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 **27th July 2022** at **8.30 am to 12.00pm** at the **via MS Teams**

The agenda is as set out below.

Yours sincerely

Mark Addison
Trust Chair

AGENDA

1.	**Staff Story**	Presentation	Dawn Harvey Emma Hallett Roxxanne Dean	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: Stephen Slough, Stephen Tilton	Verbal	Mark Addison	Note	
	b) Conflicts of Interests	Verbal	Mark Addison	Note	
	c) Minutes of the Meeting dated 25th May 2022	Enclosure	Mark Addison	Approve	
	d) Matters Arising: Action Log	Enclosure	Mark Addison	Approve	
3.	**COVID Update**	Verbal	Nicky Lucey Anita Thomas	Note	9.00-9.05
4.	**CEO Update**	Enclosure	Nick Johnson	Note	9.05-9.35
5.	**Performance Scorecard and Board Sub-Committee Escalation Reports** (June and July 2022) a) Finance and Performance Committee b) People and Culture Committee c) Quality Committee d) Risk and Audit Committee e) Charitable Funds Committee f) System Performance Update (Standing Item)	Enclosure	Committee Chairs and Executive Leads	Note	9.35-10.05
Coffee Break 10.05-10.20					
6.	**Board Assurance Framework and Corporate Risk Register**	Enclosure	Paul Lewis Phil Davis	Approve	10.20-10.35

			Mandy Ford		
7.	**Medical Revalidation Annual Report** (July PCC)	Enclosure	Alastair Hutchison Julie Doherty Catherine Youers	Approve	10.35-10.45
8.	**Research Strategy Refresh**	Enclosure	Alastair Hutchison Zoe Sheppard	Approve	10.45-11.00
9.	**Blood Sciences MHRA Response Plan** (June QC)	Enclosure	Anita Thomas	Note	11.00-11.15
10.	**Equality Diversity and Inclusion Annual Report** (Including WRES and WDES) (July PCC)	Enclosure	Dawn Harvey Julie Barber	Note	11.15-11.30
11.	**Well Led Review – Action Plan Update**	Enclosure	Nick Johnson	Note	11.30-11.40
12.	**Questions from the Public**	Verbal	Mark Addison	Note	11.40-11.45
	CONSENT SECTION				11.45-11.55
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.				
13.	**Maternity Safety Update Continuity of Carer Report (**July QC)	Enclosure	Nicky Lucey Jo Hartley	Note	-
14.	**Annual Reports:** • **Safeguarding** (June QC) • **Complaints** (June QC) • **Infection Prevention and Control** (July QC)	Enclosure	Emma Hoyle	Approve	-
15.	**Paediatric Service Action plan Update** (June QC)	Enclosure	Anita Thomas	Note	-
16.	**Nutrition Strategy Assurance Report** (May QC)	Enclosure	Katherine Cockerell	Note	-
17.	**Subco Annual Performance Report and Financial Statements** (July FPC)	Enclosure	Nick Jones	Note	-
18.	**ICB Board Minutes Part 1**	Enclosure	Nick Jones	Note	-

19.	**Any Other Business** Nil notified				
20.	**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 28th September 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 25th May 2022 via MS Teams videoconferencing.

Present:		
Mark Addison	MA	Trust Chair (Chair)
Sue Atkinson	SA	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:		
Julie Barber	JB	Head of Organisational Development *(item BoD22/021)*
Sam Crowe	SC	Director of Public Health *(item BoD22/019*)
Phil Davis	PD	Head of Strategy and Corporate Planning *(item BoD22/015)*
Jo Hartley	JH	Head of Midwifery
Trevor Hughes	TH	Head of Corporate Governance *(Minutes)*
Paul Lewis	PL	Deputy Director of Strategy and Transformation *(item BoD22/014)*
Kyle Mitchell	KM	Guardian of Safe Working Hours *(Item BoD22/020)*
Paul Murray	PM	Director of Medical Education *(Item BoD22/018)*
Laura Symes	LS	Corporate Business Manager
Members of the Public:		
Judy Crabb	JD	DCHFT Governor
Kathryn Harrison	KH	DCHFT Governor
Lynne Taylor	LT	DCHFT Governor
David Thorpe	DT	DCHFT Governor
Apologies:		
Margaret Blankson	MB	Non-Executive Director
Simon Bishop	SB	DCHFT Governor

