for publication, not including the appendices • Quality Account • Clinical Audit Team Summary of Trust Register of Audits • Committee Priorities and Work Plan
Implications for the Corporate Risk Register or the	• Unresolved concerns following the blood science and blood bank audit

Board Assurance Framework (BAF)	
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: 19th April 2022

Presented by: Stephen Tilton (Chair)

Significant risks / issues for escalation to Board for action	• Cyber Security Update • Operational Plan • CCG Community Diagnostic Centre Business Case – Direction of travel supported by FPC and concerns re future staffing of units raised. • Atrium Business Case • Multi-storey Car park funding structure • Roche Managed Service Contract Extension – Microbiology • South Walks House Business Case / TIF Bid Update

Key issues / other matters discussed by the Committee	The Committee received, discussed and noted the following reports and updates:
	• Cyber Security Quarterly Update
	• Performance Report noting:
	  ○ National review of ambulance handover delays
	  ○ Achievement of waiting list trajectories
	  ○ No Reason to Reside Deep Dive and continued impact on patient flow
	  ○ The need for further work to improve ethnicity recording
	• Divisional Exception Reports noting the review of Divisional reports underway and the inclusion of divisional risk mitigations in future reports.
	• Operational Plan noting the financial challenges in the coming year
	• Finance Report noting
	  ○ Delivery of the year end break-even requirement and a small surplus
	  ○ Underlying Deficit position of the Trust and the System
	• Health Inequalities Update
	• Multi-storey Car Park Funding Structure
	• South Walks House Business Case / TIF Bid Update

Decisions made by the Committee	The following items were approved by the committee: • Operational Plan • Community Diagnostic Centre Proposal by Dorset CCG • Atrium Business Case • Roche Managed Service Contract Extension - Microbiology
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Trust and system underlying deficit position in the coming year. • Mutli-storey Car Park funding structure • South Walks House development pending outcome of the TIF bid

Items / issues for referral to other Committees	• None

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Finance and Performance Committee

Date of Meeting: 16th May 2022

Presented by: Stuart Parsons (Vice Chair)

Significant risks / issues for escalation to Board for action	• New Hospitals Programme Outline Business Case is recommended to the Board
	• Committee Priorities and Work Plans
	• Safe Staffing Return is recommended to the Board
	• Contract Awards:
	  ○ Blood Gas Analyser Contract
	  ○ Intraocular Contact Lens Contract
	  ○ Enteral Feeding PPSA

Key issues / other matters discussed by the Committee	The Committee received, discussed, and noted the following reports and updates:
	• Quality Impact Assessment process – Interventional Cardiology
	• Performance Report noting
	  ○ Marginal improvements in performance and quality metrics
	  ○ No Reason to Reside trajectory
	  ○ Delivery of the waiting list trajectory
	  ○ National and local staffing difficulties affecting Diagnostic services
	  ○ Continued pressure to deliver a break even plan
	  ○ Progress on the delivery of cancer waiting times and achievement of the 28 day standard
	• No Reason to Reside Deep Dive
	• Finance Report noting
	  ○ £160k variant to plan
	  ○ A reduction in Agency expenditure
	  ○ Loading of the Cost Improvement Programme
	• Division Escalation Reports noting
	  ○ Ambulance handover performance continued to benchmark well
	  ○ Escalation of Continuous Positive Airway Pressure (CPCP) service issues
	  ○ Recruitment and mutual aid arrangements to support pathology service provision
	• ED 15 Update
	• DCH Subco Escalation Report

Decisions made by the Committee	The following items were approved by the committee and recommended to the Board::
	• New Hospitals Programme Outline Business Case
	• Committee Priorities and Work Plans
	• Safe Staffing Return
	• Contract Awards:
	  ○ Blood Gas Analyser Contract
	  ○ Intraocular Contact Lens Contract
	  ○ Enteral Feeding PPSA

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

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Risk and Audit Committee

Date of Meeting: 24th May 2022

Presented by: Stuart Parsons

Significant risks / issues for escalation to Board for action	• Annual Report and Audited Accounts including:
	  ○ ISA 260 Report (VFM, Management Over-ride, Going Concern)
	  ○ Annual Audit Report (Annual Report and Accounts)
	  ○ Draft External Audit Opinion (Prior to Council of Governors)
	  ○ Draft Letter of Representation
	• Annual Declarations of Compliance with License Conditions
	• Losses and Special Payments Report
	• Committee Annual Work Programme
	• Board Assurance Framework

Key issues / other matters discussed by the Committee	The committee received and noted the following reports: • Internal Audit Progress Report noting good response and implementation of recommendation actions • Internal Audit Annual Report including the Head of Internal Audit Opinion providing **Moderate** assurance on the Trust's overall systems of internal control. • Corporate Risk Register • Senior Information Risk Owner (SIRO) Report noting challenges in completing Information Asset Audits • Sub Group Escalation Report – Information Governance Group

Decisions made by the Committee	The committee supported the approval of the following, recommending these to the Board for approval:
	• . External Audit Reports:
	  ○ ISA 260 Report (VFM, Management Over-ride, Going Concern)
	  ○ Annual Audit Report (Annual Report and Accounts)
	  ○ Draft External Audit Opinion (Prior to Council of Governors)
	  ○ Draft Letter of Representation
	• Annual Declaration of Compliance with License Conditions
	• Losses and Special Payments Report
	• Committee Annual Work Programme with insertion of the Annual Risk Summit.
	• Board Assurance Framework

Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• The Board Assurance Framework and Corporate Risk Register were considered by the committee
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: 29 April 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 Q4 review planned for 23.5.22
Key issues / matters discussed at the Committee	**Decision taken to defer this meeting to next committee meeting (29.6.22)** **For information:** • **DCH Charity Income** (M12 Mar 2022): The Charitable Funds closing balance as at 31st March 2022 was **£1,507,777.38.** Income 21/22 totalled **£579,326.08** • **DCHC Business Plan 22/23** including key fundraising activities and budgets **approved by** Board (Mar 22) • **DCHC Capital Appeal Plan (ICU/ED)** Draft Capital Appeal Plan **approved by** Board (30.3.22). • **DCH Charity Governance review:** - DCH Charity Funds re-structure proposal supported by Charitable Funds Committee; submitted to Risk & Audit Committee to note (22.3.22) and Board **approved** (30.3.22). - Final Governance review meeting (25.5.22)
Decisions made by the Committee	• Nil
Implications for the Corporate Risk Register or the Board Assurance	• Nil

Framework (BAF)	
Items / issues for referral to other Committees	Nil

Meeting Title:	Board of Directors
Date of Meeting:	25 May 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	16/05/2022	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: • At the end of February 2022, emergency attendances were significantly higher than levels at the end of February 2021. • Ambulance handover delays continue to set new records week on week. • Hospital bed occupancy remains consistently above 95% due to a high proportion of patients who do not meet the clinical criteria to reside. The planned trajectory of a 50% reduction by the end of March was not achieved. • Referral to treatment waiting list increased by 1,835 in February, however there was a reduction in patients waiting over 52 weeks by 111 patients. • Diagnostic performance waiting list increased by 1,504 in February. • Cancer performance continues to be challenged with the backlog of patients waiting over 62 days remains a challenge for both Trusts, however the latest National backlog position shows Dorset as being the second best performing Integrated Care System (ICS) nationally. Quality: • The number of COVID-19 outbreaks in March continued to run high among the providers within Dorset, in both acute and community hospital settings which had an impact on operational flow. • Outbreaks in care homes continue to run quite high with a slow decline beginning to develop. • Following publication of the final Ockenden report on 30 March 2022, the Local Maternity and Neonatal System (LMNS) is reviewing the 15 essential actions and will build on the progress already made. • The number of Never Events (NE) reported has reduced by almost half compared with the previous year, with 6 reported between April – March 2021/22 compared to 11 in 2020/21. • The draft Liberty Protection Safeguards (LPS) and Mental Capacity overarching Code of Conduct has been published which includes several implications for health. Finance: • At month 11 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. • The system planned to achieve £16.3M ERF income in the second half of the year. This level of income is now not expected to be earnt, and expectations have reduced to an income of £4.1M. • NHS system Capital Departmental Expenditure Limit (CDEL) envelope will be overspent this financial year, leading to a brokered reduction in the 2022/23 envelope of £3M in order to manage the 2021/22 position.
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	25 May 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 21 April 2022.

2.0 Performance

At the end of February 2022, emergency attendances were significantly higher than levels at the end of February 2021. However, this is following a similar trajectory to 2020. 999 activity is gradually reducing and is in line with 2020/21 levels, and 111 call answering performance has decreased to 48.2% in February 2022 from 64.24% in January 2022. However, activity in Dorset has increased by 29% compared to the same period in 2019. South West Ambulance Service Foundation Trust (SWASFT) have been at their highest alert level (REAP Black) since mid-June 2021.

Ambulance handover delays continue to set new records week on week. Whilst both acute hospitals in Dorset have delays, there remains a significant East/West difference in approach and performance to ambulances arriving at Emergency front doors. Following Clinical Commissioning Group (CCG) site visits, sharing of learning across providers to reduce delays has taken place however the situation is not improving at University Hospitals Dorset (UHD). Further discussions are taking place with UHD in relation to this continued poor performance.

Hospital bed occupancy remains consistently above 95% due to a high proportion of patients who do not meet the clinical criteria to reside. The planned trajectory of a 50% reduction by the end of March was not achieved given rising COVID-19 infection rates and workforce issues across all of health and social care.

The referral to treatment waiting list increased by 1,835 in February. Increases were experienced across most specialties except for Trauma & Orthopaedics. The decrease was in the non-admitted pathway at Dorset County Hospital, and it is believed this was the effect of the South Walks Care Village. The system saw a reduction in patients waiting over 52 weeks in February by 111 patients. Urgent work is underway to deliver pathways for those inconvenienced and other long waiters.

In diagnostic performance the waiting list increased by 1,504 in February. There was an overall improvement of 5.6% for those waiting over 6 weeks list (from 17.9% in January to 12.3% in February) as patients waiting less than 6 weeks rose by 2,165,

Cancer performance continues to be challenged for University Hospitals Dorset, receiving an increase in referral numbers by 25% in January 2022 compared to January 2021. The size of their patient tracking list (PTL) in February continues to be above 3,100 and ranks 20th when compared nationally. Dorset County Hospital's referral rate has steadied with less spikes but the rate is higher than the recovery trajectory. In December their PTL reduced to 1,100, which continued to decline in January with it reaching 1,000.

The backlog of patients waiting over 62 days remains a challenge for both Trusts, however the latest National backlog position shows Dorset as being the second best performing Integrated Care System (ICS) nationally.

There continues to be Workforce challenges within community mental health teams linked to increased demand and recent surges in COVID-19 infection rates. Perinatal mental health access has sustained improvement in recent months but remains below locally agreed target. Access time for Children & Young People with eating disorders remains challenging as a result of increased demand and lack of readily available skilled workforce. A review of the current operational model and demand and capacity is being finalised to inform future service development.

3.0 Quality

The number of COVID-19 outbreaks in March continued to run high among the providers within Dorset, in both acute and community hospital settings. Both acute and community Trusts experienced several outbreaks, where staffing absences had the most impact and were identified as the main risk factor which had an impact on operational flow.

Outbreaks in care homes continue to run quite high with a slow decline beginning to develop. Supportive Infection Prevention Control (IPC) visits and Incident Management Teams continue when required, still with no identifiable themes at present.

Following publication of the final Ockenden report on 30 March 2022, the Local Maternity and Neonatal System (LMNS) is reviewing the 15 essential actions and will build on the progress already made. NHS England are planning a series of insight visits to maternity units across the South West to provide assurance against the 7 immediate and essential actions from the initial Ockenden report using an appreciative enquiry and learning approach. The LMNS and Trusts are also providing assurance to NHS England on the recommendations from the Kirkup review (2017) and mapping these against the Ockenden actions.

The number of Never Events (NE) reported has reduced by almost half compared with the previous year, with 6 reported between April – March 2021/22 compared to 11 in 2020/21. This improvement has been achieved by Dorset patient safety teams through sharing 72 hour reports to ensure early learning, at NE panels and through the local and regional shared learning groups.

In Infection Control, the CCG Infection Prevention Control (IPC) team performed a supportive IPC quality assurance visit to an acute trust in Dorset. The visit highlighted evidence of good IPC practice, particularly around hand hygiene and appropriate use of personal protective equipment amongst the staff. It also identified many environmental refurbishments that had been undertaken as part of the full renovation of the setting, allowing an effective cleaning process. Although significant progress was noted, further estate aspects remain on the action plan to complete, and therefore a further IPC visit will take place in 6 months' time. This will allow re-evaluation of the outstanding actions from the previous visit and to provide further support and advice if necessary.

In safeguarding, the initial health assessments on all unaccompanied asylum-seeking young people who are challenging their age will commenced in March and will be delivered by a bespoke service and will be completed in three months. This includes children from both Bournemouth, Christchurch and Poole (BCP) and Dorset Local Authority areas.

The draft Liberty Protection Safeguards (LPS) and Mental Capacity overarching Code of Conduct has been published which includes several implications for health, including robust training of the whole workforce, minimum data set to be collated and coded within current IT systems, and the appointment of Approved Mental Capacity Practitioner 's to undertake review of complex cases. The LPS will apply to all young people aged 16-17 years as well as adults.

4.0 Finance

At month 11 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. This level of income is now not expected to be earnt, and expectations have reduced to an income of £4.1M. 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 system is not currently forecasting full achievement of the £29.8M savings required in the second half of the year, with a balance of £3.1M yet to identify that currently requires mitigation via non-recurrent flexibilities.

NHS system Capital Departmental Expenditure Limit (CDEL) envelope will be overspent this financial year, leading to a brokered reduction in the 2022/23 envelope of £3M in order to manage the 2021/22 position.

Although the system has achieved a breakeven plan for 2021/22 there remains a significant underlying deficit. After adjusting for non-recurrent income and expenditure, returning to pre-COVID allocations, and reflecting the actual run rates in organisations the current position is that NHS organisations have a total deficit of circa £80M in the underlying position. This value is expected to be further refined in line with the 2022/23 planning round and recovery work.

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	24 May 2022
Document Title:	**Strategy Update**
Responsible Director:	Nick Johnson – CEO
Author:	Philip Davis – Head of Strategy

Confidentiality:	*No*
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Board	Dec 2021	Trust Strategy Approved by Board and published, (Developed following series of Trust wide engagement events)
Board	Mar 2022	Board approval of People, Clinical & Digital Plans underpinning Trust Strategy

Purpose of the Paper	Biannual update to Board Directors on progress in delivering the Trust Strategy, and the achieving the ambition and benefits therein.							
	Note	✓	Discuss	✓	Recommend		Approve	
Summary of Key Issues	Delivery of the Trust Strategy is a multi-year project involving Organisation wide change, to meet the demands of our population and to align with the ICS Strategy. Critical to delivery will be balancing day to day BAU demands and achieving the Operational Guidance for 22/23, with longer term strategic change. Ring fencing Resource to drive the Projects underlying the Strategy is complicated in the current operating environment. The Trust has laid down its People, Clinical and Digital Plans and the New Hospital Programme (with Sustainability & Efficiency Programme is in development) These Plans guide Teams on the Strategic Objectives and Priorities, and the benefits measures where they are targeting improvement. New Analytics in the areas of Productivity and Peer Benchmarking, and providing insights into where to focus our efficiency efforts. Work is ongoing to Prioritize Strategic projects, and in developing a Strategy Dashboard that bring together monitoring & progress of Strategy delivery Trust wide. Board Assurance Framework (BAF) is reviewed 2 monthly at Risk Assurance Committee, and outlines the risks to Trust Strategy delivery and the proposed mitigations.							
Action recommended	The Board is recommended to: 1. **NOTE** the progress made since the Trust Strategy was published in Dec-22 2. **DISCUSS** how delivery of the Trust Strategy can be further supported, and the adequacy of Governance/Monitoring in place today and planned							

Governance and Compliance Obligations

Legal / Regulatory	Y/N	N
Financial	Y/N	N
Impacts Strategic Objectives?	Y/N	Y
Risk?	Y/N	Y
Decision to be made?	Y/N	Y - Delivery of Trust Strategy is critical to securing a sustainable future for the Trust, and partnering with ICS
Impacts CQC Standards?	Y/N	Y – Trust Strategy is closely focused on improving Patient Outcomes & Patient Experience, as well as staff wellbeing
Impacts Social Value ambitions?	Y/N	Y - Social Value Action plan sits within Sustainability & Efficiency Workstream, underlying the Trust Strategy.
Equality Impact Assessment?	Y/N	N
Quality Impact Assessment?	Y/N	N

1.0 Executive Summary

1.1 2022 has seen the five workstreams underpinning the Trust Strategy be further developed – the People, Clinical and Digital Plans were approved at Mar-22 Board, and work is underway to further develop the New Hospital Programme and Sustainability & Efficiency Programmes

1.2 These Workstream Plans and Programmes outline the Strategic Objectives and Priorities, as well as the target benefits and KPIs, and act as a framework for teams to develop and plan the projects that will drive delivery of the Trust Strategy on the ground. They will be reviewed at least annually.

1.3 Delivery of the Trust Strategy (and the benefits described in Workstreams) will be monitored via the Strategy Dashboard, which will have monthly Highlight reports produced covering progress, next steps & milestone, risks, teams and KPI improvement. This is currently in development.

1.4 At the time of writing the Trust Leadership is working to agree the Strategic Priorities to focus on first, around which resource will be ring fenced. This recognizes that the trust has a finite Resource and must also meet our BAU demands and delivering the Operational Guidance for 22/23.

1.5 At the time of writing high profile projects are underway in the following priority areas: High Cost Agency (Sustainable Workforce), Theatres Efficiency, Outpatient Transformation and South Walks House (EL Recovery), FIP/CIP Improvement Plans (Efficiency), ED-15 (New Hospital Plan)

1.6 Detailed Analytics have been developed to better understand Productivity trends within the Trust and at Speciality and Service line level, as well as Hospital Benchmarks. These are better informing our Sustainability and Efficiency Programme.

2.0 Introduction

2.1 The Trust Strategy was developed in 2021 through a series of engagement events with staff, and was approved and published in Dec-21.

2.2 Governance of the Trust Strategy and its delivery is through a 6 monthly update to board (this meeting and paper), as well as through the Board Assurance Framework (BAF) which has been through its third iteration of 2 monthly review by Risk and Audit Committee.

3.0 Narrative

3.1 Delivery of the Trust Strategy is critical to the long term sustainability of DCH, in meeting the changing demands of its population and aligning with the emerging Dorset ICS Strategy

3.2 In common with the National picture, DCH is presented with major challenges as it emerges from the Covid Pandemic, many of which now stand at unprecedented levels.

3.3 These challenges include workforce sustainability (the reliance on high cost Agency staff and Staff sickness and turnover rates), Patient flow (numbers of No Reason to Reside Patients), Elective Recovery (Theatres Efficiency and Wait list reduction) and Financial Sustainability (CIP and wider Financial Improvement plans)

4.0 Conclusion

4.1 Delivering on the longer term Strategic change described Trust, whilst never compromising on our patient's safety, is now critical to us addressing these challenges, as well as in meeting our Operational Planning Guidance for 22/23.

4.2 Support of the Board is requested in helping drive successful delivery of the Trust Strategy and in actively monitoring the effectiveness of Governance

5.0 Recommendation

5.1 Trust Strategy should be brought back to Board for Review in Dec-22, with Strategy Dashboard having been in place and monitored in the preceding months

5.2 Dec-22 update should report on progress in delivery of benefits/KPIs, quantifying the impact made by discrete Strategy Projects.