BoD22/001	**Patient Story**	
	JH presented the story on behalf of the patient who was unable to attend the meeting. The patient 'Jane' had a baby at DCH 5 years previously and was having her second baby under the care of another trust. The antenatal and delivery clinical records had been requested by the trust as the patient had been dissuaded from having epidural pain relief during her labour previously. Whilst requests for a copy of the record was not unusual, it was not normal midwifery practice to influence patient choice regarding analgesia and JH undertook to investigate the matter. Patient choice was an important element of midwifery care and had been highlighted in the Ockenden Report. The midwife who had provided the previous care at DCH had kept good	

	clinical records that had helped the investigation. The patient had requested an epidural but had been coping well during her labour and had been encouraged to birth in the pool. Discussion with Jane clarified that she did not wish to make a complaint and that she only wanted to understand the reasons for not having epidural previously. The patient had not considered use of the birthing pool and had no clothing which she had found embarrassing. The midwife had praised Jane on her progress but had disempowered her and removed her planned coping strategies. The patient blamed herself for not having been more assertive at the time. JH offered sincere apologies for not listening and hearing Jane's request and sought permission to use her experience to promote learning. The need to revisit our views as to what was best for patients regularly was emphasised and had been highlighted in the Morecombe Bay review. Midwifes were trained to promote natural birth although not all women wanted this. JH concluded with the message that birth was miraculous – no matter how or where it happened. NL highlighted the importance of professional curiosity which had led to the further investigation and noted this as a learning point for all services. The learning point about active listening and hearing what our patients want rather than professionals 'knowing what was best for patients' was being shared with doctors and other members of the multidisciplinary team. The need to reassert the role of patient advocate was also noted, as patients often felt out of control of their own care. The continuity of carer work across the service supported the advocacy role of the midwife through better understanding of patient needs. JH outlined that the Montgomery ruling had changed consent in maternity care, emphasising the need to make sure that information was shared in an accessible manner, that this was recorded and that women were supported to make informed choices and decisions. The Board thanked JH for the powerful and emotional presentation and requested that their thanks be extended to Jane for her story.	
	Resolved that: the Patient Story be heard and noted.	
BoD22/002	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed members of public and Governors to the meeting. Apologies were received from Margaret Blankson and Simon Bishop. MA remarked on the unusually large volume of papers for the meeting and the process of distribution and sought the Board's co-operation in focussing discussion. MA noted that DH and SS had been successful in their system role applications and congratulated them on their appointment which would be positive for the system and DCH.	

BoD22/003	**Declarations of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD22/004	**Minutes of the Meeting held on the 30th March 2022**	
	Members of the Board considered the minutes of the meeting held on 30th March 2022 and these were approved as an accurate record**.**	
	Resolved: that the minutes of the meeting held on 30th March 2021 were approved.	
BoD22/005	**Matters Arising: Action Log**	
	The action log was considered and updates were noted with approval given for the removal of completed items. **BoD21/121** SA reiterated the need for greater inclusion of health inequalities and social value within the Board Assurance Framework. The Board noted discussion of the same point at the Risk and Audit Committee meeting held the previous day.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD22/006	**CEO Update**	
	NJ reported that • The Health and Care Bill had received royal assent so the ICS would be formally established on 1st July 2022. The Dorset Integrated Care Board had been appointed in the main. • The NHS was under considerable pressure to deliver a balanced finance plan and to address the long waiting times and elective recovery. • The incidence of COVID was reducing and alleviating staffing pressures. The focus remained on ambulance handover times although these continued to be impacted by high numbers of patients with 'No Reason to Reside' which had in turn been adversely affected by changes in discharge funding arrangements. NJ expressed pride in DCH staff and highlighted the positive Staff Survey results, He also noted the positive outcomes from the Royal College of Anaesthetists review recently. A letter of appreciation would be sent on behalf of the Board. The Board heard about overseas recruitment for care and social care workers roles in other areas and noted that this was currently in the early stages of development in the system. The Board supported the progressive parking charge proposal and noted the need to revitalise messaging around active travel and the variety of schemes to support this across the Trust. The Board was reminded of the potential challenges to overseas	**NJ / MA** **NJ**

	recruitment arising from bullying and harassment incidents reported in the national WRES report. Addressing this issue formed part of the Cultural Development programme. The Board noted that the 'Greatest Need' DCH Charity appeal had been launched and Non-Executive colleagues offered their support to initiatives going forward.	
	Resolved: that the CEO Update be received and noted.	
BoD22/007	**Review of the Previous Year Committee Priorities, this year's Priorities and Work Plans**	
	MA thanked committee Chairs for their input to the development of the focussed priorities and detailed work plans. The Board noted that the Finance and Performance Committee Chair had not had opportunity to review the final draft. Further emphasis was needed in respect of the underlying deficit position as COVID funding was withdrawn. Discussion ensured around assurance and review of effectiveness, noting the annual review process and that the Performance Report and Scorecard included performance and other metrics which were reviewed by the Board and committees. A bi-annual stock take would be undertaken by Non-Executive and Executive colleagues at committees' regularly scheduled meetings and this would be fed back to the Board. The Board noted that the People and Culture Committee Work Plan flowed from the People Plan. There was discussion of the need to ensure that health inequalities, social value and environmental sustainability were reflected within the workplans. The Board noted that the respective committee priorities and workplans would flex as agendas developed. The need to avoid duplication, in terms of monitoring progress, with strategy updates was noted. The Risk and Audit Committee had not proposed a set of priorities as such, but this would be reviewed at the mid-year point. There were some themes the Risk and Audit Committee would cover over the year. The Board requested that the Risk Summit be reinstated to the Risk and Audit Committee workplan. Discussion was had regarding Clinical Audit, noting discussion of this by the Quality Committee and that a meeting had been established to map the Clinical Audit Programme to clinical risks. A mid-year update of key themes would be presented to the Risk and Audit Committee. The Committee Priorities and Workplans were approved subject to the discussion noted above. The DCH Subco Ltd Terms of Reference were approved.	**Chairs**