Name and Title of Author: Philip Davis
Date:18.05.2022

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

DCH Trust Strategy

6 monthly update to Board

24 May 2022

Outstanding care for people in ways which matter to them

Trust Strategy – 6 Monthly Update to Board

Strategy Workstreams

BAF

Productivity

Delivery / Monitoring

Strategy Workstreams

Status of 5 Workstreams underpinning the Trust Strategy:

- People Plan — Finalised, Approved March Board
- Clinical Plan — Finalised, Approved March Board
- Digital Plan — Finalised, Approved March Board
- Sustainability & Efficiency — Drafting
- NHP — Approved 2021

The Strategic plans outline:

- Strategic Objectives & Priorities for action
- Target Benefits and KPIs for monitoring

Teams can use Strategic Plans to Develop business cases/proposals

- DCH staff: develop more detailed plans and solutions that drive the Trust's Strategy
- System Partners: work more closely with DCH, & how we propose to align with ambitions of ICS
- Population: Awareness of DCH plans to improve patient outcomes/Experience and efficiency

Board Assurance Framework (BAF)

Monitors risks to delivery to Trust Strategy, and the benefits within it:

- Good engagement from EMT, SLG and RAC
- In its 3rd iteration, 2 monthly review
- Governance noted as effective by the Internal Audit (BDO)
- 36 risks noted, 5 scored 20+, mapped to Trust Strategy objectives, with SROs appointed
- Mitigations next to each risk, with target date to be in place

Productivity

Detailed internal analysis of DCH Productivity, and benchmarking vs peers undertaken

Insights drawn from this are informing the CIP/FIP plans, and Sustainability & Efficiency Plan

Strategic Services Review ongoing

Delivery / Monitoring

Trust wide Strategic Priorities pulled together for EMT - pending approval
- TIO/wider trust resource to be ring fenced around these

Major Projects in Strategic Priority areas already underway
- Sustainable Workforce: High Cost Agency reduction
- EL Recovery: Theatres Efficiency & OP Transformation, South Walks House
- Sustainability & Efficiency: FIP/CIP Financial Improvement plans
- NHP: ED15 project

Monitoring of Trust Strategy delivery
- Strategy Dashboard in advanced development
- Monthly Highlight Reports by Workstream/Project
- Status, Timeline, Recent Progress, Next Steps, Risks

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25 May 2022
Document Title:	**BAF Review**
Responsible Director:	Nick Johnson – CEO
Author:	Philip Davis – Head of Strategy

Confidentiality:	*Yes: Whilst Trust Strategy is a public document – the delivery details underneath would not be considered public domain.*
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
EMT	28 Apr 2022	BAF discussed – recommendations: - new risk PA4.2 be taken to SVPG - check target dates (for mitigations only) - PL1.11 be removed as an Op issue - PA3.3 be re-considered for relevance
RAC	22 Mar 2022	BAF discussed – recommendation - target date for mitigations of risks be added

Purpose of the Paper	*Monitor risks to delivery of the Trust Strategy (and benefits within) - Approved by Board Dec-21. The BAF is in its 3rd round of 2 monthly review.*						
	Note	✓	*Discuss*	✓	*Recommend*		*Approve*	
Summary of Key Issues	*There are 5 risks scored >20: PL1.1, PL1.5, PA2.1, PL1.3, PE 1.2 – an additional risk PL2.2 has been down scored to 16 following mitigations.* *An additional risk PA4.2 relating to Social Value Governance has been proposed (and sits alongside PA4.1) – RAC to approve this being formally added* *Consider whether PA3.3 continues to be relevant to Strategy (Centres of Excellence) &/or whether scoring appropriate ?* *Consider whether PL1.11 should be removed as relating to an operational issue (Coding Accuracy) and not a strategic issue ?*						
Action recommended	The Board is recommended to: 1. **NOTE** the addition of Target Dates, and consider adequacy of mitigations proposed next to risks (particularly those 5 scoring >20.) 2. **APPROVE** the addition of risk PA4.2, removal of risk PL1.11, rescoring of PA3.3						

Governance and Compliance Obligations

Legal / Regulatory	Y/N	*N*
Financial	Y/N	*N*
Impacts Strategic Objectives?	Y/N	*Y*

Risk?	Y/N	*Y*
Decision to be made?	Y/N	*Y - Delivery of Trust Strategy is critical to securing a sustainable future for the Trust*
Impacts CQC Standards?	Y/N	*Y - Clinical Plan is closely focused on improving Patient Outcomes & Patient Experience, and People Plan strongly focused on staff wellbeing*
Impacts Social Value ambitions?	Y/N	*Y - Social Value Action plan sits within Sustainability & Efficiency Workstream, underlying the Trust Strategy.*
Equality Impact Assessment?	Y/N	*N*
Quality Impact Assessment?	Y/N	*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,	25
4	Major	4	PA1.1, PA3.1, PA3.2	12 PE2.1, PE3.3, PA2.2	16 PE1.1, PL1.2, PL1.10, PA3.3, PL1.11, 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	9 PA1.2, PA4.1, PL2.3	12 PA3.3, PL1.6, PL3.2, PL 3.3, PL4.1, PL4.2, PA1.4	15 PE3.2
2	Minor	2 PL1.9	4	6	8	10
1	Negligible	1	2	3 PL3.1	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	Target Date	# 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	Apr-24	
								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	Apr-24	
								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	Apr-23	
								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	Apr-23	
								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	Apr-24	
								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	Oct-22	
								Gaps in Control and Actions:						

BAF

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	Target Date	# 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	QC - (triagulation with PCC)	CNO	CPO - Recruitment and retention and People Strategy	**Risk description:** If there is a continous 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 NHSEI 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 • Increase in covid pandemic wave impacting on staffing resource, epidemiology shows a wave with a slight plateau at present. Ongoing waves likely for forseeable year	• Sub board reports: PCC; QC & RAC • Recruitment activity reports • Patient feedback • Staff feedback • Incident data • External assurance monitoring: CQC; CCG; auditors inc GIRFT;Networks • Corporate risk register actions and tolerated/managed risk	Good	Strong	8	2024	
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 pathways design and system working for sustained capacity • Estates strategy • Workforce planning including job planning • Quality Improvement to redesign pathways to more efficient or productive with funded capacity • Access policies and processes to ensure effective waiting list management in order of clinical need with consideration for health inequalities • Recovery plan and oversight of the delivery through sub-board committee • ICS partnership working through provider collaboratives • ICS governance framework • Clinical networks to support pathway design and resources based on population need **Gaps in Control and Actions:** • Gaps in patient pathways out of hospital for those with complex care needs. ACTION: ICS escalation and collboration 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	8	2025	
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	• April 22 - Planning Guidance submissions agreed. Guidance acknowledges this is a multi-year improvement plan. Key steps are outlined in the plan for this coming year. DCH has agreed trajectories for achievement which will be tracked through EPMG and reported up through both Divisional governance and EPMG to FPC/Quality ctees. • Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement **Gaps in Control and Actions:** National Elective Recovery Plan sets out a 3 year plan towards achievement of NHS Constitutional Standards. Trajectories agreed for achievement of in year milestones and will be reported via FPC both in the Performance/EPMG report and the	• 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	monthly targets to be reviewed at FPC	
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 **Gaps in Control and Actions:**	• 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	is at target	
PL 1.5	FPC - performance QC - 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:** Twice weekly operational meetings in place for the system to map out and agree the interim steps (between end of HDP funding and the full implementaton of the integrated CH pathways). Updates to FPC (April/May and June) while the steps are finalised and then tracking via the Performance report is in place. Interal flow cell in place and a refresh of the Patient Flow Program underway - mapped to the interim arrangements. Focus on Pathay 0 patients and front door (ED/Bichester) multi-agency response to prevent admission - April: Actions agreed and	• 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	Dec-23	
PL 1.6	FPC - performance QC - 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 pathwyas, 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. • VSCE 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, **Please see action detailed above.**	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	Apr-24	
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) **Gaps in Control and Actions:**	• Reports to SLG and through to Board via Strategy updates	Good	Good	2	Mar-23	
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	Ongoing	
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 KPIs such as the Summary Hospital-level Mortality Index.	4	4	16	The coding department is attempting to recruit a new full-time manager (2 x FTC now under consideration) 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:**	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	8	?	
Place Objective 2: We will build sustainable infrastructure 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 NHSEI/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	Completion of FBC - circa 31/12/2022	
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	4	16	• 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 OCH 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	Ongoing	
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	Achieved - currently at Target Risk	
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	Ongoing task, no fixed delivery date	
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 . 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	Ongoing task, no fixed date	
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 Male - Patient Engagement Jo Hartley, Maternity voices 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 then.	3	4	12	• Your Voice group of service users • Maternity Voices Partners as part of the Local Maternity & Neonatal System • Communication and Engagement lead for estate development to support further engagement with local population • Learning Disability Advisor linked activity with independent groups of service users • Engagement roadmap with leadership from Head of patient Experience and Engagement • Networked links with external engagement partnerships such as Healthwatch Dorset, CCG/ICS team, Dorset Council • Council of Governors links into community coordinated by the Corporate Trust Secretary • Quality Improvement methodology includes service user engagement • Public Health networks into key work streams for population health and wellbeing (such as smoking cessation) • Health Inequalities group and networked activity across ICS to support engagement with diverse population • Communication teamwork across the ICS - ICS strategy work to commence with engagement of population May to June 2022 **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 related to engagement • Local independent groups reports or complaints • Dis Data and Public Health reports • Health Inequalities data	Good	Good	4	Apr-24	
PL 4.2	QC	CNO & CMO	CIO - digital and BI Alison Male - Patient feedback CMO - AHSN CEO/Director or 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 • Partnership in ICS with Public health and Local authority at PLACE level • Primary care Networks • Digital data sources with shared records • Business intelligence resources across the system • ICS Health inequalities group • ICS integrated working on pathways • Clinical networks membership with data sharing • Academic Healthcare science networks • ICS governance **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	Apr-24	

BAF

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	Target Date	# Partnership risks: 12
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 The resolution requires more staff/more experience , this is pending outcome of planning round, and subsequent recruitment &/or training following	• Health Inequalities Programme • Digital Portfolio Board	Requires Improvement	Requires Improvement	6	Mar-23	
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	Jul-22	
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	Sep-22	
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	31/03/2023	
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:** CIP programme for 22/23 not fully identied	• Model hospital, GIRFT reviews, Reference costs index, Corporate services benchmarking.	Good	Good	9	31/03/2023	
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 COO involved in discussions surrounding the development of Provider Collaboratives with System partners - nothing concrete to describe as at April 2022	• 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	Dec-22	
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	3	4	12	• 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		
PA 4.2	FPC	CEO	AD S&T	**Risk description:** Governance behind delivering against Social Value Action Plan is not sufficiently clear or robust, and will not drive delivery of Social Value commitments made in Trust Strategy, and wider culture change **around Social Value.**	3	4	12	pending approval by SVPG/EMT **Gaps in Control and Actions:**		Poor	Poor	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:	25 May 2022
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,

Purpose of the Paper	The Corporate Risk Register assists in the assessment and management of the high level operational risks, escalated from the Divisions and any risks from the annual plan. The corporate risk register provides the Board with assurance that corporate risks are effectively being managed and that controls are in place to monitor these. 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 • Agree escalation of risk reference 1251 to the Corporate Risk Register • Agree closure of risk reference 449 – Financial Sustainability 21/22 • Agree closure of risk reference 979 - Removal/reduction of education funding from HEE commencing April 21. • Note addition of risk reference 1252 – Financial Sustainability 22/23 • 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	

Risk and Audit Committee
Corporate Risk Register as at 09.05.2022

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 09.05.2022 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' (Appendix 4).

2. Recommendations to move risk to 'managed/closed' status.

2.1 **Financial sustainability Financial Year 21/22(449)**
Risk level remains at Moderate. Details are contained in Appendix 2.

2.1.1 We have delivered a breakeven position as at the end of the financial year 21/22 but are facing an entirely different scenario for 2022/23. This will be added to the Corporate Risk Register as a new financial risk for 2022/23.

2.1.2 The Committee is requested to agree closure of Risk Reference 499.

2.2 **Removal/reduction of education funding from HEE commencing April 21. (High (16))**

2.2.1 Following a review of education finances by the government and Health Education England (HEE) National team, funding streams for Continuous Professional Development (CPD) and upskilling education changed from April 21.

2.2.2 The risk was that this would have a financial impact on the organisation as we would no longer receive direct funding for training other than the National CPD funding for Nurses, Midwifes and Allied Health Professionals (AHPs), resulting in no allocated funding for other staff groups to support upskilling and CPD (Healthcare Scientists, Pharmacy and Non clinical staff).

2.2.3 The Dorset ICS now receive funding directly from HEE for which we submit our Training Needs Assessment (TNA) requests to them to receive the funding for the staff groups who sit outside of CPD funding. The process is now aligned and agreed across all the Dorset trusts and the CCG.

2.2.4 The Committee is requested to agree closure of Risk Reference 979.

3. New items to be added to the Corporate Risk Register

3.1 1252 Financial Sustainability 2022/23 (Extreme 20)

3.1.1 The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective. There are a number of workstreams in progress across the Dorset system which should improve the position but it is unlikely that the DCH share of these will ensure that the Trust gets back to financial balance by the end of the 2022/23 fiscal year.

3.1.2 The Committee is requested to agree the addition of Risk Reference 1252 to the Corporate Risk Register.

4. Top Themes:

4.1 **Covid 19**

- 919 – Covid 19 (Extreme 20 (down from 25))

4.1.1 As at 04 May 2022, we are still the second highest region for infection rates, with significant numbers of Covid patients in hospital and we have a higher proportion than the national figure, where people are in hospital in order to treat covid (as opposed to incidental). As such the risk itself still remains Extreme due to the impact on service capacity, ward admissions (during April 2022, 8 bays were closed due to Covid positive and contact patients) and staff absence.

4.1.2 Clearly the number of positive cases remain variable throughout the hospital as does staff absence.

4.1.3 In order to mitigate the risk to the staff, the Trust continues to provide 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 (now in post) and staff from the Divisions.

4.2 1221 - Tackling the backlog of elective care (Extreme (20))

4.2.1 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.

4.2.2 The access team are continuing to keep contact with patients on the waiting list. Patients are being called in clinical priority with consultants having oversight of the lists. The Board will receive performance reports in terms of progress against trajectories.

4.2.3 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.

4.2.4 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.

4.3 Mortality

- 641 – Clinical coding (High 15) (update as at 20.04.2022)
- 464 – Mortality Indicator (Moderate 12) (update as at11.05.2022)

4.3.1 Both of these items are discussed and reviewed regularly at the Hospital Mortality Group (HMG) chaired by the Chief Medical Officer.

4.3.2 The Coding Department's current focus is to ensure 21/22 coding is up to date by the end of the second week of May to avoid carrying incomplete months for the year. The Coding Lead is fairly optimistic this deadline will be met.

4.3.3 However, meeting this deadline means that coding of the data from April 22, which needs to be complete by the first week in June to meet the PDR payment deadline, has been rolled forward as part of the elective recovery.

4.3.4 Discussion at the HMG noted that there are two parts to the Clinical coding risk going forward.

- Firstly, the high value, high risk area which includes complex medical patients that were not getting depth of coding and therefore not expected to die but should have been.
- Secondly, the forward work of how to off load some of the coding work to be undertaking remote and external working, which was the low risk but high volume work of elective recovery.

4.3.5 The department had done all they can to increase capacity for people working remotely, but they are limited to what they can do due to low number of scanned records. Difficult

cases still have to be done by the notes and even some elective work does require notes to be reviewed.

4.3.6 In order to have mortality stats that are an accurate reflection of our activity, in an ideal world we code everything to the best of our ability. We have compromised but not to the extent of not worrying about co-morbidities with low impact.

4.3.7 The compromises we have made have given us the lowest risk and the Coding Lead is cautiously optimistic we will meet the deadline and will then need to work on elective recovery work.

3.4 Staffing

Staffing remains challenging due to the impact of Covid although it is now improving. 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:

4.1 **461- High volume of patients with no reason to reside (Extreme (20))**

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 11 May 2022, the figure stands at 74 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 4 week covid funding stream discontinued 25 April 2022. Mitigations and actions have been reviewed and updated and are detailed below: -

- LA to return social workers to site to support care act assessments.
- First point providing alternative discharge support pathways with volunteer sector.
- Complex discharge huddles to allocate funding streams.
- Discharge summits aimed at reducing care packages.
- Social admission avoidance pathways being explored.
- Flow cell review of P0 and criteria led discharge.
- Pathway for step-down patients from ED to COHOs in place.
- Escalated complex huddles to allocate section 256 funds to fund out of hospital if responsible commissioner cannot be agreed.
- Rapid home to die pathway expanded for placements as well as home.
- CCG attending MDTs to facilitate quick decision making for 'barn door' CHC complex health funding.

4.2 474 - Review of Co-Tag system and management of issuing/retrieving tags to staff (High(16))

4.2.1 It was reported to the previous Committee that the actions to have this work completed by the end of March 2022 was on track. This date has since had to be revised to the end of August 2022.

4.2.2 Unsuccessful Tenders were sent notice of the Trust intention to award the contract to Open view Ltd Dec 2021, shortly following this one of the unsuccessful bidders lodge a complaint which followed due process causing the award to successful bidder to be delayed. The was successfully then awarded in February 2022.

4.2.3 Installation works have commenced on site, original revised programme planned for completion in July 2022, currently waiting on updated programme from installer due to delays in award and digital hardware lead in, following the dilapidation survey they have carried out as part of the enabling works.

4.2.4 We intend to start to roll out the replacement local door controller door by door / area by area on a rolling programme once the head end has been set up. Currently we are waiting on the digital service server hardware to arrive which is expected imminently. Door controllers are currently being programmed in advance for network ID`s and security VLAN has now been provided by Digital networks team.

5 Emerging Risks from Divisions.

5.1 Urgent and Integrated Care

5.1.1 <u>1251 – Critical Failings in hospital blood bank (Extreme 20)</u>

The Trust underwent an MHRA visit in January 2022, where a number of issues were identified that required some corrective action. Failure to take corrective action could result in the service receiving a 'Cease Service' order. This would have severe consequences for services across the Trust.

5.1.2 The main areas for concerns are:

- Demand for service outstripping capacity and staffing shortfalls leading to the Quality Management System not being maintained. This would result in tests not being reported in a timely manner.
- Delays in blood test results reporting leading to delays in resulting in delays in ED.
- Staff competencies in using the equipment not maintained.
- Risk of losing the UCAS accreditation
- Vacancy for Blood bank Lead

5.1.3 Mitigations currently in place:

- Action plan in place which is being reviewed currently
- Recruitment plan to address vacancies in place
- Training plan for staff in place
- Training resources in place for the training in systems
- Weekly reviews being undertaken
- Digital plan in place around resolution.
- Concerns have been raised at One Dorset Pathology Board w/c 09/05/2022

5.2 **Family Services and Surgical Division**

5.2.1 There are no new emerging risks from the Division which the Committee are not already sited on or that are already detailed on the Corporate Risk Register.

6. 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.

7. Recommendation

The Board is recommended to:

- review the current Corporate Risk Register; and
- note the Extreme and High-risk areas and actions
- Agree the closure of Risk 449 Financial Sustainability 21/22
- Agree escalation from Divisional to the Corporate Risk Register for 1251 - Critical failings in hospital blood bank
- Note new 1252- Financial sustainability Risk added for financial year 22/23
- Note revised completion date for risk reference 474 in relation to the replacement of the Co-Tag system.
- 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 11.05.2022
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register detail (Appendix 2)
- Details of emerging themes from Divisions (Appendix 3)
- Risk Register items recommended for movement to ‘managed’ (Appendix 4).

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	20 (919)	25
	4 Major	4	8	12 (450, 690)	16 (474)	20 (472, 840,1221, 1252↑)
	3 Moderate	3	6 (979↓)	9	12 (464)	15 (641)
	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.**			
	New	1252 (Extreme – next review date 06.06.22) Financial Sustainability year 2022/23				
	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.

Ref: **NEW**	Risk Statement Added to Risk Register 01/04/2022	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:05.05.2022
1252	**Financial Sustainability year 2022/23**	Previous Rating	New Risk
Impact on Strategic Objectives		Lead Executive	Paul Goddard
Strategic Objective: People **Strategic Objective: Place** **Strategic Objective: Partnership** The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective.		Local Manager	Claire Abraham
Current position As at 05.05.2022(data correct as at 05.05.2022)		TARGET RATING Target date:	Low (6) Consequence: Moderate Likelihood: Unlikely 31.03.2023
Mitigation: Exploring additional options to mitigate risks against plan not delivering, which will link back to the Trust risk appetite and Board decisions when escalated through FPC **Update:** There are a number of workstreams in progress across the Dorset system which should improve the position but it is unlikely that the DCH share of these will ensure that the Trust gets back to financial balance by the end of the 2022/23 fiscal year. Ongoing working across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	30.06.2022

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: 04.05.2022
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	Mark Taylor from 27.05.2022
Current position As at 10.05.22 (data correct as at 04.05.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible **Undetermined**
Mitigation: • Regular virtual IMT meeting between once and five times a week in response to each covid wave, • significant investment in remote working tech to enable staff to be able to continue to work in some form while isolating where necessary **Update:** • Currently we are still the second highest region for infection rates, significant numbers in hospital and a higher proportion than the national figure where people are in hospital in order to treat covid (as opposed to incidental).		Next review date **All actions identified to date have been completed**	30.06.2022

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 As at 09.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target date	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 30.06.2022
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 **Update:** Dorset CCG has undertaken a further review of ASD, Autism needs in the population and as such working with all providers and local authorities on the next steps		Next review date **ACTION RE APPOINTMENT COMPLETED** **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	30.06.2022

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: 22.03.2022
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 As at 22.03.2022 (data correct as at 10.05.2022)		TARGET RATING Target Date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 01.12.2022
Mitigation: • Band 7 bank dietician covering part time PDSN tasks (within scope of practice) • 2 PA's Consultant time currently covered by Speciality Doctor SZ, no long term plan to cover the role. • 3ELLS Clinical Psychologist has agreed to cover 4 hours week as an interim measure until Paediatric Diabetes Clinical Psychologist post is recruited to. To start April 2022. **Update:** • Band 7 Paediatric Diabetes CNS post advertised, x2 candidates shortlisted. Awaiting interview (date to be confirmed.		Next review date **TARGET DATE EXTENDED DUE TO RECRUITMENT PROCESS.**	22.04.2022 (OVERDUE FOR REVIEW _ CHASED WITH SERVICE)

• Paediatric Diabetes Clinical Psychologist post out to advert following rebanding to 8b. Closing date 23.3.22 – awaiting outcome of shortlisting and interviews. • PEER review action plan - subject to regular review overseen by Chief Operating Officer Anita Thomas. • Majority of action plan relates to staffing of service.		