	Remuneration and Terms of Service Committee Terms of Reference were approved subject to a minor change.	
	Resolved that: the Committee Priorities, Work Plans and Terms of Reference be approved.	
BoD22/008	**Quality Account**	
	The Board was informed that the Quality Account, which followed a set format, had been reviewed by the Quality Committee and that a final review and edit would be undertaken prior to submission of the report in June 2022. Although there was no formal requirement this year to do so, the Trust had reached out to Governors and partners for comment and these would be included in the final report. The report highlighted maintenance of the Trust's quality improvement and safety focus despite the pandemic challenges. The report was approved and the Board's thanks were extended to the wider team for compiling the comprehensive report.	
	Resolved that the Quality Account be approved.	
BoD22/009	**Annual License Condition Declarations**	
	The Board was reminded of the annual requirement to review and publish statements of compliance with the following Provider License Conditions: • Continuity of Service condition 7 • General condition 6 • Foundation Trust condition 4 • Training of Governors. The Declarations had been reviewed by Risk and Audit Committee the previous day. The Board considered the financial challenges for the coming year and the potential impact of this on the Continuity of Service declaration and agreed that statement 3b and accompanying the rationale be approved, noting these.	
	Resolved that: the Annual License Condition Declarations be approved.	
BoD22/010	**Safe Staffing Return**	
	NL advised that the return had been reviewed by the People and Culture Committee and the Finance and Performance Committee the previous week. Board review of Safe Staffing was a requirement arising from the Francis Report. The review methodology used the national tool, considered benchmarking and applied professional judgement. NL advised that the conclusion of the sub committees was to support and recommend the outcomes and recommendations of the review to the Board for approval. The review recommended that a number of	

	posts, currently within the run rate, be converted to substantive posts. The Board supported the proposal and acknowledged the need to see an impact on Agency expenditure reduction and overall pay costs. The level of Agency expenditure currently exceeded the amount of investment requested. Discussion of the current skill mix and cover for staff leave and training noted that these were lean. A similar review of Maternity service staffing levels would be undertaken in due course. NL emphasised the importance of providing safe quality care for patients and reminded that the Board's appetite for quality and safety risks was low. The additional staff would also support the appropriate supervision of trainees and attraction and retention of staff. The Board noted the additional training and development requirement for any additional permanent staff also. The Board noted the robust review process that had been undertaken and noted the need to maintain safe care. The Safe Staffing recommendations were approved noting the need for Agency expenditure reductions to be demonstrated in monitoring reports going forward.	
	Resolved that; the Safe Staffing Return be approved.	
BoD22/011	**Ockenden Report Update**	
	JH presented a summary of national learning from the final Ockenden Report outlining a concise history of the development of the report and key findings. A number of 'immediate and essential actions' and 'further actions' were identified and some additional funding was available to support delivery of the recommendations. JH reported that a regional team review of the Trust's response to the report was expected in September 2022. A regional Task and Finish Group was in formation to develop joint actions. JH reported that a review of workforce and governance processes had commenced and that next steps were being reviewed on a monthly basis by the Local Maternity and Neonatal System (LMNS) which would be working with local families in the co-production of services. The Trust's Ockenden lead would participate in the regional task group and areas of concern highlighted in the report were currently being reviewed. These included safe staffing, having a well-trained workforce, learning from incidents and listening to patients. JH outlined the detailed actions being taken within the Trust in response to the final Ockenden Report. She highlighted the profound effect that the report had on staff and potential impact on attracting staff to the speciality and level of attrition. JH acknowledged the transformational change opportunity and noted the continued building of collaboration and development of outcome-based measures. The Trust's compliance against the first Ockenden Report had been	