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: 10.05.2022
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 As at 10.05.2022 (data correct as at 10.05.2022)		POST MITIGATION RATING (TARGET) Target date	Very Low (8) Consequence: Minor Likelihood: Likely 31.03.2025
Mitigation: • Escalation process in place if clinical priority needs reviewing • Validation of waiting lists to ensure capacity utilised for those remaining on the list • Harm review process in place to monitor and mitigate where possible **Update:** • 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.		Next review date	30.06.2022

• A significant part of this will be invested in staff – both in terms of capacity and skills.		

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 As at 13.05.2021 (data correct as at 13.05.2022)		TARGET RATING Target date	Very Low (2) Consequence: Negligible Likelihood: Unlikely 31.08.2022
Mitigation: • Estates managing ad-hoc issues as the arise; Communications on management of site security; Site security in place Update: • Contract finally awarded February 2022. This was delayed due to a challenge from an unsuccessful bidder. • Installation works have commenced on site, original programme planned for completion in July 2022, currently waiting on updated programme from installer due to delays in award and digital hardware lead in, following the dilapidation survey they have carried out as part of the enabling works. • We intend to start to roll out the replacement local door controller door by door / area by area on a rolling programme once the head end has been set up. Currently we are waiting on the digital service server hardware to arrive which is expected imminently. Door controllers are currently being programmed in advance for network ID`s and security VLAN has now been provided by Digital networks team.		Next review date	30.06.2022

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: 10.04.2022
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 As at 10.04.2022 (data correct as at 10.05.2022)		TARGET RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.12.2022
Mitigation: • Monitor other data for assurance on mortality, Escalation of any variance from plan for consideration of resources and prioritisation where possible. **Update:** • The department current focus is to ensure 21/22 coding is up to date by the end of the second week of May to avoid carrying incomplete months for the year. Coding Lead is fairly optimistic this deadline will be met. • This comes at a cost as coding have not started April 22 which needs to be complete by the first week in June to meet the PDR payment deadline which has been rolled forward as part of the elective recovery.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	31.05.2022

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 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**	**Target rating following**

	local review	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

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 As at 16.02.2022 (data correct as at 09.03.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.08.2022
Mitigation: Triangulation of other data for assurance on mortality; SJR process; Medical Examiners escalation process; Learning from deaths Mortality report reviewing situation and learning. **Update:** In order to have mortality stats that are an accurate reflection of our activity, in an ideal world we code everything to the best of our ability. We have compromised but not to the extent of not worrying about co-morbidities with low impact. The compromises we have made have given us the lowest risk and Head of Coding is cautiously optimistic we will meet the deadline and will then need to work on elective recovery work.		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641**	30.06.2022

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 As at 10.05.2022 (data correct as at 10.05.2022)		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. POSITION: 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. **Mitigation:** There are full mitigations and actions in place, and these risks are reviewed monthly to ensure no concerns to counter the risk. **Update:** DTI continue to raise awareness of the risks of a Cyberattack through regular Trust-wide communications. Communications have also gone out to enforce a password change – DTI have targeted staff who have a weak password that is identified by the use of algorithms.		Next review date **ACTIONS AND MITIGATION EFFECTIVE AND ONGOING**	02.09.2022

Emerging Risks from Division

Appendix 3

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: 10.05.2022
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 As at 10.05.2022 (data correct as at 10.05.2022)		TARGET RATING Target date:	Moderate (10) Consequence: Minor Likelihood: Certain 31.12.2022
Mitigation: • NRTR patients – 4 week covid funding stream discontinued 25th April. Additional mitigations in place as follows: • LA to return social workers to site to support care act assessments. • First point providing alternative discharge support pathways with volunteer sector. • Complex discharge huddles to allocate funding streams. • Discharge summits aimed at reducing care packages. • Social admission avoidance pathways being explored. • Flow cell review of P0 and criteria led discharge. • Pathway for step-down patients from ED to COHOs in place. • Escalated complex huddles to allocate section 256 funds to fund out of hospital if responsible commissioner cannot be agreed. • Rapid home to die pathway expanded for placements as well as home. • CCG attending MDTs to facilitate quick decision making for 'barn door' CHC complex health funding.		Next review date TARGET DATE REVISED.	30.06.2022

Recommended for Closure: **Appendix 4**

Movement on Risk Register: 	Risk Statement **Date added to Risk Register 11.11.2020**	CURRENT RISK RATING (Following review and mitigations)	Low (6) Consequence: Moderate Likelihood: unlikely Reviewed: 13.05.2022
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 As at 10.05.2022 (data correct as at 10.05.2022)		TARGET RATING Target date	Low Risk (6) Consequence: Minor Likelihood: Possible 31.03.2022
Update: The Dorset ICS now receive funding from HEE for which we submit our TNA requests to them to receive the funding for the staff groups who sit outside of CPD funding. The process is now aligned and agreed across all the Dorset trusts and the CCG.		**Confirmation of funding received by the end of Q4 21/22**	**RECOMMEND CLOSURE**

Ref:	Risk Statement	CURRENT RISK RATING	Moderate (12)

		(Following review and mitigations)	Consequence: Major Likelihood: Possible Reviewed:05.05.2022
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
Update: We have delivered a breakeven at the end of 21/22			RECOMMEND CLOSURE

Meeting Title:	**Board of Directors**
Date of Meeting:	**25th May 2022**
Document Title:	**Well Led Review Draft Action Plan**
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	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 in 6 weeks' time
Trust Board	March 2022	Final version of the Report presented. Action Plan to be presented for approval in May 2022.
Senior Leadership Group	April 2022	Further discussion with Divisional triumvirates and Executives to make additions to the Action Plan.

Purpose of the Paper	This paper provides an updated Action Plan in response to the Well Led review undertaken in Quarter 3 2021/22 by PriceWaterhouseCoopers following further discussions with the Senior Leadership Group, divisional teams and the Executive Team. The paper is presented to the Board of Directors' for approval.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The final report following the PriceWaterhouseCoopers review of the Trust's 'Well Led' arrangements was received in January 2022 and makes nine recommendations on areas for further development by the Trust. The Action Plan in response to the nine recommendations is presented to the Board of Directors for approval and subsequent monitoring of progress and includes divisional actions following discussions. It is proposed that the Board monitors progress of delivery of the plan on a quarterly basis.							
Action recommended	The Board of Directors is asked to: 1. **APPROVE** the Action Plan and arrangements for delivery of the development actions.							

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	N	Ensuring that the Trust is Well Led is a fundamental requirement to

Objectives?		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

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST

WELL LED ACTION PLAN

Well Led Review 2021 – Board Action Plan

RAG Key			
Action Progress	**Green = Recommendation action complete**	**Amber = Recommendation action in progress**	**Red = Recommendation action not fully developed**
Level of Assurance	**Green = Full assurance**	**Amber = Partial assurance**	**Red = No collated assurance**

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
1	**Leadership**	Strengthen oversight and scrutiny by the board and subcommittees over aspects of finance and performance, in particular, ensuring there is adequate assurance over financial plans to deliver sustainability, including the internal accountability processes for delivering plans.	September 2022	**Medium**	1. Promote opportunities for greater NED scrutiny and challenge on the financial and deficit positions		Paul Goddard	Claire Abraham		Operational Plan approved by committee and Board Annual Budgets approved by committee and Board Monitoring of annual operational performance and finance plans via the standard reports and recorded within Minutes. See action 4 for the establishment of a formal sub group to be formed to undertake deeper dives on financial hot topics.
					2. Regular reports to FPC on CIP trajectory delivery and the underlying deficit position going forward into 2022/23		Paul Goddard	Claire Abraham		Finance Reports to FPC include CIP progress and monitoring for onward escalation to Board. Underlying deficit position is routinely reported to FPC.
					3. Develop a medium term financially sustainable strategy of which DCH will be a part		Paul Goddard	Paul Goddard		DCH playing into the wider Dorset ICS medium term financial plan which will commence at the conclusion of the 22/23 planning round.
					4. Enhanced financial monitoring in place, sub-group of FPC		Paul Goddard	Paul Goddard		Sub group approved at May FPC.
Responsible Committee:		Finance and Performance Committee								

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
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.	September 2022	**Medium**	1. Complete NED recruitment process review and agree with Governors.		Dawn Harvey	Trevor Hughes		Revised NED recruitment process agreed with Governors. Flexible induction programme to meet individual needs in place.
					2. Board Development Programme for 2022/23 to commence with individual Myers Briggs self-assessments and team discussion in April 2022. This will inform the future Development Programme		Dawn Harvey	Julie Barber		Agenda for April Board Development session.
Responsible Committee:		Board								
3	**System Working**	In order to accelerate progress in the Integrated Care System 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	September 2022	**Medium**	1. Develop the DCH Strategy narrative and promote discussion and sharing of financial and other plans via various system mechanisms. Invite ICB representatives to attend DCH Board & Senior Leadership meeting where appropriate.		Nick Johnson	Paul Lewis Phil Davis Ciara Darley		Weekly System Sustainability meetings in place with Directors of Finance and Chief operating Officers. Weekly CEO calls and Senior Leadership Team meetings in place. Attendance by Head of Strategy at ICS Planning meeting. Awaiting ICS Strategy, DCH Strategy aligned to the 4 aims of the ICS and is published on the external DCH website.
		• Ensuring DCH is communicating in a way that is impactful -	September 2022	**Medium**	2. Stakeholder Messaging Strategy to be developed.		Nick Johnson	Paul Lewis Phil Davis Ciara Darley		ICB formed by July 22, processes being put in place to support communications:

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		consider who is giving the messages and in what forum.			Develop regular key messages for sharing. Agree with Trust Board key messages & positives relating to ICS/ICB					Developing new tools to better articulate our strategy and messaging, for example updating the BAF and the ability to express our productivity in a monetary value. Dashboards in development easily access strategic implementation. SLG(T) provides a communication avenue from the system to Trust + vice versa
		• A Board to Board session with acute partners to build relationships and set out the processes to accelerate progress	September 2022	**Medium**	3. Set up a meeting via the IC Provider Collaborative.		Nick Johnson			Regular updates on system issues and collaborative working within CEO updates to Board. Provider collaborative progress
		• Training to service managers and clinicians on system working, including the leadership skills and capabilities required to deliver successful cross-system projects	November 2022	**Medium**	4. Linked to People Plan – development and roll out of the Management Matters Programme for all staff stepping into management post – bands 6 and above. Leadership engagement events twice a year		Dawn Harvey	Julie Barber Paul Lewis Phil Davis Ciara Darley		QI Lite/QSIR - continued roll out Knowledge from SLG re ICS working to projects involving this group.
		• As the strategy development process comes to an end, consider ways to communicate the outputs with external stakeholders.	September 2022	**Medium**	5. Communication & stakeholder engagement plan		Nick Johnson	Paul Lewis Phil Davis Ciara Darley		Strategy completed and published on Trust Website with simple People, Place, Partnership summary.
Responsible Committee:		Board								

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
4	**Strategy Refresh**	As the Clinical, Digital and People Plans 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.	November 2022	**Medium**	1. Review of recruitment, appraisals, performance management, policies and procedures.		Nick Johnson Dawn Harvey	Paul Lewis Phil Davis Ciara Darley		Recruitment and appraisals on track Clinical Plan aligned to the Strategy and any new business cases will also need to be aligned (monitored through Strategy and Transformation SLG) Annual refreshing of Clinical Plan will support alignment to the Trust Strategy and ambition is for this to be complimentary to the Business Planning Process.
Responsible Committee:		Quality Committee – Clinical Plan Finance and Performance Committee – Digital Plan People and Culture Committee – People Plan								
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 managing its focus on wellbeing and support to staff.	September 2022	**Medium**	1. Single Oversight Framework Slide pack reporting by Care Groups to Divisional meetings to cover Quality of Care, Finance and Use of Resources, Operational Performance, Strategic Change and Leadership / Improvement Capability.		Anita Thomas	Adam Savin		The Board and committees triangulate well with cross referrals on actions and Escalation Reports to the Board. Comprehensive reporting provided to committees facilitate scrutiny. Slide deck in play and will be presented via Performance meetings in June 2022.
					2. Establish Performance Indicators against new contract standards for the respective Strategic Plans; reporting on these to respective committees.		Anita Thomas Paul Goddard Nicky Lucey Dawn Harvey Stephen Slough	Adam Savin		Performance Dashboards being further developed – see 5.3 Quality metrics agreed at Quality Committee and with the system (See Quality Committee Reports)

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					3. Develop and implement Care Group level Performance Dashboards in support of quarterly reporting requirements.		Anita Thomas	Adam Savin		
Responsible Committee:		Finance and Performance Committee.								
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 Groups governance meetings. Ensure that where divisional or Care Group leaders are unable to attend meetings, suitable deputies attend in their place and this is recorded in the Minutes.	September 2022	**Medium**	1. See 5 above re Performance Management Framework.		Anita Thomas	Divisional Managers		Care Groups completing Slide packs for Divisional meetings.
					2. Identify Care Group clinical leaders to lead Care Group meetings.		Anita Thomas	Divisional Managers		
					3. Implement a programme of divisional and care groups leadership development – consider Myers Briggs or 4OD.		Anita Thomas	Education and OD Team		Management Matters at focus groups stage currently and will launch in October 2022.
					4. Implement fortnightly Care Group Business / Governance meetings to review Single Oversight Framework / Performance Framework domains in rotation and quarterly reporting up to Divisional Business		Anita Thomas	Divisional Managers		

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					Governance meetings					
					5. Standard Agendas for Care Group meetings to be re-established.		Anita Thomas	Divisional Managers		
					6. Care Group action plans outlining how the above will be delivered to be developed.		Anita Thomas	Divisional Managers		Clear systems, process and infrastructure in place at care group level. Divisional teams re-energising local communications and meetings
					7. Audit divisional and Care Group meetings to ensure these are happening, are quorate and are covering score card domain subjects		Anita Thomas	Corporate Governance Team		
Responsible Committee:		Divisional Performance Reviews with Executives – see also section 5								
7	**Leadership Visibility**	Implement a more structured approach to Board visibility across the organisation for example through periodic Executive briefings	September 2022	**Low**	1. Re-energise the Executive Walkabouts Programme and Staff Wellbeing visits		Dawn Harvey			Wellbeing and safety walk arounds Weekly CEO communications to all staff
					2. Recommence NED Safety Visits Programme to site in May 2022 in line with national guidance which were paused in line with national guidance.		Nicky Lucey	Kerry Little		Recommenced as per plan and change in guidance (May 2022) Structured programme in place and recorded in the CEO Office NED feedback to Board

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					3. Review of Team Brief.		Dawn Harvey	Susie Palmer		Executive briefings
Responsible Committee:		People and Culture Committee – visibility and wellbeing Quality Committee – Non-Executive Director Safety Walkabouts and feedback								
8	**Patient Communications**	Ensure communications to service users and the public are simple, easy to read and jargon-free.	September 2022	**Medium**	1. Patient group restarted and reviewing all patient information produced locally		Nicky Lucey	Ali Male		Patient Experience Group notes and partnership with Healthwatch Dorset, independent providers (such as charities) and Patient and Public engagement groups. Dorset Abilities co-design work on ED build and accessible information People First Dorset collaboration on Learning Disabilities and Autism (see Safeguarding Group notes and annual report) Young Volunteers work with Dorset Council and Healthwatch Dorset to help with transition work stream Dorset Parent and Carer council supporting transition for young people into adult services.
					2. Maternity Voices Partners (part of the LMNS Transformation Programme in place		Nicky Lucey	Jo Hartley		LMNS transformation programme evidence submitted to region and via sub-board committee
Responsible Committee:		Quality Committee.								
9	**Clinical Audit**	Divisional clinical audits to be aligned to Trust's key priorities, in addition to national standards.	September 2022	**Medium**	1. Letter sent from CMO to Divisional Directors and Divisional Managers		Alastair Hutchison	Stuart Coalwood & Andy Miller		Email available on request
					2. Divisional teams to present outline plan to June		Alastair Hutchison	Stuart Coalwood & Andy Miller		See minutes of meeting

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					Quality Committee					
Responsible Committee:		Quality Committee.								

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
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NHS Foundation Trust

Director of Medical Education Overview

May 2022

Dr Paul Murray

Outstanding care for people in ways which matter to them

Recent Personnel Changes

- Appointment of new DME, commenced Jan/Feb 2022
- New F2 Programme Director, February 2022
- New F1 Programme Director, May 2022

- 2021 GMC Survey of doctors in training - updates and actions
- Interim update on 2022 GMC NTS (closed 17th May)
- Progress from previous surveys and from the GMC Visit
- Medical staffing update
- Future developments in Education

Staffing update

• Recognition of the impact of gaps in rotas

•Deanery post expansion, especially in Foundation (due start Aug 2022)

•Opportunities through Covid: F3s, Medical Support Workers, change in opportunities in 2022

•Increasing LTFT working options for Doctors in Training (rota challenges)

• IMGs, LEDs

• Wellbeing – session at induction for all new doctors, facilitated groups for our most junior doctors, peer mentor training, Deanery-funded evening seminars

Our doctors

- A mix of consultants, doctors in training (almost exclusively from Wessex Deanery), and Locally Employed Doctors (LEDs: Staff Grades, Specialty Doctors, Trust Doctors, ‘F3s’, Associate Specialists, Fellows); and now Medical Support Workers
- Deanery trainees are here for between 6 months and 2 years
- Rotas are designed around a certain number of doctors but lower levels of doctors training in some specialties around the nation plus increased numbers of LTFT (less than full time) working mean rotas are not filled

Overall results, highlights and hotspots

- All trainer and trainee scores overall are in line with national averages
- Questions are asked in 10 categories, giving rise to the 'overall satisfaction' score.
- Results are only published if at least 3 responses
- 'Above' outliers (top 5% nationally) within Trainers and Trainees in Anaesthetics; trainees in T&O, and GP trainees in Emergency Medicine
- '**Below' outliers (bottom 5% nationally) in O and G**
- Good experiences and practice also highlighted in Surgery, Medicine for Older People, Paediatrics, Renal Medicine
- Concerns also raised in Urology, General Surgery and Foundation level Medicine

Concerns relating to patient safety

- In Obs and Gynae, and in Medicine out-of-hours: taking consent when not trained to do so; coping with problems beyond competence/experience; being supervised out-of-hours by someone not competent to do so
- In Urology: strong disagreement with the statement ‘if I had concerns I would know who to talk to in confidence’
- In one of the Medical specialties, in ED and in General Surgery, trainers (consultants) flagging concerns about handover of patients between departments. ED and Gen Surgery also concerned about handover between shifts.
- In Paediatrics, trainers (consultants) flagging daytime workload concerns, with all respondents working beyond rostered hours and half feeling sleep-deprived as a result

Progress from previous years

- Workload in ED – (2019: 100% working beyond rostered hours weekly, with 60% feeling short of sleep as a result) - responses have changed significantly
- ‘Below’ outliers in Foundation Surgical posts – this has improved
- **O&G results had improved overall, but 2021 shows a downturn again**

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

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O+G Update

- Regular departmental teaching with feedback and review
- Locum registrar employed to ensure increased exposure to theatre time
- Trainees invited to joint meeting with CG manager and CD monthly to discuss training issues
- Review GMC survey results (ends 17th May)

Current GMC Survey

- Concern raised about patient safety on orthopaedics weekends.

- Discussion with Divisional and orthopaedic leadership, alongside junior doctors to establish action plan – increased acuity of orthopaedic patients, overstretched medical support

GMC Visit February 2018

- 'Trainees and Trainers are well supported as both clinicians and educators at DCH, with Senior members of the organisation being visible, identifiable and approachable. All groups said they would recommend working at DCH, and Undergraduate education was highly rated'
- Raised serious concerns about clinical supervision of F2s in Surgery at nights, with a requirement to review and monitor out-of-hours supervision for F2 trainees and ensure F2s working at night in the specialty for the first time are appropriately supported
- Asked that we continue to develop clear and transparent systems to monitor how educational resources are allocated and used.
- Review local induction, LTFT training and systems for granting annual and study leave

Over the last 6 years…

- ED recognised as a site for Emergency Medicine training
- Significant increase in medical staffing, mostly in LED group; appointment of consultant lead for LEDs, establishment of appraisal system for LEDs
- DCH has never had as many learners as now; use of other posts to work alongside doctors- PAs, ANPs, Specialist nurses plus UHS medical students
- Involvement of junior doctors in management decisions – rota design, induction planning, redeployment
- Exception reporting, with results driving change
- SuppoRTT scheme; appointment of consultant lead for SuppoRTT and LTFT training, increased opportunities for LTFT training at different levels of training
- Joined up thinking around medical staffing in DCH and across Dorset working with Recruitment, DME, Business Managers, Chief Medical Officer

The future?

- Expansion of Medical Student and Junior Doctor numbers, meaning an increased requirement for Supervision, appraisal, space and accommodation, further medical students
- Possible higher training site for new specialties – radiology, histopathology, ICM
- LTFT trainees – Category 3 from Aug 2022 may have significant impact on rota design and workforce plans
- Action plans in areas of concern; areas of good practice asked to share the learning

- £60K Recovery funding – Simulation, Local teaching sessions, Teaching clinics, AV kit, supplemented by further £20k in early 2022, **further funding for 22/23 nationally (£20-25m)**

- Continuing work on LEDs – aim to provide parity of experience (to include supervision), CESR academy?

- Ongoing focus on Wellbeing and support – med student/F1 debt now estimated £106k

- Continuing involvement of junior doctors in management, service design

Thankyou

For your ongoing commitment to teaching, training and supervising

Meeting Title:	Board Meeting
Date of Meeting:	25 May 2022
Document Title:	Integrated Care Partnership Strategy Update
Responsible Director:	Sam Crowe, Director of Public Health
Author:	Rebecca Kendall, Head of Strategy and Assurance Dorset ICS

Confidentiality:	If Confidential please state rationale:
Publishable under FOI?	Yes

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

Purpose of the Paper	This section is to assist the Board / Committee to understand the reasons why the paper is being presented and what you are asking the Board / Committee to do.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The purpose of the presentation is to provide the Board with: • An overview of the of the requirements of the Integrated Care Strategy and the opportunities this will bring for integration, collaboration and to do things differently in Dorset • Provide an update on the approach being taken to develop the strategy and the progress made to date • The next steps and • Seek support from the Board to the approach and continued engagement.							
Action recommended	The Board is recommended to: 1. **NOTE** the update on the approach and development of the ICP Strategy							

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	

Dorset Integrated Care System

ICP Strategy – update for Boards

Updated 04 May 2022

Purpose of Today's session

- Reminder of requirements
- Progress to date
- Highlighting resources
- Next Steps
  - Strategy content
  - System Leaders workshop
- Timeline
- Questions and discussion

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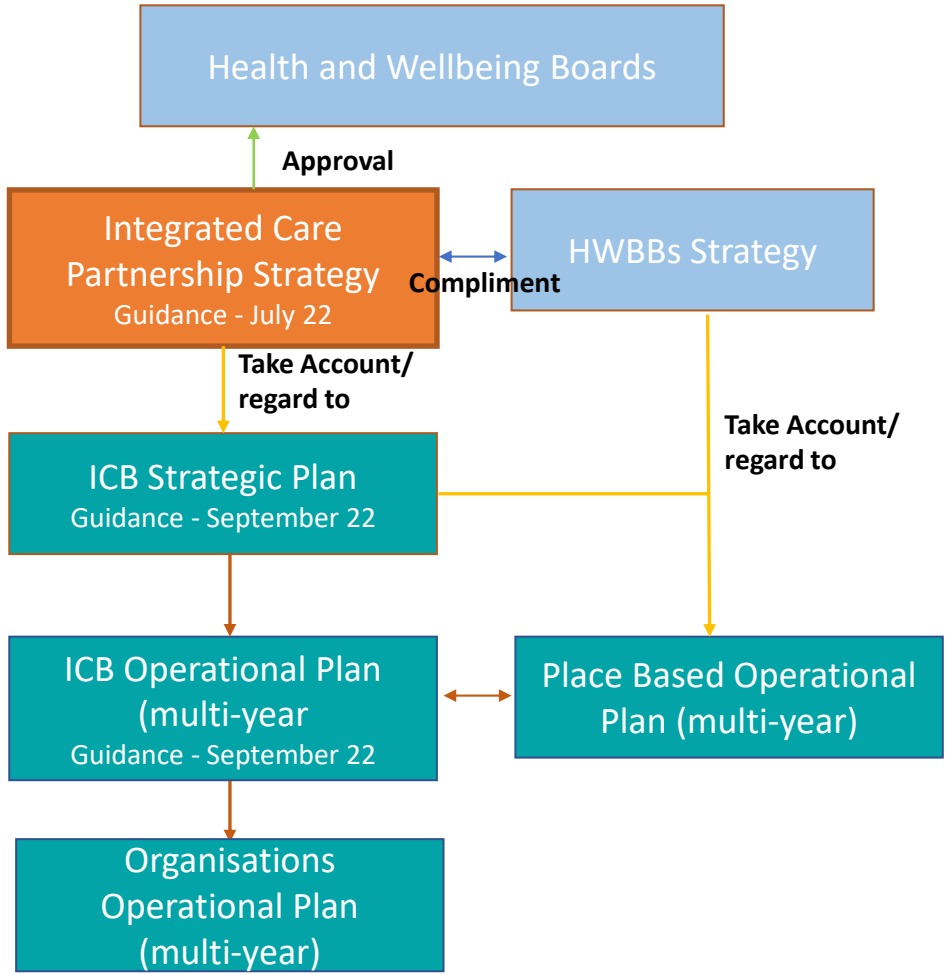
Health and Care Bill Strategy and Planning Requirements

- Integrated Care Partnership responsible for:
  - Developing and agreeing an **integrated care strategy** for improving health care, social care and public health across the whole population including wider determinants of health such as employment, environment, and housing issues
  - Sets out how the needs identified in the JSNA will be addressed (NHS and LA) complemented by the HWV
  - Demonstrate progress in reducing inequalities and improving outcomes
- HWB Boards statutory responsible for ensuring undertake JSNA which feeds through into the ICP strategy
- ICS NHS Board responsible for:
  - developing a 5 year strategic plan for delivering the NHS contribution to the integrated care strategy
  - Capital plan
  - ICS Operational plan
- Organisations, provider collaboratives and place
  - Responsible for delivery of operational plans



ICP Strategy Requirements

- Addressing the ***broad health and social care needs of the population***, including employment, environment, and housing issues, ***highlighting where coordination is needed*** on health and care issues such as:
  - helping people live more independent, healthier lives for longer
  - taking a holistic view of people's interactions with services across the system and the different pathways within it
  - addressing inequalities in health and wellbeing outcomes, experiences and access to health services
  - improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
  - improving the life chances and health outcomes of babies, children and young people
  - improving people's overall wellbeing and preventing ill-health

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

Current ICS vision and mission

Our **vision** is:
Working together to deliver the best possible improvements in health and wellbeing

Our **mission** is:
To transform the planning and delivery of health and care services

We will deliver our vision and mission by:

- planning together for the investment of ICS resources;
- joining up delivery of services and enabling collaborative working across public, independent and voluntary organisations;
- listening to our communities and working with them;
- collectively reviewing how well we perform for our communities.

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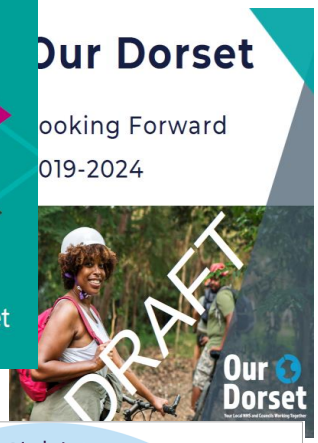
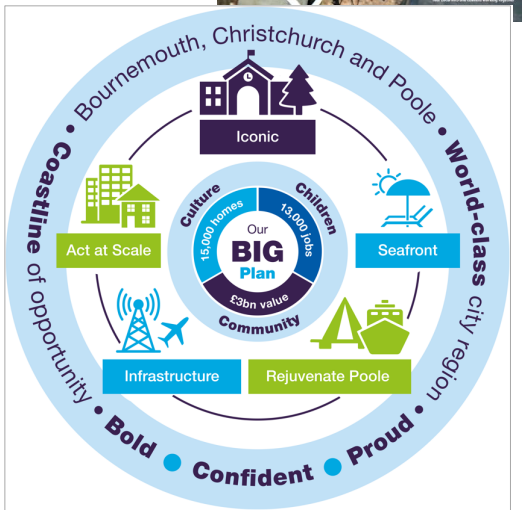
What do we have in place already? What should we do differently?

- System:
  - Sustainability and Transformation Plan
  - Long Term Plan
  - Joint Strategic Needs Assessment
  - Collaboration between HWBBs
- Dorset and BCP:
  - LA Corporate Plan
  - Health and Wellbeing Strategies
  - Joint Strategic Needs Assessment
- Organisational:
  - NHS Organisational strategies and annual plans
  - LA strategies





Dorset Integrated Care Partnership Strategy- Design Principles

- Need a common message for employees and public
- Opportunity to do things differently
    - not a tick box exercise
- Shared commitment from all partners
    - codesign approach
    - joint working with ICS partners to develop the strategy
- Codesigned with communities
    - engage and understand
    - what support do people need to live their best lives?
- Take time
    - continues conversations and communication
    - regular review and refresh

Design principles

- Need a **common message** for employees and public
- Opportunity to **do things differently** - not a tick box exercise
- Shared commitment and ownership from all partners – ***a contract between us***
  - Co-design approach
  - joint working with ICS partners to develop the strategy
- **Codesigned** with communities and employees
  - engage and understand
  - what support do people need to live their best lives?
- **Take time**
  - continues conversations and communication
  - regular review and refresh – reporting back on progress

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Progress to date

- A working group from across VCSE, Local Authorities, Public Health and Dorset CCG has been established
- Sam Crowe, Director of Public Health SRO
- Three workstreams agreed as follows:
  - **Research**: including the JSNA, insights and understanding opportunities (Paul Iggulden)
  - **Engagement**: public, service users and employees (Kirsty Hillier) – 100 conversations
  - **System Leadership**: leadership engagement, building ownership (Sam Crowe)
- Workshop held to further develop timelines, resource requirements, strategy purpose and content and alignment of plans for cultural programme to that of the strategy
- Two Health and Wellbeing Board development sessions in May / June to review priorities

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Research approach

Joint Strategic Needs Assessment, population health management insights in neighbourhoods

Key priorities from each 'place' and health and wellbeing board strategies

Patient and public engagement findings, community voice, service users views

Concerns, opportunities, issues and barriers identified through JSNA panel process and other forums

ICP strategy informed by common priorities and understanding of needs in each place – informs actions for ICB

Annual review workshop for the ICP

- review the data and priorities
- Identify emerging issues and what's working well
- Develop and agree priorities
- Revisit ICP strategy and action plans

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Engagement approach

Our Dorset approach to public engagement has a strong focus on working in partnership with people, communities and the voluntary sector.

Putting people at the forefront and co-producing and co-designing services is a vital element within our ICS.

We are taking a fresh approach to engaging on our Integrated Care Partnership strategy and hearing direct from people to build our story in Dorset.

Ensure we have similar narrative when talking to residents and employees

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100 conversations

Over a six month period we plan to interview and chat to over 100 people living across Dorset.

Working together with engagement champions from across the ICS and recruiting additional ones from the community and voluntary sector, we will create a team of 40 interviewers collecting the ‘story in Dorset’ and what it means to people to ‘live their best life’.

We’ll be talking to people from all walks of life with a particular focus on wide representation across geography, age, sex, protected characteristics, deprived communities, minority communities and disability groups.

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The process

Working with industry experts ‘Point of Care Foundation’, interviewers will receive training and guidance in interviewing techniques.

Interviewers will be supported throughout the process by colleagues with access pastoral support.

Themes from the conversations will be gathered throughout the process and tested back with wider audiences and/or make any changes to our approach.

Consider how we use digital engagement platform to have wider conversations about themes as they are identified

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System leadership approach

1) Progress insights into content of the draft strategy including:

- **Population health outcomes** that offer opportunities to work differently in each 'place' including inequalities in health;
- **Health and care pathway opportunities** – to inform future commissioning, quality and service improvement programmes;
- **Transformation opportunities** – combining professional and public views and insight to identify where working better together could transform how we support people to live healthier for longer, with less recourse to services

2) System Leaders Workshop, July 2022:

- Developing the over-arching vision
- Aim of the strategy
- What outcomes should we focus on

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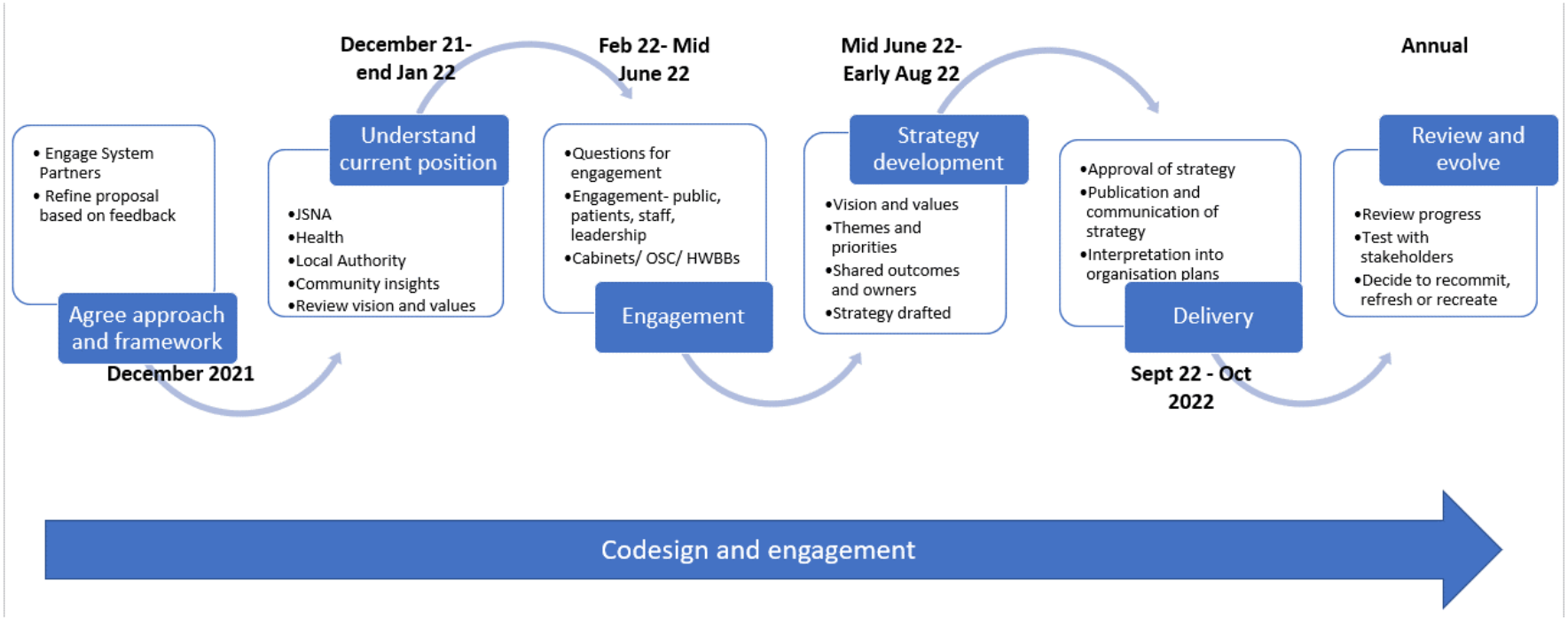
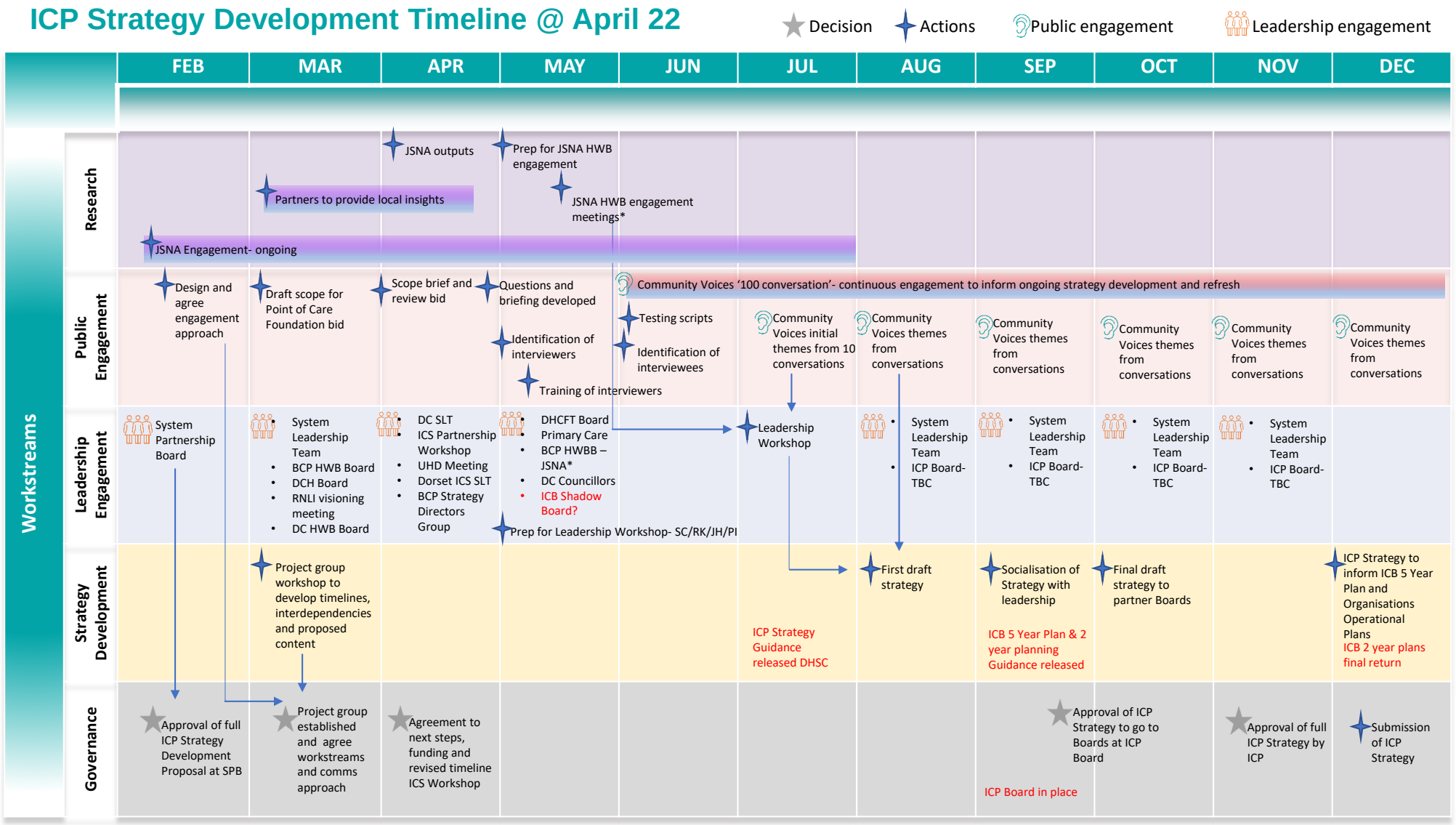
Timeline


Agree approach and framework
• Engage System Partners
• Refine proposal based on feedback
December 2021
December 21- end Jan 22
Understand current position
•JSNA
•Health
•Local Authority
•Community insights
•Review vision and values
Feb 22- Mid June 22
Engagement
•Questions for engagement
•Engagement- public, patients, staff, leadership
•Cabinets/ OSC/ HWBBs
Mid June 22- Early Aug 22
Strategy development
•Vision and values
•Themes and priorities
•Shared outcomes and owners
•Strategy drafted
Sept 22 - Oct 2022
Delivery
•Approval of strategy
•Publication and communication of strategy
•Interpretation into organisation plans
Annual
Review and evolve
•Review progress
•Test with stakeholders
•Decide to recommit, refresh or recreate
Codesign and engagement

ICP Strategy Development Timeline @ April 22



Questions and discussion

1. Is there anything you would change at this stage in the approach and design principles?

2. What is the best way of building ownership and participation in developing the strategy with your organisation and our employees?

3. What matters to you – where are the overlaps between your organisational goals and ambitions / culture, and the ICP strategy? What will you champion?