	good overall although further assurance that risk assessments were being undertaken at every contact was needed. Key messages from the report were noted to have application across all specialities and care providers. NL highlighted wider national changes in the review of incidents and the patient safety function with an emphasis on promoting greater openness and transparency and links to education and training. The Board noted that the Non-Executive lead role for maternity services had transferred to EJ from SA as SA was approaching the end of her term of office. The Board acknowledged the level of assurance provided to committee in respect of maternity safety and the strong leadership within the service. The Ockenden Report Update was noted.	
	Resolved that: the Ockenden Report Update be received and noted.	
BoD22/012	**Learning From Deaths Q3 and Q4 Reports**	
	AH reported that the clinical coding backlog had been cleared and that Hospital Episode Statistics (HES) data had been submitted which would improve the Standard Hospital Mortality Index (SHMI) position over the coming months. Venous Thrombo-embolism (VTE) assessment compliance had also improved as inaccuracies in data had been rectified. Review of historic data had shown that compliance had remained over 95%. No questions were raised in respect of the report.	
	Resolved that: the Learning from Deaths Q3 and Q4 Reports be approved.	
BoD22/013	**COVID-19 Update**	
	AT reported that service and staffing pressures had continued through April. The Easter period had been less busy than expected as a result of good prior planning. The prevalence and incidence of COVID had continued to decline over previous month and there were further reductions in the number of patients in hospital with COVID. 10-15 patients were being managed via side rooms rather than by cohorting wards. The national COVID incident level had been reduced to a regional level 3 incident during the previous week. The Trust remained vigilant with daily reporting until after the June bank holiday and weekly meetings of the Incident Management Team. AT proposed that COVID be removed as an item on the Board Agenda and that future reporting should be by exception. Ongoing management arrangements would be considered as part of the winter planning	

	activity currently underway. The Board noted the recent influenza outbreak in Australia and the need for consideration of this in the Trust's winter plans. They also noted the infection prevention controls and escalation arrangements in place. The Board approved the removal of COVID-19 as a specific Board agenda item going forward.	
	Resolved: that the COVID-19 Update be noted and that the item be removed from future Board Agendas.	
BoD22/014	**Performance Scorecard and Board Sub-Committee March Escalation Reports**	
	AT reported the ending of hospital discharge funding and the impact this was having on patient flow with increasing numbers of patients remaining in hospital with 'No Reason to Reside'. Patient flow had been supported by the use of community hospitals although the use of interim acute beds was reducing also. Discharge assessments were taking place. However, there was an increasing number of patients waiting for care at home. There were currently 78 patients awaiting onward care packages and the Trust was working with partners to reduce this number. The Trust was also working to reduce the length of stay for patients on pathway zero – those that did not require onward care packages, in order to improve patient flow. The Board noted development of the Balanced Score Card to reflect the key areas of concern including waiting times, No Reason to Reside and People metrics. A refreshed Score Card would be presented to the Board in July. In response to a query regarding readmission rates, the Board noted that this would be included in future reporting. On cancer the two week wait trajectory had been impacted by staff shortage in March and April and the position was being recovered. The focus would move to the 28 day standard to receive a diagnosis going forward and this would be included in future reports. Discussion followed regarding the impact on cancer patients waiting for their appointments. A full review had been undertaken and one case was being more thoroughly reviewed using a Root Cause Analysis approach. The Trust was providing feedback nationally on cancer standards and had achieved the 62 day standard. DP requested that consideration be given to the future use of a non-binary RAG rating system. The following Committee Escalation Reports were taken as read and no questions were raised in respect of these. • People and Culture Committee: • Quality Committee: • Finance and Performance Committee: • Risk and Audit Committee:	

	• Charitable Funds Committee **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.	
BoD22/015	**DCH Strategy Implementation Update**	
	PD joined the meeting for this item and advised that the outcome of a recent Internal Audit on the Trust Strategy had been presented to the Risk and Audit Committee the previous day. PD summarised key aspects of the six-monthly strategy update, highlighting: • The development of formal plans to support each of the five Strategy Work Streams'. The Board noted the importance of ensuring that the Quality Improvement Strategy was included within the relevant plans. Additionally, the need for inclusion of patient feedback with plans was noted. • The Board Assurance Framework (BAF) had been discussed at the Risk and Audit Committee the previous day and the approach taken had been endorsed. Updates and changes to risk scores were noted and discussion of the target dates for mitigating actions was being fed into the report. • Productivity was being reviewed by NHS England and was an issue NHSEI was focusing on in the South West especially. The Trust was able to benchmark with peers and this was informing cost improvement planning and review at service level. • Delivery and monitoring would be reviewed bi-monthly by the Senior Leadership Group and the developing dashboard aimed to produce a highlight report outlining performance improvements and benefits realised. The Board noted the need to make social value and environmental sustainability explicit and for additional risks relating to these to be included within the BAF. The plan to implement Service Line Reporting to better engage clinicians had been hampered by the pandemic. Work was planned to resume this work and the Board remitted responsibility for oversight and assurances on this and the in-depth monitoring of productivity to the Finance and Performance Committee.	
	Resolved: that DCH Strategy Implementation Update be noted.	
BoD22/016	**Board Assurance Framework (BAF) and Corporate Risk Register**	
	The Board noted that the BAF had been discussed by the Risk and Audit Committee the previous day. The social value and environmental sustainability risks would be developed further and discussion relating to mitigation action target delivery dates was noted. NL summarised recommendation actions approved by the Risk and Audit Committee relating to the Corporate Risk Register: • The financial risk relating to the previous financial year was	**NL / SA**