4. Managing risk – gap between ICP strategy and everyday experience in frontline health and care

Our Dorset
Your Local NHS and Councils Working Together

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25 May 2022
Document Title:	**Annual Guardian Report of Safe Working report: Doctors in Training (2021/22)**
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**

Purpose of the Paper	The production of an annual 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 2021/22.							
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	**16 May 2022**
Report Title	**Annual Guardian Report of Safe Working report: Doctors in Training (2021/2022)**
Author	**Mr Kyle Mitchell, Guardian of Safe Working (GoSW)**

1. Executive summary

- Junior Doctors continue to work flexibly, over and above their contracted hours, to help the Trust deliver safe patient care.
- On a proportion of these occasions, Junior Doctors make use of contractual mechanisms to record and receive remuneration for their efforts, through the submission of *Exception Reports.*
- The same reporting mechanism also allows Junior Doctors to escalate immediate concerns for patient safety (ISCs); occasions when they work with inadequate service support; and when clinical workload causes them to miss their contracted educational opportunities.
- Themes apparent in Exception Reports during the last year include intense pressures in Trauma & Orthopaedics, Geriatric Medicine and Respiratory Medicine, all areas with a high volume of frail/ complex patients exacerbated by an increase in the number without clinical need to remain in hospital but who cannot be discharged.
- Delays in the turnaround of routine laboratory blood testing has also been highlighted as a risk to patient safety and a reason for Junior Doctors to work beyond their contracted hours.
- Junior Doctors continue to engage with exception reporting.
- Under-reporting remains a concern, compromising the reliability of conclusions that can be drawn from scrutiny of Exception Report data.
- Since the implementation of the Exception Reporting mechanism in 2016, its successful working has also depended on the active engagement of Educational Supervisors (hospital consultants with formal training and job-planned supervision time) who review and agree resolution of submitted reports).

2. Introduction

All eligible doctors in training at the Trust in 2021/22 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 2021/22 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual 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):	185	(from 166 in 20/21; 154 in 19/20)
Number of doctors in training post (total):	159.2	(from 157 in 20/21; 141 in 19/20)
Annual average vacancy rate among this staff group:	24.75	(13.4%; 7.2% in 20/21; 13% in 19/20)

4. Exception reports

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (01/04/22)
Accident & Emergency		1	1	0
Acute Medicine		7 (1 ISC)	7	0
Anaesthetics		1	1	0
Cardiology		10	10	0
Gastroenterology	1	21 (1 ISC)	21	0
General Medicine		8	1	7
General Practice		7	6	1
General Surgery		28	26	2
Geriatric Medicine		43	40	3
Medical Oncology		9	9	0
Obstetrics & Gynaecology		3	3	0
Paediatrics		1	1	0
Respiratory Medicine		25 (1ISC)	22	3
Trauma & Orthopaedics		44 (6 ISCs)	39	5
Urology		5	5	0
Total	1	213	192	21

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (01/04/22)
CT1		4	4	0
CT2		24	24	0
F1	1	150	137	13
F2		13	13	0
ST1		15	7	8
ST3+		7	7	0
Total	1	213	192	21

Exception reports (response time) **this is a formal requirement of the annual report*				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open (01/04/22)
CT1	1	0	3	0
CT2	4	3	17	0
F1	41	31	78	13
F2	3	10	0	0
ST1	0	2	13	8
ST3+	2	2	3	0
Total	51	48	114	21

Total number of Exception Reports submitted	213	(from 117 in 20/21; 249 in 19/20)
Number of Immediate Safety Concerns	9	(from 5 in 20/21; 11 in 19/20)
Number of Work Schedule Reviews	28	(from 29 in 20/21; 15 in 19/20)

5. 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	ST1
Acute Medicine	1	0
Cardiology	1	0
General Practice	0	1
General Surgery	9	0
Geriatric Medicine	10	0
Respiratory Medicine	3	0
Trauma & Orthopaedics	3	0
Total	**27**	**1**

Rota	Total
F1 Medical (15 person) 04/21 - 08/21	2
F1 SURG APR 2021	1
F1 Resp (2 person) 08/20 - 12/20	1
AP 2021 F1 Surgical 08/21	6
AP 2021 F1 Medical - 08/21	2
AP 2021 F1 Medical - 12/21 - 04/21	3
AP 2021 F1 Surgical - 12/21 - 04/22	2
AP 2021 F1 Medical - 12/21 - 04/22	7
2021 GPST ST1/2/3 GP	1
F1 Ortho Rota 1:4 - 12/20 – 04/21	3
Total	**28**

Seven work schedule reviews remain open as of 01/04/22
- F1 General Surgery (12/21 – 04/22) x2
- F1 Trauma & Orthopaedic (12/20 – 04/21) x3
- F1 Geriatric Medicine (12/21 – 04/22) x2

One Work Schedule was escalated and closed at Level 2 – F1 Respiratory Medicine (04/21 – 08/21)

6. Vacancies

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

7. Fines

There were no fines levied during this period.

8. Qualitative information

8.1 The total number of exception reporting is not high. Under-reporting of true working patterns undoubtedly continues. This year, 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 infrequency of Immediate Safety Concerns, suggest that, on most days and for most doctors, individual work schedules match up with actual clinic demands.

8.2 Scrutiny of Exception Reports and 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 considered *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 but never perfect.

8.3 Busy specialties such as Respiratory Medicine and Gastroenterology have experienced frequent or long-term sickness at junior doctor level, and this causes repeated Reporting. There is the risk that this becomes a vicious cycle whereby a challenging job increases the probability of sick leave which increases the challenge of the job for those left doing it.

8.4 There has been a trend towards inpatient laboratory blood tests taking longer to be processed and reported. This delays clinical decision making and often necessitates time consuming hand-over of clinical information between shifts and increasing activity out-of-hours. This has been repeatedly highlighted as a cause for concern in recent Exception Reports.

8.5 A part of the Guardian role, not directly related to Exception Reporting, is to provide oversight of a Junior Doctors' Forum (JDF). As previously reported, social distancing efforts have hampered efforts to ensure there is a meaningful and quorate JDF. The Guardian, Chief Executive and Medical Director have discussed and agreed in principle to relaunch a pre-pandemic format JDF including food, to be held in the Junior Doctors Mess. The timetable of this is under review.

9. Issues arising

Guardian has not observed or identified any cultural trends within the trust that put Junior Doctors at risk. The trust actively promotes a culture of freedom to speak up. Submission of Exception Reports is encouraged by Trust leadership. Divisional leadership take action to promote fairness and respect.

However, work pressures (across the Trust but most frequently in Trauma and Orthopaedics, and acute medical specialties) and systemic issues (currently related to laboratory blood test delays) have been escalated as causes of immediate risks to patient safety.

10. Summary

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.

11. Recommendation

The increase in the Trust's Junior Doctor staffing establishment is appropriate and admirable, but this has not yet been matched with a proportional increase in Junior Doctors in post. Successful recruitment of Junior Doctors is vital to avoid increasing frequency of unsafe working.

Successful discharge of patients without medical reason to reside in hospital is a priority for safe Junior Doctor working as well as a key issue in general patient flow.

Delays in laboratory blood testing have a major impact on prompt clinical decision making, increasing hand over time, and exposing patients to risk.

The Guardian asks the committee to note this annual 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

ANNUAL GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING - 2021/22

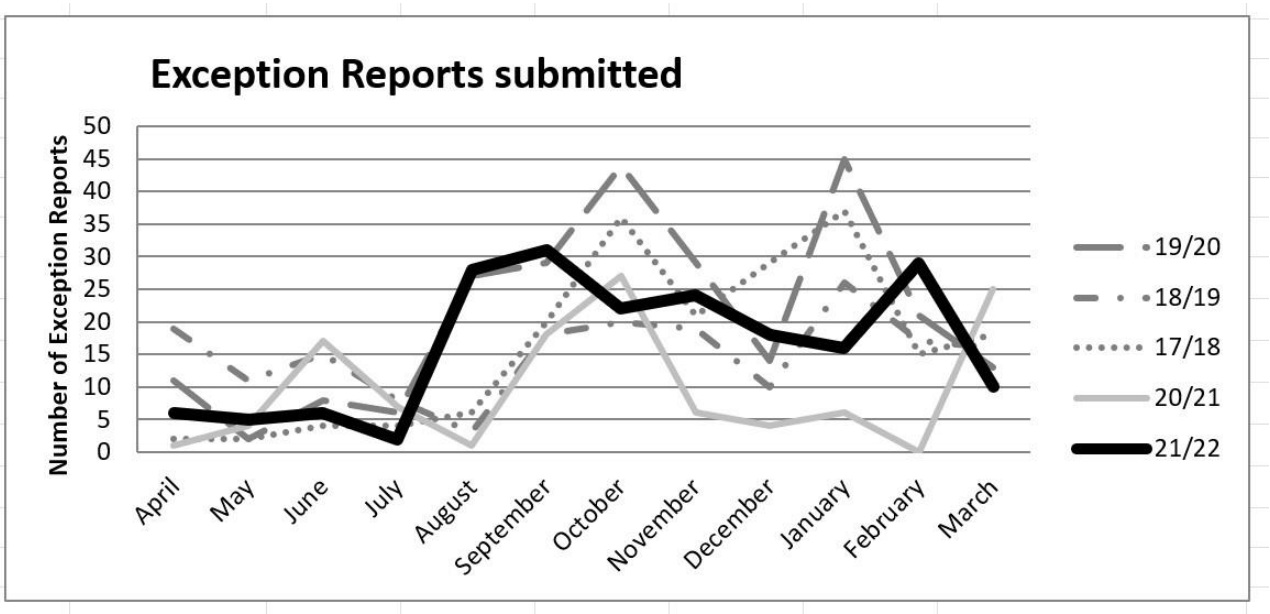
Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Q1				Q2				Q3				Average Q4				Annual Average
		Apr	May	June	Avr Q1	July	August	Sept	Avr Q2	Oct	Nov	Dec	Avr Q3	Jan	Feb	Mar	Avr Q4	
Paediatrics	ST3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0	0.4	1.2
Paediatrics	ST4+	1.2	1.2	1.2	1.2	1.2	1.2	1	1.1	1	1	1	1.0	1	1	1.4	3.4	6.7
O&G	ST1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
O&G	ST3+	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0	0	0	0.0	0	0	0	0.0	1.2
ED	ST3+	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.6	0.6	1.6	2.8
Surgery	CT1	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	CT2	0	0	0	0	0	1	1	0.7	1	1	1	1.0	1	1	1	3.0	4.7
Surgery	ST3+	1	1	1	1	1	1	1	1.0	1	1	1	1.0	1	1	1	3.0	6.0
Orthopaedics	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Anaesthetics	CT1/2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	3.6	7.2
Anaesthetics	ST3+	0.4	0.4	0.4	0.4	0.4	1.2	1.2	0.9	0.4	0.4	0.4	0.4	0.4	1.2	1.2	2.8	4.5
Medicine	CT1/2	2.2	2.2	2.2	2.2	2.2	3	3	2.7	2.8	2.8	2.8	2.8	2.8	3.8	3.8	10.4	18.1
Medicine COE	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0.4	0.4	0.4
Medicine Diab/Endo	ST3+	0	0	0	0	0	1	1	0.7	1	1	1	1.0	1	1	1	3.0	4.7
Medicine Gastro	ST3+	0	0	0	0	0	0	1	0.3	1	1	1	1.0	1	1	1	3.0	4.3
Medicine Resp	ST3+	0	0	0	0	0	1	1	0.7	1	1	1	1.0	1	1	1	3.0	4.7
Medicine Cardio	ST3+	0	0	0	0	0	1	1	0.7	1	1	1	1.0	1	1	1	3.0	4.7
Medicine Renal	ST3+	0.1	0.1	0.1	0.1	0.1	0.1	1	0.4	1	1	1	1.0	1	1	1	3.0	4.5
Haematology	ST3+	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Med/Surg	FY1	0	0	0	0	0	0	0	0.0	1	1	1	1.0	1	1	1	3.0	4.0
Med/Surg	FY2	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
GPVTS	ST1	5	5	5	5	5	0.8	0.8	2.2	1.8	1.8	1.8	1.8	1.8	1.8	1.8	5.4	14.4
GPVTS	ST2	0.8	0.8	0.8	0.8	0.8	1.6	1.6	1.3	0.4	0.4	0.4	0.4	0.4	1	1	2.4	4.9
GPVTS	ST3	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Orthodontics	ST3	0	0	0	0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Total		13.2	13.2	13.2	13.2	13.2	15.4	17	15.20	16.2	16.2	16.2	16.2	16.2	18.8	19.4	54.40	99.00

Trainees vacancies outside the Trust overseen by the LET guardian

General Practice	GPVTS	4	4	4	1	4	1	1	2.3	1	1	1	1	1	0	0	1	5.3
Public health trainees	FY1/2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total		1	1	1	1	1	3	3	2.3	1	1	1	1	1	0	0	1	5.3

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



Meeting Title:	Board of Directors, Part 1
Date of Meeting:	25th May 2022
Document Title:	**Freedom to Speak Up Report Q3 & Q4**
Responsible Director:	Dawn Harvey – Chief People Officer
Author:	Julie Barber – Head of Organisational Development

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	16th May 2022	

Purpose of the Paper	To provide an update Freedom to Speak Up cases raised in Quarter 3 & 4 2021/22 and activities to date. Outline plans moving forwards.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The number of concerns raised through the FTSU process in Q3 and Q4 was significantly more than the previous two quarters. The increased activity is in the context of increasing operational pressure due to Covid related staff shortages. Also, in Q3, awareness of the FTSU process was further raised as part of 'Speak Up' month during October 2021. Development activities such as the Trust's Dignity & Respect at Work (DRW) Programme have raised awareness about acceptable and unacceptable behaviour. Concerns involving elements of bullying rose to a peak during Q3. The numbers of patient safety issues have remained reasonably static throughout the year. An increase in concerns over work safety have been linked to staffing shortages. The Trust recognises that the groundwork has been laid over the last year in developing a 'speaking up' culture'. Approaches and activities now need to be elevated to take the Trust to the next level.							
Action recommended	The Board is recommended to: 1. **NOTE** the update 2. **APPROVE** the Next Steps							

Governance and Compliance Obligations

Legal / Regulatory	Y	Contractual requirement to have FTSUG. Reporting follows national guidelines.
Financial	N	
Impacts Strategic Objectives?	Y	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.
Risk?	N	
Decision to be made?	N	
Impacts CQC	Y	Links to well-led leadership & management promoting open & fair culture

Standards?		
Impacts Social Value ambitions?	Y	Recognised as a Good Employer, ensuring employees have a positive & fulfilling experience
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Freedom to Speak Up Report (Q3 & Q4)

Executive Summary

The Trust has benefitted from a full-time Freedom to Speak Up Guardian (FTSUG) since August 2021. The FTSUG's key role is to support the creation of a positive, open learning culture where our people feel listened to, and feedback is welcomed, and acted on.

The network of FTSU Champions has increased and awareness training for this group is underway. Champions work to ensure colleagues understand and can access routes to speaking up and provide a confidential source of signposting. This model follows the recommendations of the National Guardian and CQC.

The number of concerns raised through the FTSU process in Q3 and Q4 was significantly more than the previous two quarters. We welcome concerns raised as part of our commitment to a culture of speaking out safely. The increased activity in Q3 was likely through raised awareness of the FTSU process in 'Speak Up' month during October 2021. This follows a national trend.

Concerns involving elements of bullying rose to a peak during Q3 whereas the numbers of patient safety issues have remained reasonably static throughout the year. An increase in concerns over work safety have been linked to staffing shortages.

Development activities such as the Trust's Dignity & Respect at Work (DRW) Programme have raised awareness about acceptable and unacceptable behaviour. Whilst the DRW programme highlights ways to respectfully challenge the perpetrator, it is recognised that some staff may not yet have the confidence to do so. Staff are signposted to a variety of routes to speaking up and sources of support.

The Trust recognises that the groundwork has been laid over the last year in developing a 'speaking up' culture'. Approaches and activities now need to be elevated in order to take the Trust to the next level.

The Committee is recommended to note this update and approve next steps.

1.0 Introduction

1.1 It is a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian (FTSUG). The Guardian's key role is to support the creation of a positive, open learning culture where our people feel listened to, and feedback is welcomed, and acted on.

1.2 The FTSUG provides bi-annual updates to the Trust Board, as recommended by the National Guardian's Office (NGO).

1.3 The Trust currently employs a full-time FTSUG who is supported by a network of FTSU Champions. Champions work to ensure colleagues understand and can access routes to speaking up and provide a confidential source of signposting. This model follows the recommendations of the National Guardian and CQC.

2.0 Reporting Speaking Up Cases

2.1 The FTSUG submits Quarterly DCH Speaking Up data online via the NGO Portal. This is published nationally alongside all other NHS Trusts' data.

2.2 Quarter 4 saw almost a 50% reduction in cases from Quarter 3 (44 to 24).

2.3 FTSU data for Q3 and Q4:

Total concerns raised	Q3	Q4
	44	24
Raised anonymously	2	0
Elements of bullying	20	11
Elements of patient safety	5	6
Detriment for speaking up	9	1
Element of work safety	1	6
Other	7	0

2.4 Around 70% of concerns have been resolved within the timeframe set for action (3 weeks) through signposting to routes of support and supporting individuals to raise concerns directly with their line managers.

2.5 Other concerns are in the process of resolution. Progress has been hampered in some cases when triangulation of data has taken longer than anticipated, delaying understanding of the full picture around a concern. This in turn has impacted on effective and timely signposting in some cases.

3.0 Emerging Themes

3.1 There was a significant decrease in concerns raised in Q4 compared to Q3.

3.2 The increased activity in Q3 was likely through raised awareness of the FTSU process in 'Speak Up' month during October 2021. Speak Up month is a national campaign, led by the National Guardian's Office, aimed at raising awareness of speaking up.

3.3 An increase in concerns over work safety have been linked to staffing shortages. Examples include staff moving to areas of work they are not familiar with and instances of junior staff feeling unsupported. These types of concern have revealed certain 'hot spots', including our Pathology Department, Sterile Services and a number of wards across the Trust.

3.4 Patient safety elements have remained reasonably static throughout the year and have been linked to staff shortages across the Trust including increased numbers of staff having to isolate due to Covid, in keeping with Trust guidelines.

3.5 Elements of bullying rose to a peak during Q3. This increase may be linked to engagement and development activities such as 'Speak Up' month and the Trust's Dignity & Respect at Work (DRW) Programme. The latter has raised awareness about acceptable and unacceptable behaviour and explores what may constitute harassment and bullying.

3.6 Whilst the DRW programme highlights ways to respectfully challenge unacceptable behaviour directly with the perpetrator, it is recognised that some staff may not yet have the confidence to do so. Staff are signposted to a variety of routes to speaking up and sources of support.

4.0 Next Steps

4.1 Having a full-time FTSUG since August 2021 has allowed us to lay the groundwork for an effective 'speaking up' culture to be developed further. Our activities now need to be elevated to achieve that aim.

4.2 As the current iteration of the FTSUG comes to a close, a more senior FTSUG will be recruited to build on our more mature speaking out culture and operate independently, impartially and objectively, whilst working in partnership with individuals and groups across the Trust, to help us drive continuous improvement in this area.

4.3 A stronger 'speaking up' culture will be supported through our maturing Staff Networks, the move to a Just & Learning Culture and our inclusive and compassionate programmes of work as outlined in our People Plan.

4.4 More effective triangulation of data from different sources is anticipated through collaborative approaches with the Workforce Business Partners (WBPs). The WBPs are actively working with the Organisational Development Team to develop a 'heat map' of areas for targeted intervention across the Trust.

4.5 The FTSUG will be instrumental in identifying and tackling barriers to speaking up, informing organisational development and learning to achieve improvements.

5.0 Conclusion

5.1 The FTSU Guardian role supports the creation of a positive culture and environment for raising concerns. It helps protect patient safety and quality of care, improve the experience of staff and promote learning and development leading to continuous improvement.

5.2 Our current FTSUG has done some great work encouraging staff to raise concerns and raise the profile of FTSU across DCH. It is envisaged she will continue to champion FTSU as part of any new role.

5.2 The appointment of a more senior FTSUG will ensure a positive culture of speaking up gains momentum across the Trust and that robust governance is achieved through learning and improvement processes.