	closed. • A new financial risk for the current financial year was opened. • The Health Education Funding risk was closed as funding had been received. • The CoTag risk had been amended. • A new blood bank risk noted remedial mitigations to ensure safe service provision. A further meeting with the Medicines and Healthcare Regulatory Agency (MHRA) was to be held later that week and medium and longer term mitigations were being implemented.	
	Resolved: that the Board Assurance Framework be received and noted.	
BoD22/017	**Well Led Review – Action Plan**	
	NJ introduced the Action Plan which had been developed in response to the PriceWaterouseCoopers (PWC) report on the Trust's Well Led arrangements. Action plan progress would be monitored going forward. MA commented that PWC report had been generally positive about Trust's governance arrangements and had noted the need to refocus on financial matters. He questioned whether the actions with the plan had been sufficiently prioritised given the current pressurised circumstances. Actions would continue to be progressed to the identified timescales and further reflections would be undertaken on the priorities.	
	Resolved: that the Well Led Review Action Plan be approved.	
BoD22/018	**Medical Education Report**	
	MA welcomed PM to his first the meeting noting that PM had taken on the role from Audrey Ryan in February 2022. PM reported that the outcome of a recent General Medical Council survey was expected in July, and that a number of changes made following the previous survey were outlined within the report. A multidisciplinary approach to training across Midwifery and Obstetrics and Gynaecology staff was supporting effective working relationships and the impact of changes following the previous year's survey would be reflected in the current year survey results. PM advised that a new cohort of foundation doctors was due to commence in the near future and noted that this placed pressures on existing staff. The Board noted that a Junior Doctor Lead had not yet been identified and difficulties in recruitment to this role was reflected nationally. There had been an increase in flexible working arrangements and Health Education England trainee funding had been recovered. PM highlighted the Trust's increasing reliance on Locally Employed Doctors and need for parity in access to training, development and supervision.	

	The Board noted the importance of retaining and further developing skilled staff. Aspects of the CESR Academy approach were being taken forward and would be monitored via the People and Culture Committee. AH offered the example that recruits were being supported through the academy approach in critical care and this approach aimed to support recruitment of consultants in the area. A plan was in place to raise awareness amongst Urology staff about how to raise concerns or report incidents in confidence and further work was to be undertaken. The Board noted the report.	**DH**
	Resolved that: the Medical Education Report be received and noted.	
BoD22/019	**Integrated Care Provider Engagement Activity**	
	MA welcomed Sam Crowe (SC), Director of Public Health Dorset, CCG to the meeting. SC advised that the slide pack had been previously circulated and outlined the three ICP workstreams. SC invited discussion of how DCH envisaged its support in providing a sustainable system going forward and encouraged participation in the further development of the ICS Strategy and Joint Needs Assessments. He acknowledged the need to identify a pathway between the immediate pressures faced by organisations and the medium and longer-term strategy aims. AH noted NHS England's recovery focus and the opportunities for secondary care providers to make better use data to manage waiting lists, population health and inequalities. AH cited the management of hypertension in stroke prevention and that better use of data across provider sectors would reduce the life expectancy gap in Dorset. The Board noted the need to ensure that a number of engagement methodologies needed to be adopted in order to promote participation and engagement in the strategy development process, particularly given the current operational pressures and the capacity of staff to be released from clinical obligations. Greater local engagement via links to existing forums was being established and a digital portal was being launched to support engagement. The use of social media channels would also drive engagement. The Board also noted the need for clarity in the use and interpretation of language and terminology as this differed across agencies within the system. Greater focus on child health, whole family health and inequalities would help to improve the longer term health of the population. In consideration of published research, the Board noted the impact of inward migration to the county by people with long term health conditions and the impact this had on healthy life expectancy. The need to address 'front door' issues and support the management of people	

	out of hospital would support greater system resilience. The DCH focus on social value, inequalities and the wider determinants of health was noted. The development of a shared understanding of individual organisational strategies would also support more effective system planning. The Board noted the importance of acute providers understanding their contribution to the prevention agenda in supporting delivery of population health. The provision of quality data to support effective planning and delivery based on need would be essential to this. The need to consider development of the strategy from a 'people' perspective was emphasised and providing end of life care in the home environment was cited an example of best to meet individual needs. The Board noted the need for clinical leadership in productivity discussions and greater integration between organisations and the Integrated Care Board. The Board reiterated its commitment to this. The co-production approach seeking a better understanding of what people needed to stay healthy would be built around communities and addressing the needs of young people would be the transformational piece in promoting population health. SC highlighted the need to ensure that local authorities were integrated into the process and to identify a single joint ambition that all agencies could engage with. The level of engagement with both councils had been positive and they had actively engaged in the process. SC advised that council leaders were alighting on a common vision of wellbeing. There was an opportunity to learn from previous system working arrangements, to honestly challenge these, and to further extend opportunities to promote greater integration with community and primary care providers. The need to develop ownership of the key strategic themes through the engagement of all partners to deliver the necessary health improvement outcomes and address the gaps was noted. SC thanked the Board for their participation and reiterated his invitation for further engagement as the strategy developed. He noted that employee engagement would continue to be a feature of the process going forward.	
	Resolved that: the Integrated Care Provider discussion be noted.	
BoD22/020	**Guardian of Safe Working Hours Report**	
	KM attended to present this item and advised that the report provided assurance that the Trust had fully met its obligations to provide a reporting tool for medical staff to report when they worked above their contracted and to escalate clinical challenges. The most significant challenge was the need to provide ongoing care of medically fit patients not able to be discharged which added pressure on the junior medical team. Trauma and Geriatric Medicine services	

	were particularly challenged in this regard due to the volume of patients experiencing discharge delays. Frailty was an increasing issue as more procedures were being undertaken on the elderly which had not been the case historically. KM highlighted the need to rebuild the frailty service and the ongoing care requirement was outside the remit of specialists. There were mitigations in place to reduce the workload impact and the Board noted the ongoing duty of care requirement to this patient group and the need to ensure doctors were appropriately skilled to provide this. The Board also noted the need to re-establish the Junior Doctors' Forum and work out how best to do this, taking into account the infection controls.	
	Resolved: that the Guardian of Safe Working Hours Report be received and noted.	
BoD22/021	**Freedom to Speak Up Report**	
	JB attended for this item and highlighted the increased focus on 'Speaking Up' and the consequential increase in activity. Building on the foundations established by the outgoing Guardian, the ambition was to address barriers to speaking up and promote the learning from concerns raised. The Board noted Ula Brocklebank's (UB) contribution in establishing the Guardian role and the need to proactively progress to 'listening up'. A successor Guardian would be sought and the Board extended their thanks to UB for her contribution to the role.	
	Resolved that: the Freedom to Speak Up Report be noted.	
BoD22/022	**Questions from the Public**	
	KH commented on the extensive papers and questioned the necessity and meaningfulness for the public. KH updated on recent Press reports outlining the return to pre pandemic visiting arrangements in clinics and on wards and enquired about arrangements within the Trust. Discussion had taken place through the Incident Management Team and with Matrons and the Trust was aware of the psychological impact of reduced visiting on patients. The Trust had implemented changes to visiting arrangements and were taking the opportunity to review visiting and carer attendance arrangements further. KH informed the Board that she had raised £250 for the Greatest Need Appeal and the Board thanked her for her contribution.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions were previously raised by Board members prior to the meeting.	
BoD22/023	**Maternity Safety Update**	

	Resolved that: the Maternity Safety Update be received and noted.	
BoD22/024	**Quarterly Communications Update**	
	Resolved: that the Quarterly Communications Update be received and noted.	
BoD22/025	**Any Other Business**	
	No other business was raised or notified.	
BoD22/026	**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.**	

Action Log – Board of Directors Part 1

Presented on: 27th July 2022

Minute	Item	Action	Owner	Timescale	Outcome	Remove? Y/N
Meeting Dated: 25th May 2022						
BoD22/006	**CEO Update**	A letter of appreciation to be sent on behalf of the Board to Anaesthetic colleagues following the positive review by their Royal college.	**MA / NJ**	July 2022	Complete	Y
		Revitalise messaging around active travel and the availability of supporting schemes to staff	**NJ**	July 2022	Isabel Bourne, Sustainability Manager, is meeting with the Comms team to work on sending an updated message to all staff around active travel and the availability of supporting schemes.	
BoD22/007	**Review of the Previous Year Committee Priorities, this year's Priorities and Work Plans**	A bi-annual stock take of assurances and effectiveness to be undertaken by Non-Executive and Executive colleagues at committees' regularly scheduled meetings and fed back to the Board	**Committee Chairs**	November 2022	Not Due	No
BoD22/015	**DCH Strategy Implementation Update**	Oversight monitoring and assurances in respect of Service Line Reporting implementation remitted to the Finance and Performance Committee	**TH**	June 2022	Added to the Finance and Performance Committee Action Log	Yes
BoD22/016	**Board Assurance Framework (BAF) and Risk**	Further discussion to reframe the social value strategic risk to be had	NL/SA	June 2022		