6. Recommendation

The Committee is recommended to:

1. NOTE the update.
2. APPROVE the Next Steps

Author: Julie Barber, Head of Organisational Development

Date: 4th May 2022

Meeting Title:	Board Meeting
Date of Meeting:	17th May 2022
Document Title:	**Maternity Safety Report May 2022**
Responsible Director:	Nicky Lucey, CNO
Author:	Jo Hartley, Associate Director of Midwifery & Neonatal Services

Confidentiality:	
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	17th May 2022	

Purpose of the Paper								
	Note (✓)		*Discuss*	✓	*Recommend*		*Approve (✓)*	✓
Summary of Key Issues	This report sets out to the Board the quality and safety activity covering the month of April and where relevant, quarter four. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board. • Data from Power BI provided • Maternity staff meeting with good attendance focusing on safety and speaking out • First meeting to discuss actions from Ockenden 2 – good attendance with all local actions reviewed and allocated • |data • Maternity staffing remains challenging although workload has been reduced on some shifts. • SCBU staffing is improving • One informal and one formal complaint in April • One new HSIB case • Digital lead midwife focusing on better recording of VTE assessment as Maternity a outlier • Provision of smoking cessation service – consumables now delivered to the Trust and in use. Interviews for Public Health Lead Midwife • Compliance has improved with K2 training,							
Action recommended	The Trust Board is recommended to: 1. **DISCUSS** the report 2. **APPROVE** the contents							

Governance and Compliance Obligations

Legal / Regulatory	Y	Publication of full Ockenden Report
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. Financial implications of Ockenden Report have yet to be identified and confirmed
Impacts Strategic Objectives?	Y/N	Compliance with Ockenden actions, the Maternity Incentive Scheme and Better Births is included within the Trust's Clinical Plan
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

May 2022 (data from April 2022)

Submitted by Jo Hartley, Associate Director of Midwifery & Neonatal Services

Executive sponsor: Nicky Lucey, CNO

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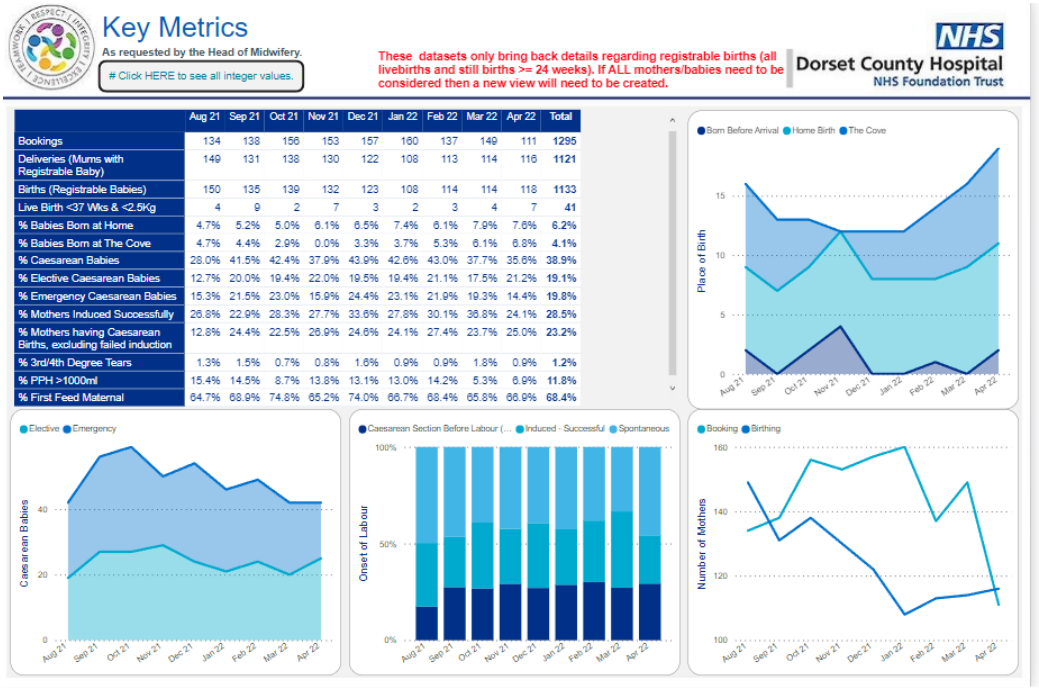
Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of March and where relevant, quarter four. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Data from Power BI provided
- Maternity staff meeting with good attendance focusing on safety and speaking out
- First meeting to discuss actions from Ockenden 2 – good attendance with all local actions reviewed and allocated
- |data
- Maternity staffing remains challenging although workload has been reduced on some shifts.
- SCBU staffing is improving
- One informal and one formal complaint in April
- One new HSIB case
- Digital lead midwife focusing on better recording of VTE assessment as Maternity a outlier
- Provision of smoking cessation service – consumables now delivered to the Trust and in use. Interviews for Public Health Lead Midwife
- Compliance has improved with K2 training, but midwives and doctors, including consultants who have not completed their K2, will not be able to provide intrapartum care.

Activity and incidents reported.

Activity



	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	Total
Bookings	134	138	156	153	157	160	137	149	111	1295
Deliveries (Mums with Registrable Baby)	149	131	138	130	122	108	113	114	116	1121
Births (Registrable Babies)	150	135	139	132	123	108	114	114	118	1133
Live Birth <37 Wks & <2.5Kg	4	9	2	7	3	2	3	4	7	41
% Babies Born at Home	4.7%	5.2%	5.0%	6.1%	6.5%	7.4%	6.1%	7.9%	7.6%	6.2%
% Babies Born at The Cove	4.7%	4.4%	2.9%	0.0%	3.3%	3.7%	5.3%	6.1%	6.8%	4.1%
% Caesarean Babies	28.0%	41.5%	42.4%	37.9%	43.9%	42.6%	43.0%	37.7%	35.6%	38.9%
% Elective Caesarean Babies	12.7%	20.0%	19.4%	22.0%	19.5%	19.4%	21.1%	17.5%	21.2%	19.1%
% Emergency Caesarean Babies	15.3%	21.5%	23.0%	15.9%	24.4%	23.1%	21.9%	19.3%	14.4%	19.8%
% Mothers Induced Successfully	26.8%	22.9%	28.3%	27.7%	33.6%	27.8%	30.1%	36.8%	24.1%	28.5%
% Mothers having Caesarean Births, excluding failed induction	12.8%	24.4%	22.5%	26.9%	24.6%	24.1%	27.4%	23.7%	25.0%	23.2%
% 3rd/4th Degree Tears	1.3%	1.5%	0.7%	0.8%	1.6%	0.9%	0.9%	1.8%	0.9%	1.2%
% PPH >1000ml	15.4%	14.5%	8.7%	13.8%	13.1%	13.0%	14.2%	5.3%	6.9%	11.8%
% First Feed Maternal	64.7%	68.9%	74.8%	65.2%	74.0%	66.7%	68.4%	65.8%	66.9%	68.4%

DCH reported incidences

Dorset County Hospital reported Maternity Patient Safety incidents 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 May 2021 to April 2022:

May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
52	50	60	60	65	98	91	87	64	43	55	70

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	11 datix for delayed IOL which relates directly to reduced staffing numbers. I datix for SCBU staffing
RF2	Missed medication	2
RF3	Delay in providing or reviewing an epidural in labour	0
RF4	Delay of more than 30 minutes between arrival and admission in ANDAU -	
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	11
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	1
RF10	Delay of time critical activity	0

Incidents in the last 6 months requiring RCAs

	Nov	Dec	Jan	Feb	Mar	Apr
Incidents requiring RCAs	1	1	0	0	1	2

Incidents of interest without RCA required (updated and new)

reference	detail	Further information	Update
DCH72549	Patient discharged home after birth without the Clexane required.	Records checked on BadgerNet, patient intermediate VTE Risk with 2 risk factors. Clexane had been prescribed but had not been administered. TTO box was	The discharge was completed by a senior postnatal support worker. The medication was not documented as a

		not recorded to have been given. Arrangements made to provide Clexane to the patient. Community midwife attended at home to explain administration	requirement on discharge. Postnatal Lead Midwife to email the senior postnatal support workers to remind them to check the prescription charts prior to discharge and then for any tto's to be documented on Badgernet.
DCH72767	Clexane dose missed	Clexane prescribed and administered.	As above, escalated to postnatal lead midwife for reminder to all staff

RCAs round-up and update

reference	detail
April 2022 DCH72663	IOL. Baby born in good condition but required support a short time later.
DCH66382	An intrauterine death
March 2022 DCH71346	An intrauterine death
DCH68908	Transfer to ITU
DCH66427	An intrauterine death
DCH66488	Significant shoulder dystocia
DCH66603	Baby collapsed Resuscitated successfully

Risk Register

ID	Title	Risk Statement	Open	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.. **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. **Update:** recent delivery of consumables following national shortage	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 **Update** May 2022 only one datix in April relating to poor staffing. Improvement in shift coverage because of staff returning from sickness. However, still reliance on agency and staff working extra shifts to ensure safety. funding agreed for banding for nurses and HCAs - thus making the vacancies more attractive for recruitment	18/12/2019	moderate	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	High	Care Group

		Apr 2022 – audit completed. Containers packaged to be collected by courier – not collected so resent to cairns for analysis **Update** Awaiting results from analysis			
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 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, **Update:** staffing remains challenging with many shifts carrying vacancies. recruitment continues but there is a high number of midwives retiring. there is also some LTS, compassionate leave and staff having medical/surgical care that was delayed due to the pandemic. The mitigation remains the same - reallocating staff, asking staff to work extra shifts, utilising bank staff.	20/07/2021	high	division

Learning from Claims and from NHS Resolutions early Notification Scheme

reference	details	learning
DCH2359	The importance of consent before any procedure	It is essential to obtain consent for all examinations and this must be documented All clinicians must respond to a patient's clear distress and even if consent has been granted, the clinician must ask again if they can continue
M17CT236/022 NHS Resolutions	Caesarean should have been offered at admission to a labouring woman and two further periods during the labour.	Maternity coordinator reviews labouring women, including fetal wellbeing, every 1-2hrs Fetal monitoring leads appointed – midwife and consultant Regular, interactive fetal monitoring teaching sessions provided with good attendance We are finalizing a guideline for Conflict

		of Clinical Opinion

Complaints

Month	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Formal	1	0	3	2	4	1	0	0	0	0	0	1
Informal	0	0	0	1	3	4	1	0	2	0	2	1
Total	1	0	3	3	7	5	1	0	2	0	0	3

Complaint about the management of an appointment to talk about where to have a baby	Providing detailed information about risks and benefits of giving birth at home, can be difficult. These conversations require significant tact and sensitivity – whilst at the time, the risks must be made clear. The homebirth midwives are skilled in supporting women and clinicians to discuss the risks and benefits – however, due to the way this appointment was arranged, the homebirth midwife could not be present
DCH in escalation so a patient had to attend a neighbouring trust at short notice. Discharge not handed over from neighbouring trust to DCH	The Associate Director of Midwifery has telephoned the complainant and thanked her for taking the time to provide feedback and apologised for her experience. A formal response to follow. Initial learning is the impact of diverting patients at such a sensitive time – and the importance of a sympathetic response and careful explanation as to why the divert is required

Mortality, Morbidity, Serious Investigations, External Reporting & Learning

Mortality MBRACE (Mothers and Babies Reducing Risk through Audit & Confidential Enquiries) reportable cases

March 2022	
March 2022 DCH71346 IUD	

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	**1 plus case revisited as above**
No of cases awaiting pending PM/final review/review closure	
TOTAL cases requiring review completion	1

Morbidity including M&M meetings

Date of Meeting: 23/03/2022

Learning and Actions
Team commended on organisation and administration of medications in a short space of time. Pre-term guidelines recently updated, women in per-term labour will now be offered IV antibiotics. **Neonatal learning** Paeds resus documentation proforma was useful and aided contemporaneous documentation Delayed cord clamping was facilitated Delivery room cuddles were facilitated Baby temperature was high on admission to SCBU – we now have single use baby temperature probes on resuscitaires/emergency trollies which can be used if babies require resuscitation Time limited the chance for antenatal antibiotics but would have been indicated after steroids and magnesium if there had been time Baby was not transferred out as good weight and tolerating feeds well so no need for ongoing respiratory support or parenteral nutrition No actions following this case.

Date of meeting: 27/04/2022

Learning and Actions
Baby admitted to SCBU. Received antibiotics. Group discussed Kaiser Permanente calculator for neonatal sepsis. No ongoing concerns for baby. The group acknowledge that it can be challenging to provide information surrounding plans of care to women with severe anxiety or possible undiagnosed learning difficulties.
Dedicated time for GROW training for staff especially since the introduction of Badgernet. Aspirin guideline updated and training on update day. No ongoing concerns for baby.

Further maternity learning

HSIB quarterly review meeting

- New case reported as detailed above

Safety suggestions from staff

Improved identification of women at risk of preterm labour with increased clinic capacity so they can be seen	Workstream on the management of preterm labour, linked to Ockenden 2 led by matron and consultant. Increased clinic capacity, introduction of digital technology to improve surveillance and assessment of preterm risk
More dinamaps required	On order
Concerns about accuracy of the spreadsheet record of daily staffing	The spreadsheet is going to be discontinued and all senior staff shown how to access daily staffing on healthroster
All midwives with specialist roles should maintain their clinical skills so they are able to work on the ward when required	Incorporated into all JDs for future recruitment (although this has been custom and practice for some time)
Can the blood gas analyser be moved closer to maternity theatre (most often required for births in theatre	Being reviewed by Labour Ward Lead Midwife
Could we fund theatre hats with staff names on?	Funding being considered

Safety Champions action plan

Action Plan

MATERNITY SAFETY CHAMPIONS MEETING. MARCH 24TH 2022
CHAIR: NICKY LUCEY, CNO

Minute	Action	Owner	Timescale	Outcome
1	Staffing discussed in the light of increased rise in COVID, both hospital admissions and the impact upon staffing. Most likely health care workers will be offered a booster in the autumn. Over 75 and vulnerable adults being offered a booster now. Acknowledged that there has been an increase in hospital admission with COVID as a contributory factor (falls at home). Increase in cases noted in the South West region.	All staff	Continuous	Staff encouraged to keep up to date with changing guidance for return to work. Some may be able to return sooner than in previous months. Jo Hartley has been asked to review maternity A/L for March to ensure it was within acceptable allowance.
2	Shortage of Diamorphine, using morphine instead. Discussion initiated as there are different makes of	All staff	Continuous	Nicky Lucey will d/w Andrew Prowse

	medications being stocked with different packaging which may cause concern.			
3	Dr discussed that obstetric medical staffing has improved with limited use of locum staff currently. Formal teaching has been re-established.	For information	For information	

Service User Feedback

Not available in time for this report

Training

Compliance figures for quarter 4

Multi-professional emergency training

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	95%
	Obstetric Consultants	100%
	Doctors (Reg/SHO)	100%
	Midwives	79%
	MSW	46.5%

During the COVID pandemic we have continued to provide face to face training with restrictions on numbers of staff attending. The percentages of attendance reflect this but have also been affected by the continued staff sickness and unavailability due to having to cover the service. We are working to improve and manage the attendance by prioritising those members of staff that are out of date. We are increasing the number of maternity support workers on the days. There are currently two anaesthetists that are due to attend that could not previously due to cancellation and sickness.

Newborn life support NLS

Newborn Life support (RCUK) accredited course is a mandatory requirement four yearly for Level 7, Homebirth Midwives and qualified staff on SCBU. It continues to be challenging to allocate staff due to continued staff shortages not only for the course facilitation itself but also attendance. Covid sickness has played a part in compliance numbers as staff have been allocated but unable to attend on the day.
There are currently 4 places in June with DCH staff appointed to attend and we are awaiting confirmation of places locally in May if they become available. In the meantime, staff are attending their yearly in house update and sim session on PROMPT.

NLS (4 yearly accredited course)	**Senior Midwives/Homebirth Midwives**	91.5%
NLS (yearly update)	**Midwives**	80%

PROMPT and BLS

Staff are reminded that their Basic Life Support yearly training is due to expire 3 months prior to the date. This yearly training is included in the midwives' essential skills day and MSW and doctors are also invited to attend if they cannot make another course through the education centre. Those staff who are out of date will be allocated to the next available course/essential skills day. Maternal collapse is also discussed and practiced in PROMPT.

PROMPT	
Obstetric Anaesthetists	94%
Obstetric Consultants	75%
Doctors (Reg/SHO)	93%
Midwives	82%
MSW	57%

BLS	
Obstetric Anaesthetists	77%
Obstetric Consultants	62.5%
Doctors (Reg/SHO)	77%
Midwives	81%
MSW	75%

K2 fetal monitoring training

K2 – Fetal monitoring	**Doctors** **Midwives**	65% 90%

All doctors and midwives, including consultants will no longer be able to provide intrapartum care if they have not completed K2. The implications on the rota and on safe staffing of Labour Ward are significant. The CD will be meeting with individuals, and with the care group lead very soon to discuss management of individuals. Midwives will meet with one of the matrons with advice from HR about performance management. Current guidance around study time for doctors is being reviewed as midwives receive a day in lieu on completion.

Maternity and medical staffing

Maternity Staffing

Staffing continues to be extremely challenging

Sickness absence	March 2022
midwives	8.72

Sickness absence	March 2022

MSW	19.12

This doesn't include those members of staff self-isolating due to a family member being positive

Maternity incentive scheme Year 3

Current position

No update this month

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

Maternity VTE assessments

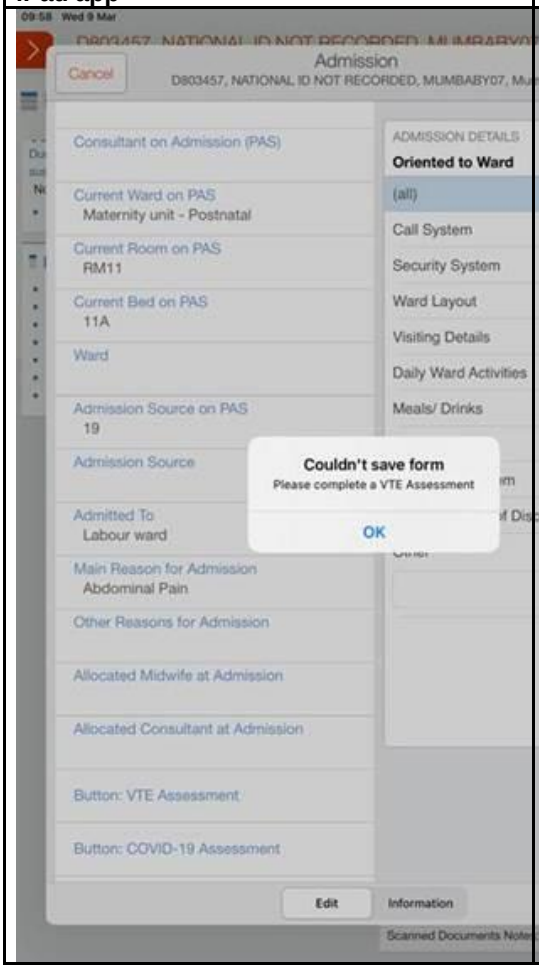
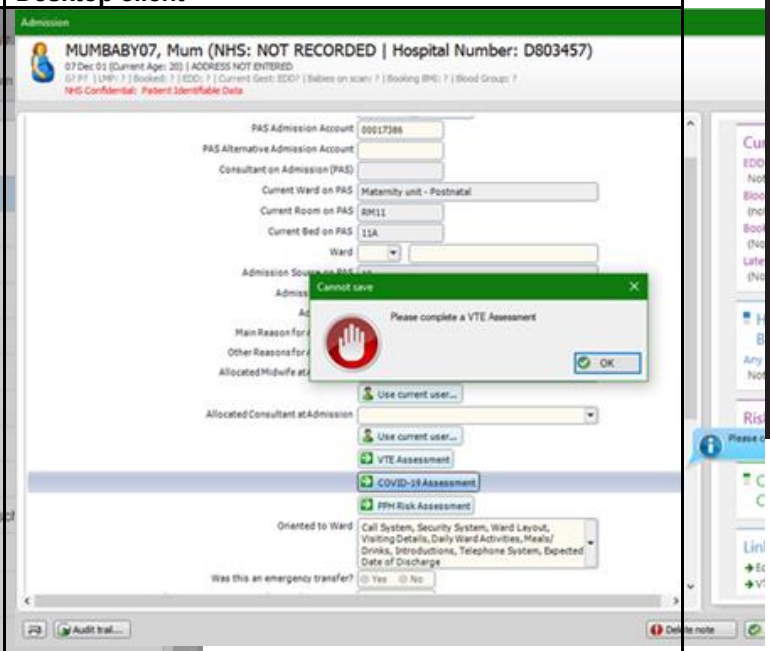
Highlighted as an outlier since the introduction of the digital maternity BadgerNet system

Response from the Digital Lead Midwife:
The lack of data regarding VTE assessment completion is a mainly due to a process issue we have recently become aware of and are taking steps to improve. It has been complicated by a few different factors which I will aim to explain.

Issue description
Our process for admission should be as follows and this guidance has been available from GO-Live in July 2021:

I have highlighted the part of the process that isn't working correctly – staff do not appear to be aware that this step/form has to be completed on admission. The screenshot below shows where the admission note can be located on the pregnancy summary page – the user can just click on the date of the admission and the note will open. The admission note is opened and displays as follows. We have set VTE risk

assessment as mandatory, this warning appears and the user is unable to save the note until the VTE risk assessment has been completed. The VTE assessment is available as a separate note but would rely on the user remembering to search for the note.

iPad app	Desktop client
	

BadgerNet is currently set up so admission notes can only be generated by a PAS message. This relies on real-time PAS admissions – this is usually complete by admin staff on Maternity Reception during the daytime. Overnight should be completed by the Maternity Support Workers (MSWs) although the midwives can also access PAS to complete this.

Planned solutions

- *Reiterating process for admissions to midwives highlighting need for admission note completion (including VTE and other risk assessments) and how to video guide already available on BadgerNet Teams site*

- *Ensuring all midwives and MSWs that should be able to use PAS for admissions still have active accounts and remind of admission/discharge/transfer (ADTs) process (how to guides already available by admission stations)*

- *Consider alternative way to process admissions - ?generate ADTs in BadgerNet to feed PAS. @Gardiner, Ruth, I would like to discuss feasibility with you at some point as this is technically possible with BadgerNet but is not current practice with clinical systems*

Ockenden 1 Immediate and Essential Actions submission

		DCH	
1) Enhanced Safety	A plan to implement the Perinatal Clinical Quality Surveillance Model	Compliant	
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	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	
	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	
3) Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	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	
	Confirmation that funding allocated for maternity staff training is ringfenced	Partial	training monies are ring-fenced but currently we are finalising a more robust system to evidence this
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	
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	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	a recent audit demonstrated reasonable compliance with this action, using our digital maternity system. However, not 100%. Actions include: repeat audit. Risk assessment discussed during all fetal monitoring teaching sessions. Homebirth team midwives reminded and the team leader is reviewing all casefiles. Badgernet focus on risk assessment in bitesize learning sessions

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	Audits complete in relation to SBLCB with actions identified. However, currently we do not have a lead consultant for SBLCB. National shortage of consumables for the CO monitoring is hampering the smoking cessation service. Antenatal clinic capacity issues are challenging for women at risk of premature birth - both consultant time and scanning availability. However, a detailed piece of work is ongoing around PeriPrem and the antenatal service
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.	Compliant	

Meeting Title:	Board of Directors
Date of Meeting:	May 2022
Document Title:	**Communications Activity Report – October 2021 to March 2022**
Responsible Director:	Director of Strategy, Transformation and Partnerships
Author:	Susie Palmer, Head of Communications Meghan Gates, Digital Communications Specialist

Confidentiality:	No
Publishable under FOI?	Yes

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

Purpose of the Paper	This report gives an overview of communications activity for the Trust.							
	Note	*(✓)*	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	Included in the report is information about key campaigns, initiatives and events, and analytics for our social media channels and public website. There is also a summary of news releases issued and media coverage.							
Action recommended	The Trust Board is recommended to: 1. **NOTE** the report							

Governance and Compliance Obligations

Legal / Regulatory	Y/N	*No*
Financial	Y/N	*No*
Impacts Strategic Objectives?	Y/N	*No*
Risk?	Y/N	*No*
Decision to be made?	Y/N	*No*
Impacts CQC Standards?	Y/N	*No*
Impacts Social Value ambitions?	Y/N	*No*
Equality Impact Assessment?	Y/N	*No*
Quality Impact Assessment?	Y/N	*No*

Communications Activity Report

Quarters 3 and 4 (2021/22): October 2021 – March 2022

1. Introduction

This regular report gives an overview of communications activity for the Trust. It is not an exhaustive round-up of what the communications team has been involved with but covers key areas of our work and a summary of activity.

2. Key Campaigns, Initiatives and Events

Coronavirus Pandemic Response and Recovery

The communications team continued to play a major role in the Trust's ongoing coronavirus response and recovery during this period. We continued to focus on ensuring staff, patients, visitors and the wider public have easy access to the latest information and guidance relating to hospital services as well as publishing 'good news' to celebrate successes and lift morale.

A comms rep attends all Incident Management Team meetings and a host of regular meetings internally and externally to maintain an oversight on developments, offer advice and action comms related tasks.

The Trust's communications team has continued to work closely with system and regional comms colleagues to ensure public messaging is coordinated and consistent around key issues such as COVID vaccination, using local services appropriately and waiting lists. The Trust has regularly fed into Dorset-wide campaigns with video content working well to strengthen key messages. Engagement continues to be high through the Trust's social media channels, enabling us to reach our audiences directly. Social media has also been hugely valuable in helping to lift staff morale, celebrating successes and positive news as well as explaining the challenges we are facing.

Staff Flu and COVID-19 Vaccination Campaign

The staff flu vaccination programme was run alongside the COVID-19 booster campaign. We have built on the success of previous years' flu comms campaigns, exceeding our previous record of 91% of staff vaccination to 95% this year. This ranked DCH third in the South West for flu vaccination uptake in acute trusts and community providers. We were also incredibly proud to be ranked as the top acute NHS trust in England for the percentage of staff vaccinated against COVID-19. In October 2021, a total of 94.6% of our staff had received both doses of the COVID-19 vaccine.

Strategic Estates Communications and Engagement

A communications strategy has been pulled together for our strategic estates programme, known as Your Future Hospital. Over the last six months we have developed branding, improved our web pages and carried out various communications and engagement activity, including:

- our first Your Future Hospital newsletter and staff bulletins
- ED15 publicity

- updates on the MSCP construction
- staff engagement on office spaces
- supporting the visit from the Government's New Hospital Programme team
- developing a patient engagement plan
- publicity for the long-term use of South Walks House

During February and March, we carried out a two-week public engagement on our latest site development plans. This included a leaflet drop to Dorchester residents, virtual sessions with staff and councillors, tours with patient reps and Governors and online engagement via our website, news outlets and social media. Our press release also featured on the front page of the Dorset Echo. Our plans were viewed nearly 1,400 times and we received almost 400 responses, with the vast majority in favour of our plans.

Strategy Enabling Plans Engagement and Design
Away days for teams ran throughout October and November to shape the enabling plans for the Trust Strategy. The comms team supported with a dedicated intranet page, the Staff Bulletin and CEO Brief as well as social media. The People Plan has been professionally designed and the Trust Strategy, Clinical Plan and Digital Plan will follow this same design so it is clear they are a linked series of documents.

Staff Networks
We now have five Staff Networks at the Trust: Pride Network, Without Limits Network, Ethnic Diversity Network, Armed Forces Community Network and the Overseas Staff Support Network. The communications team work closely with network chairs and with our new Inclusion Lead Ebi Sosseh to promote their meetings and achievements. We also have a dedicated page for staff networks on the public website and plan to create an individual section on the Staff App.

DCHFT Staff App
The DCHFT Staff App continues to be a great asset for urgent as well as routine staff updates and alerts. At the time of writing this report have registered over 3,900 downloads so we are reaching a high percentage of our staff via the app.

We are currently working with the supplier and our digital team to improve and simplify the download process and will be refreshing the design as well as the content in response to feedback we have gained from users.

DCH Thank You Week (GEM and Long Service Awards)
In November 2021 we welcomed the return of the Going the Extra Mile (GEM) and Long Service Awards evening at Kingston Maurward. The communications team worked closely with HR under a tight timeframe to plan the awards evening. This included a rebrand of the LSA pin badges and the overall structure to the evening with this year seeing a performance from the DCH Choir and a talk from guest speaker and Olympian Anna Hemmings.

The awards were held as part of a wider DCH Thank You Week to shine a light on our incredible workforce and show how much we appreciate every single member of staff for all they do for the hospital and our patients. The week's celebrations included free cake and each staff member received a 'Proud to be part of Team DCH' pin badge. Staff were also encouraged to issue 'thank you' cards to colleagues which were well received.

Public Website
The communications team continue to make ongoing improvements to the public website. Recent improvements have included adding a carousel to the homepage to highlight key information or initiatives and developing new and improved sections, such as the Research and Innovation section. We are also currently working with one of our anaesthetists on developing a 'preparing for surgery' (perioperative) section.

Recruitment
We continue to support recruitment, working closely with the recruitment manager to advertise 'hard to fill' posts. Following a discussion at the Recruitment/HR Senior People Meeting, we agreed to launch a task and finish group to develop a more cohesive strategy for advertising posts. This will include more forward planning of campaigns and using paid-for advertising on social media channels to target specific groups.

We are currently in the process of incorporating our recruitment microsite into our main public website. The microsite was built as an interim measure before we launched our new public website – it has therefore served its purpose and is now outdated and receiving little traffic.

Review of Team Social Media Channels
We understand the benefit of teams running their own social media accounts, and there are occasions where this has worked well. However, we have found that the enthusiasm for teams running their own social media accounts is often short-lived and the accounts are soon abandoned but continue to stay live and reflect poorly on the organisation. We have therefore been reviewing all current team channels to ensure they are being used effectively and appropriately.

As part of the launch of our Comms Portal in 2021, we now request all teams submit a Social Media Request Form for approval by the communications team. The person/people responsible for the channel are then also required to complete social media training with the communications team. This allows us to filter through the channels that may not be necessary and avoid problems around channels being abandoned.

Design Work
The communications team continues to support design work across the Trust. Recent work has included re-branding the membership booklet and leaflet, working with designers to create our Green Plan document and posters, ward closure signage, thank you cards, new social media graphics for ED and regularly refreshing our COVID-19 poster guidance.

Video Work
South Walks House Tour
Join our Pharmacy Department
Christmas Staff Message
COVID-19 Self-isolation Guidance for NHS Staff
Organ Donation Week - Volunteers Violet and Rosie - Service Manager Jon Fox

Other Initiatives
We have been involved in supporting a number of initiatives at the Trust such as the Carers Voice project, Green Plan and sustainability app launch and the Kickstart Scheme. In the

coming months we will be supporting the refresh of Team Brief, Hospital Hero Awards, gestures of thanks for staff and media training.

3. Social Media

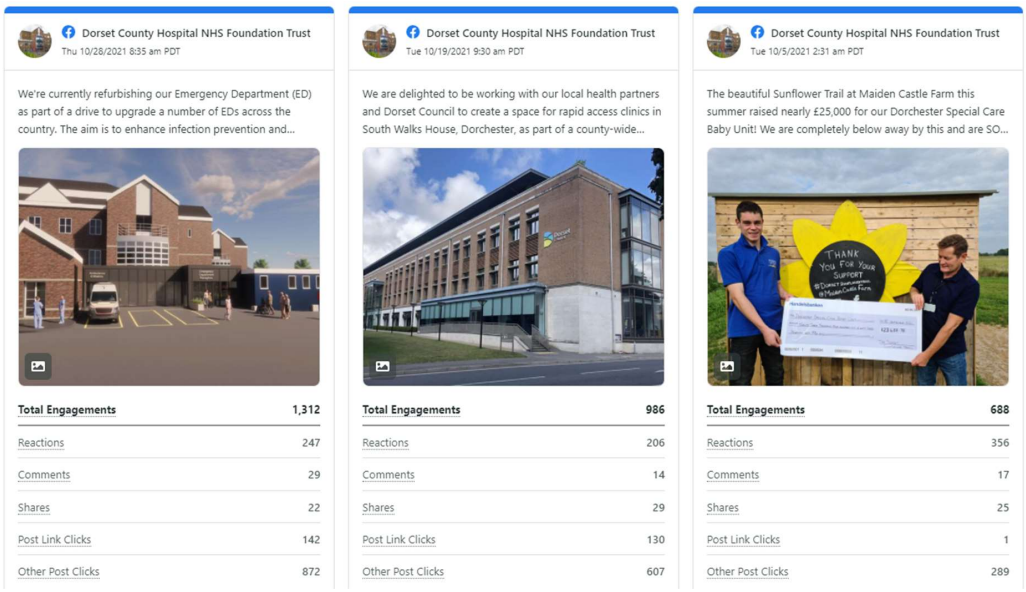
The statistics below demonstrate how many people we are reaching each quarter through each channel. Also included is a small selection of the most popular posts for each month.

Facebook Analytics – www.facebook.com/DCHFT

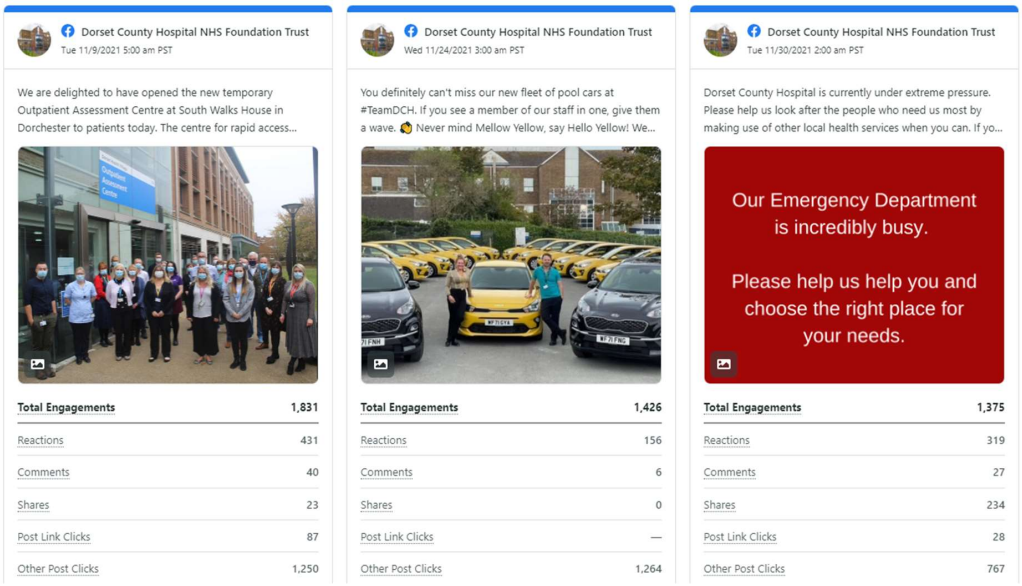
The organic reach of FB posts (how many people see your post without paid advertising) is cut after reaching 10,000 followers. This means the number of engaged users will dramatically decrease (as demonstrated in the table below). The comms team will therefore be exploring further options, such as paid-for advertising and utilising other community pages, to further the success of the Trust's page and ensure key messages and updates are seen widely.

	Q1 2021	Q2 2021	Q3 2021	Q4 2021/22
Engaged users	68,225	57,276	77,031	92,587
Number of posts	104	79	106	82
Number of followers	11,503	11,673	11,767	12,067

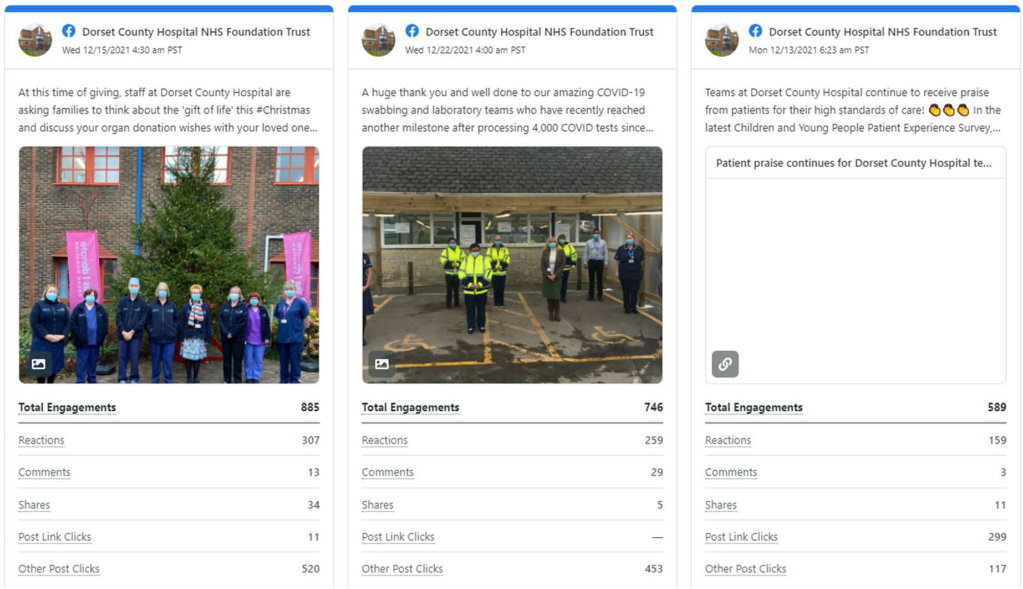
Facebook Highlights for October 2021



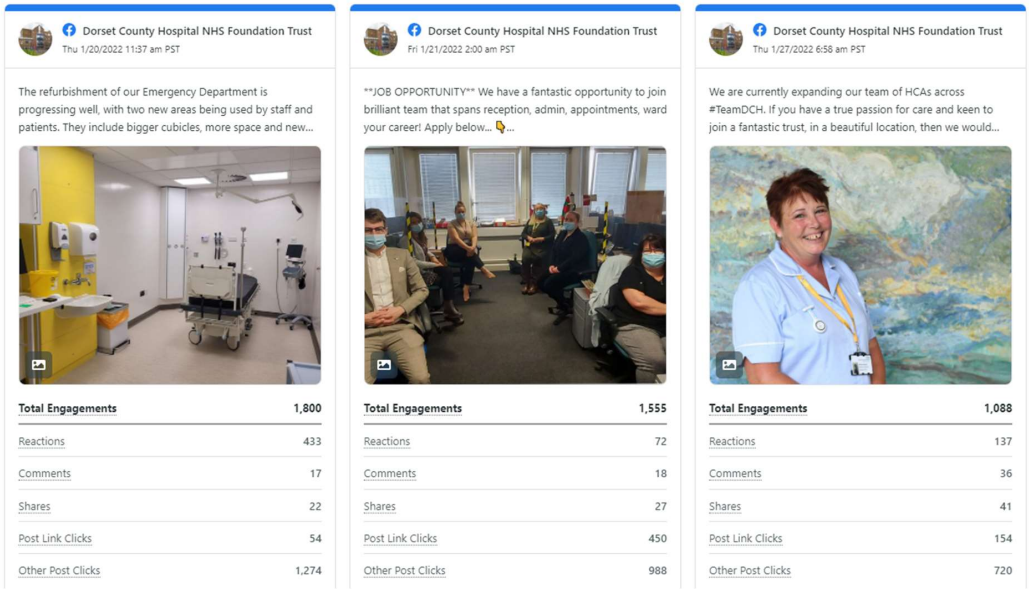
Facebook Highlights for November 2021



Facebook Highlights for December 2021



Facebook Highlights for January 2022



Dorset County Hospital NHS Foundation Trust
Thu 1/20/2022 11:37 am PST

The refurbishment of our Emergency Department is progressing well, with two new areas being used by staff and patients. They include bigger cubicles, more space and new...

Total Engagements	1,800
Reactions	433
Comments	17
Shares	22
Post Link Clicks	54
Other Post Clicks	1,274

Dorset County Hospital NHS Foundation Trust
Fri 1/21/2022 2:00 am PST

JOB OPPORTUNITY We have a fantastic opportunity to join brilliant team that spans reception, admin, appointments, ward your career! Apply below...

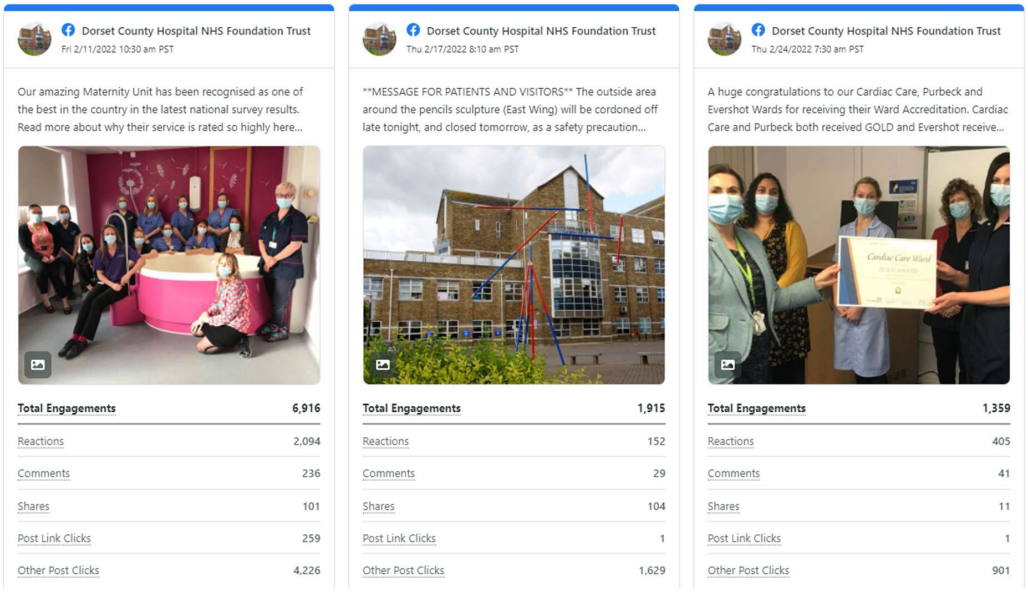
Total Engagements	1,555
Reactions	72
Comments	18
Shares	27
Post Link Clicks	450
Other Post Clicks	988

Dorset County Hospital NHS Foundation Trust
Thu 1/27/2022 6:58 am PST

We are currently expanding our team of HCAs across #TeamDCH. If you have a true passion for care and keen to join a fantastic trust, in a beautiful location, then we would...