	Register					
BoD22/018	**Medical Education Report**	Further work to raise awareness amongst Urology services as to how to raise concerns in confidence and report incidents to be taken forward.	**DH**	June 2022		
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 from the education to work setting	~~**PM**~~ **NJ**	~~November 2021~~ January 2022	This is not in the remit of the Deanery as it comes into undergraduate education. Last year there was the option to do extended shadowing, however trainees felt it interfered with their summer holidays. Some medical schools are doing clinical apprenticeships as a model of change which is an option for future review, but at this current time is not something we can easily change. Paul Murray is happy to discuss further if anyone wishes to.	
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	Revised templates review by Executive and Non-Executive teams. To be presented to the Senior Leadership Group in July for roll out implementation in August / September	Yes
Actions from Committees…(Include Date)						

Meeting Title:	Board of Directors
Date of Meeting:	27 July 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	20/07/2022	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: • On 07 July, due to a 34% increase in patients being admitted to hospital with COVID-19, all providers were advised to review their mask wearing guidance with a view to moving back towards universal mask wearing for staff and other measures to minimise the spread of COVID-19. • On 01 June 2022, following increased reported cases, the UK Health Security Agency (UKHSA) advised that there was a current outbreak of monkeypox cases in the UK. However, as from 05 July 2022, the current specific outbreak clade of monkeypox in the UK was no longer be designated as a High Consequence Infectious Disease (HCID). • Following the Royal College of Nursing's (RCN) report on structural racism in the NHS they are asking the UK government to seize the opportunity of its planned reform of human rights legislation so that health and care organisations, regulatory bodies and inspectorates are required to tackle racism, including in the workplace. • On 28 June the Government published the final terms of reference for the COVID-19 Public Inquiry. The inquiry will play a key role in learning the lessons from the pandemic and informing the Government's preparations for the future. • On 01 July 2022 the Integrated Care Board's (ICB) became legal entities. They will undertake the statutory responsibilities of the Clinical Commissioning Group (CCG). • On 01 July 2022 Sir David Sloman, Chief Operating Officer for NHS England, launched a '100-day challenge' to deliver against the 10 best practice initiatives to improve flow and should be implemented in every Trust and System to improve discharge. • On 05 July 2022 Sajid Javid, Secretary for Health & Social Care, announced that he was stepping down from the role. Steve Barclay has been appointed to the role.							
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 – July 2022

National Perspective

COVID-19 Updates
The NHS declared a Level 4 (National) Incident on 13 December 2021 to help prepare for the predicted surge in Omicron cases and to deliver the COVID-19 vaccine booster national mission. On 20 May, due to community cases and hospital inpatient COVID-19 numbers seeing a sustained decline, the incident was reclassified from a Level 4 (National) to a Level 3 (Regional) Incident.

Trusts reviewed their IPC and mask wearing guidance and started to reduce the number of areas mask wearing was required. However, 11,500 new patients were admitted to hospital with COVID-19 in the seven days to 5 July, up 34% on the week before, and slightly more people on ventilators it means that pressure on beds and staff is mounting again. Therefore, on 07 July all providers were advised to review their mask wearing guidance with a view to moving back towards universal mask wearing for staff and other measures to minimise the spread of COVID-19.

Nottingham University Hospitals Maternity Review
On 26 May 2022 NHS England has confirmed that Donna Ockenden has been appointed as Chair of the new independent review into maternity services at Nottingham University Hospitals NHS Trust. The current review team will publish their interim findings outlining areas for improvement. NHS England will make sure these improvements are made immediately in the Trust and will work on new terms of reference with Donna Ockenden so her work can begin as soon as possible.

Royal College of Emergency Medicine – Beds in the NHS Report
On 31 May the RCEM published their report detailing that since 2010/2011 the NHS has lost almost 25,000 beds across the United Kingdom, and since then the health service and its staff have faced accumulating pressures resulting in a sharp increase in long-waiting times, ambulance handover delays, delayed ambulance response times, cancelled elective care operations, and unsafe bed occupancy levels. This has also had severe consequences on mental health care provision.

It stated that the current crisis is both a patient safety crisis and a workforce crisis. The fall in bed numbers and deteriorating metrics have a real terms impact on patient care. Saffron Cordery, Interim Chief Executive of NHS Providers, said that there is an urgent need to bolster capacity across the health and care system. We need more beds, not just in hospitals, but in mental health and community services too. Any expansion in capacity must be matched by more staff to look after more patients.

Monkeypox
On 01 June 2022, following increased reported cases, the UK Health Security Agency (UKHSA) advised that there was a current outbreak of monkeypox cases in the UK. Monkeypox is a rare viral infection that does not spread easily between people, but it can be passed on through close person-to-person contact or contact with items used by a person who has monkeypox. It is usually a mild self-limiting illness, and most people recover within a few weeks. However, severe illness can occur in some individuals. In line with UKHSA guidance, confirmed cases as well as close contacts who have been assessed as high or medium risk are eligible to receive a post exposure vaccination.

On 06 July 2022 Stephen Groves, Director of Emergency Preparedness, Resilience and Response for NHS England, wrote to Trusts to confirm that as from 05 July 2022, the current specific outbreak clade of monkeypox in the UK will no longer be designated as a High Consequence Infectious Disease (HCID).