Total Engagements	1,088
Reactions	137
Comments	36
Shares	41
Post Link Clicks	154
Other Post Clicks	720

Facebook Highlights for February 2022



Dorset County Hospital NHS Foundation Trust
Fri 2/11/2022 10:30 am PST

Our amazing Maternity Unit has been recognised as one of the best in the country in the latest national survey results. Read more about why their service is rated so highly here...

Total Engagements	6,916
Reactions	2,094
Comments	236
Shares	101
Post Link Clicks	259
Other Post Clicks	4,226

Dorset County Hospital NHS Foundation Trust
Thu 2/17/2022 8:10 am PST

MESSAGE FOR PATIENTS AND VISITORS The outside area around the pencils sculpture (East Wing) will be cordoned off late tonight, and closed tomorrow, as a safety precaution...

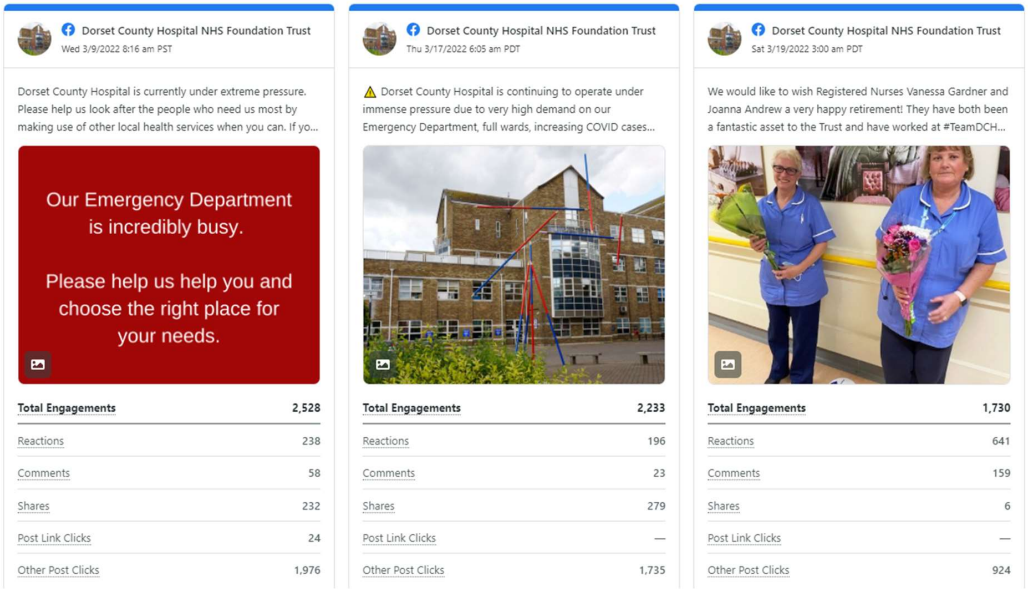
Total Engagements	1,915
Reactions	152
Comments	29
Shares	104
Post Link Clicks	1
Other Post Clicks	1,629

Dorset County Hospital NHS Foundation Trust
Thu 2/24/2022 7:30 am PST

A huge congratulations to our Cardiac Care, Purbeck and Evershot Wards for receiving their Ward Accreditation. Cardiac Care and Purbeck both received GOLD and Evershot receive...

Total Engagements	1,359
Reactions	405
Comments	41
Shares	11
Post Link Clicks	1
Other Post Clicks	901

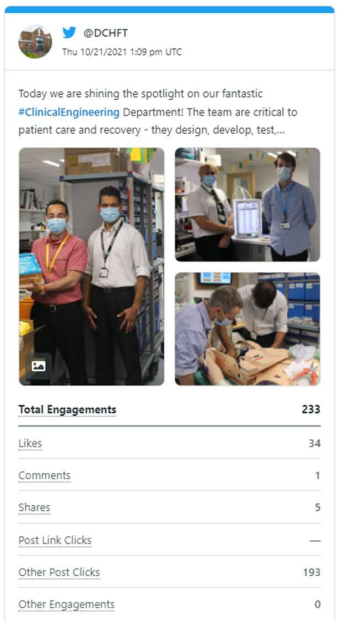
Facebook Highlights for March 2022



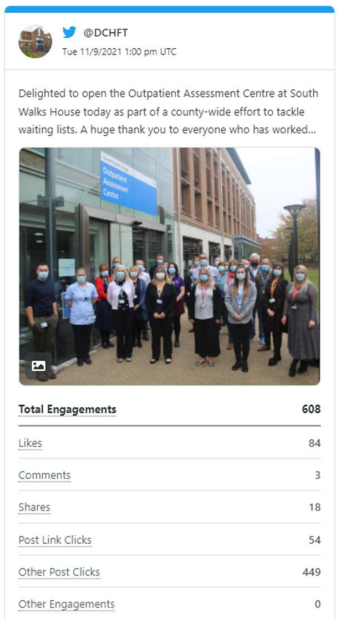
Twitter Analytics - @DCHFT www.twitter.com/DCHFT

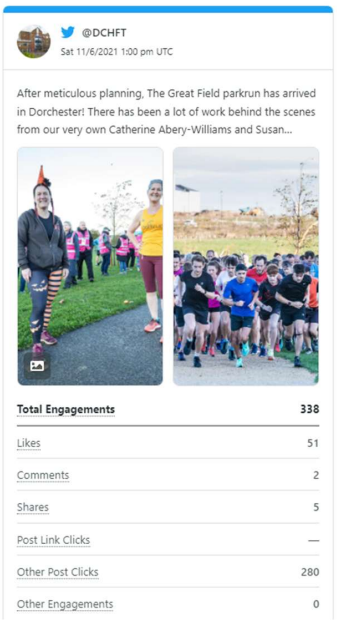
	Q1 2021	Q2 2021	Q3 2021	Q4 2021/22
Tweets	144	150	148	162
Tweet impressions	308,500	215,800	260,453	240,273
Profile visits	14,376	21,400	27,334	42,300
Mentions	965	840	1,227	1,263
Number of followers	5,856	5,980	6,216	6,456

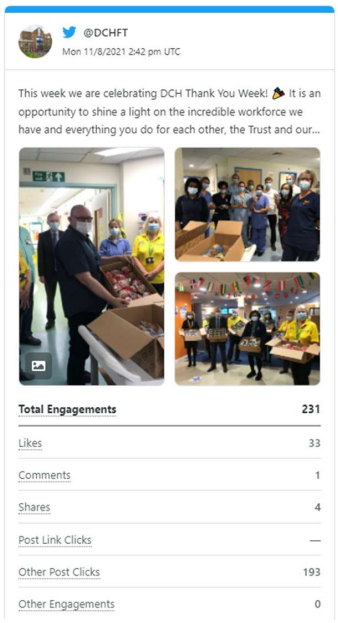
Twitter Highlights for October 2021



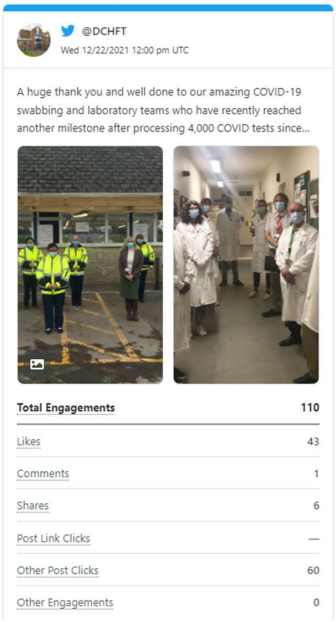
Twitter Highlights for November 2021

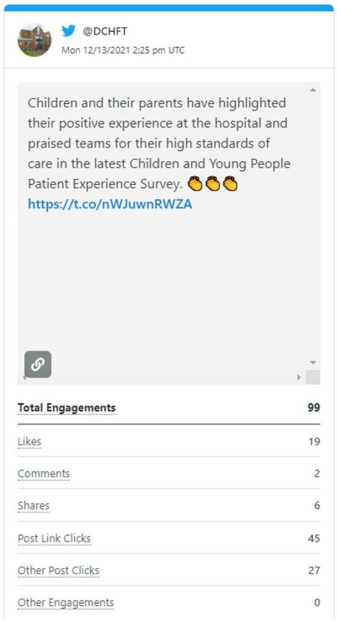






Twitter Highlights for December 2021

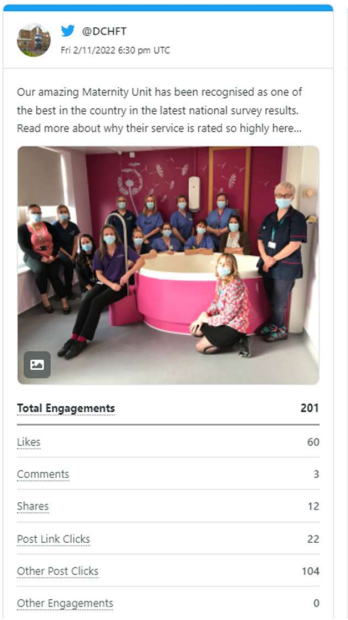




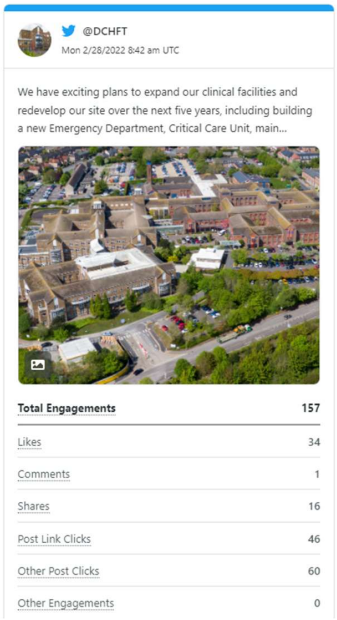
Twitter Highlights for January 2022

Twitter Highlights for February 2022

Total Engagements	287
Likes	90
Comments	11
Shares	1
Post Link Clicks	2
Other Post Clicks	183
Other Engagements	0



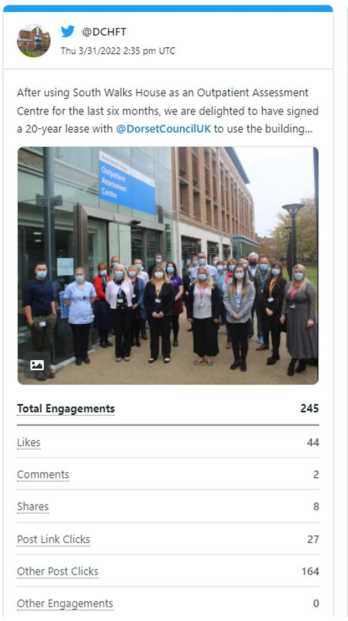
Total Engagements	201
Likes	60
Comments	3
Shares	12
Post Link Clicks	22
Other Post Clicks	104
Other Engagements	0



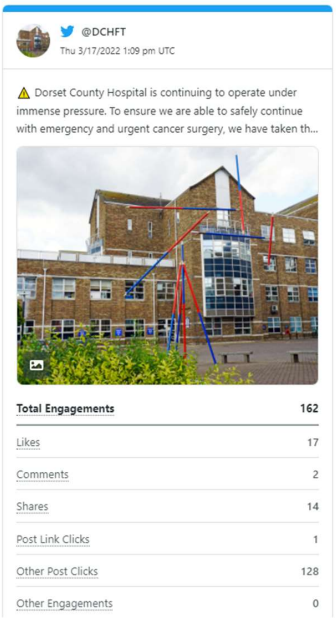
Total Engagements	157
Likes	34
Comments	1
Shares	16
Post Link Clicks	46
Other Post Clicks	60
Other Engagements	0

Twitter Highlights for March 2022

Total Engagements	312
Likes	67
Comments	4
Shares	46
Post Link Clicks	3
Other Post Clicks	192
Other Engagements	0



Total Engagements	245
Likes	44
Comments	2
Shares	8
Post Link Clicks	27
Other Post Clicks	164
Other Engagements	0

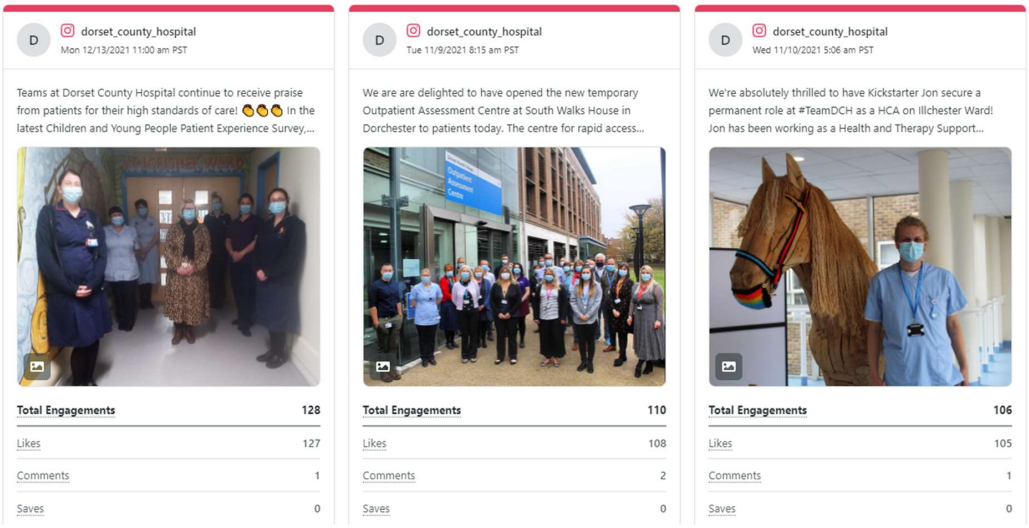


Total Engagements	162
Likes	17
Comments	2
Shares	14
Post Link Clicks	1
Other Post Clicks	128
Other Engagements	0

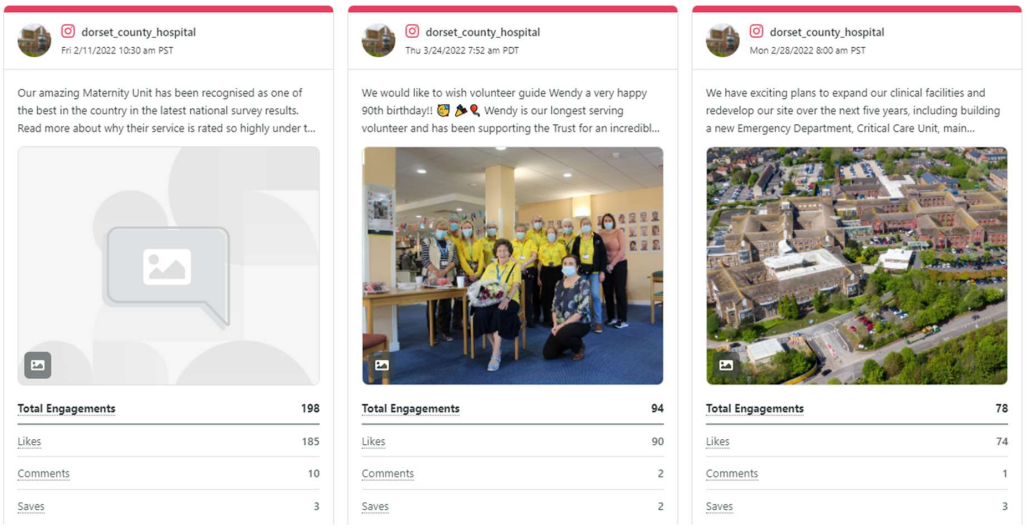
Instagram Analytics - www.instagram.com/dorset_county_hospital/

	Q1 2022	Q2 2021	Q3 2021	Q4 2021/22
Total impressions	27,586	22,316	33,228	16,391
Average impressions per day	303	242	361	182
Average daily reach per profile	153	170	255	122
Number of followers	2,429	2,482	2,521	2,573

Instagram Highlights – October to December 2021



Instagram Highlights – January to March 2022



LinkedIn Analytics -
www.linkedin.com/company/dorset-county-hospital-foundation-trust

	Q1 2021	Q2 2021	Q3 2021	Q4 2021/22
Total impressions	14,452	8,545	26,356	40,951
Total engagements	983	556	1,911	3,014
Organic followers gained	158	151	228	381
Number of followers	2,635	2,778	2,991	3,364

4. Public Website

The analytics below show general usage of the website and the most visited pages:

Website Analytics – www.dchft.nhs.uk

	Q1 2021	Q2 2021	Q3 2021	Q4 2021/22
Sessions	79,136	108,218	96,376	66,390
Page Views	167,592	175,213	167,336	118,098
Users	55,931	88,275	72,155	49,577
Average Session Duration	00:01:10	00:00:40	00:00:53	00:00:54

**We have unfortunately seen a significant drop in visits to the website due to an issue with Google search. This is currently being investigated.

Most Popular Webpages (October 2021 to March 2022)

Page	Page Views	Average Time on Page
https://www.dchft.nhs.uk/	54,404	00:01:02
https://www.dchft.nhs.uk/working-for-us/e-rostering-links/	19,527	00:00:46
https://www.dchft.nhs.uk/patients-and-visitors/a-z-of-services/	14,719	00:01:21
https://www.dchft.nhs.uk/patients-and-visitors/visiting-guidance/	8,722	00:00:50

https://www.dchft.nhs.uk/patients-and-visitors/	6,596	00:00:57
https://www.dchft.nhs.uk/patients-and-visitors/getting-here/	6,445	00:00:43
https://www.dchft.nhs.uk/about-us/contact-us/	4,884	00:00:45
https://www.dchft.nhs.uk/working-for-us/	3,914	00:00:27
https://www.dchft.nhs.uk/patients-and-visitors/getting-here/parking/	3,528	00:00:39

5. News Releases

A round-up of the news releases issued by the communications team with links to the full releases on our website. While news releases and media relations are still an important part of our comms approach, we are increasingly prioritising using our own channels to reach our audiences directly:

South Walks House to be used on a long-term basis by Dorset County Hospital – 31 March 2022
Dorset Council and Dorset County Hospital have agreed a 20-year lease for use of South Walks House building in Dorchester, owned by the council.

Dorset County Hospital's commitment to staff experience is making a positive impact in difficult times - 30 March 2022
It has been a tough two years at Dorset County Hospital (DCH) and staff remain under immense pressure as the Trust continues to deal with the impact of COVID-19 and recover services for our community.

Comment on our hospital's multi-million development plans - 28 February 2022
Plans for a once-in-a generation redevelopment of Dorset County Hospital's (DCH) site, including a new Emergency Department and Critical Care Unit building, can be viewed online.

High standards of maternity care at Dorset County Hospital - 11 February 2022
Dorset County Hospital's Maternity Unit has been recognised as one of the best in the country in the latest national survey results.

Milestone reached in Emergency Department refurbishment - 20 January 2022
Refurbishment of Dorset County Hospital's Emergency Department is progressing well, with two new clinical areas now in use.

Patient praise continues for Dorset County Hospital teams – 13 December 2021
Dorset County Hospital's teams continue to receive praise from patients for their high standards of care.

Outpatient Assessment Centre opens at South Walks House - 9 November 2021
Dorset health organisations are delighted to have opened the new temporary Outpatient Assessment Centre at South Walks House in Dorchester to patients this week.

Emergency Department refurbishment works underway - 28 October 2021
Work to improve the Emergency Department (ED) at Dorset County Hospital (DCH) is underway.

Patients praise levels of care at Dorset County Hospital - 22 October 2021
Patients have praised the level of care experienced at Dorset County Hospital.

Former council offices to be temporarily used as NHS clinics - 19 October 2021
Dorset health organisations are working with Dorset Council to create a space for rapid access clinics in South Walks House, Dorchester, as part of a county-wide effort to tackle NHS waiting lists.

7. Media Coverage

Each of our news releases generated positive local media coverage. Further coverage was prompted by events, national statistical reports, announcements and public meetings. The charts below show the balance of positive, negative and neutral stories, and the table shows each quarter.

	Q1 2021	Q2 2021	Q3 2021	Q4 2021/22
Media stories	158	160	161	125
Positive	91	90	86	55
Negative	1	1	0	0
Neutral	66	69	75	70

October 2021 to March 2022 - Coverage to note included:

- Staff at Dorset County Hospital asked to work from home due to fuel crisis
- Coronavirus deaths
- Coronavirus admissions
- Cancer waiting times breached
- Sunflower trail raises nearly £25k for DCH
- Battens Charitable Trust supports DCH Chemotherapy Appeal

- Addressing rural health inequalities as an anchor institution
- ED admissions
- DCH Charity Chemotherapy Appeal target reached
- Concerns over 'bed-blocking'
- DCH tackling ambulance handover delays
- Coronavirus behind dozens of NHS staff absences at Dorset County Hospital
- DCH Diabetes Centre's new mural painted by Weymouth student unveiled
- Two former patients run marathon for Dorset County Hospital
- Dorset County Hospital scoops top award for cancer care
- Dorset County Hospital 'under extreme pressure'
- Dorset County Hospital suspends routine surgeries

Media Coverage October 2021 to March 2022
286 Stories