Royal College of Nursing Report on Structural Racism in the NHS
On 08 June 2022 the Royal College of Nursing (RCN) published a report on structural racism in the NHS. The UK wide survey of almost 10,000 nursing staff found that white respondents and those of mixed ethnic background across all age groups were more likely than black and Asian colleagues to have received at least one promotion since starting their nursing career. The RCN are asking the UK government to seize the opportunity of its planned reform of human rights legislation so that health and

care organisations, regulatory bodies and inspectorates are required to tackle racism, including in the workplace.

NHS Oversight Framework 2022/23
On 27 June 2022 NHS England released the NHS Oversight Framework for 2022/23 which described NHS England and NHS Improvement's approach to oversight of Integrated Care Boards (ICBs) and Trusts. Ongoing oversight will focus on the delivery of the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan and the NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs.

To achieve this, the NHS Oversight Framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across Trusts and ICBs:
- Quality of care, access and outcomes
- Preventing ill-health and reducing inequalities
- People
- Finance and use of resources
- Leadership and capability

UK COVID-19 Inquiry – Terms of Reference
On 28 June the Government published the final terms of reference for the COVID-19 Public Inquiry. Publication of the terms of reference follows a full and extensive public consultation process led by the inquiry's independent Chair Baroness Hallett. Boris Johnson accepted Baroness Hallett's recommendations in full, along with a small number of refinements put forward by the devolved administrations. The inquiry will play a key role in learning the lessons from the pandemic and informing the Government's preparations for the future.

The terms of reference covers:
- preparedness
- the public health response
- the response in the health and care sector
- our economic response

Acute Hospital Discharge '100-Day Challenge'
On 01 July 2022 Sir David Sloman, Chief Operating Officer for NHS England, launched a '100-day challenge' to deliver against the 10 best practice initiatives that have been identified that demonstrably improve flow and should be implemented in every Trust and System to improve discharge.

The aim of the 100-day challenge is to improve the current position around discharge and ensure that Trusts are in the best possible position ahead of winter. By 30 September 2022, 100 days on from the 'soft launch' event on 23 June 2022, all Trusts and Systems have been asked:
- A full understanding of the 10 interventions and the associated tiered support offer available from NHS England to assist with implementation
- Infrastructure in place to focus on the implementation of the 10 initiatives.

The 100-day challenge will lead to recommendations for the ongoing improvement, support and monitoring that Systems may need around discharge going forwards.

Secretary of State for Health and Social Care
On 05 July 2022 Sajid Javid, Secretary for Health & Social Care, announced that he was stepping down from the role. He has been in post since 26 June 2021. It has been announced that Steve Barclay, previously appointed Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office, has been appointed to the role.

The George Cross Presentation Honouring NHS Staff
On 12 July 2022 Amanda Pritchard, NHS Chief Executive, was joined by May Parsons, the Nurse who delivered the world's first COVID-19 vaccination outside a clinical trial, along with Chief Executives of the NHS in Scotland, Wales and Northern Ireland, and colleagues representing the NHS front line to

receive the George Cross on behalf of the incredible 1.5 million NHS colleagues. The award was presented at Windsor Castle by Her Majesty The Queen, accompanied by His Royal Highness The Prince of Wales.

The George Cross, the highest civilian award for gallantry, recognises the incredible dedication, courage, compassion and skill shown by NHS staff – from nurses and doctors to porters, cleaners, therapists and countless other roles – over more than seven decades, particularly in the face of the COVID-19 pandemic.

Local Relevance

NHS Dorset – Chief Nursing Officer
On 30 June 2022 NHS Dorset announced the final Board appointment. Debbie Simmons will be joining the ICB as Chief Nursing Officer from Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System. Debbie is expected to commence in post in September. Vanessa Read will continue to cover the role on an interim basis.

NHS Dorset Live
On 01 July 2022 NHS Dorset, the Integrated Care Board (ICB) for Dorset, became a legal entity. NHS Dorset will undertake the statutory responsibilities of the Clinical Commissioning Group (CCG) and will also be responsible for planning to meet the health care needs of people and communities in Dorset.

Jenni Douglas-Todd, Chair, and Patricia Miller OBE, Chief Executive, are also joined by:

- Rob Morgan, Chief Finance Officer
- Dawn Harvey, Chief People Officer
- Dr Paul Johnson, Chief Medical Officer
- David Freeman, Chief Commissioning Officer
- Stephen Slough, Chief Digital Information Officer
- Debbie Simmons, Chief Nursing Officer
- Neil Bacon, Chief Strategy & Transformation Officer
- Dr Dean Spencer, Chief Operating Officer

Exploring greater collaboration between Dorset County Hospital and Dorset HealthCare
On 22 June 2022 it was announced that the Board of Directors for Dorset County Hospital and Dorset HealthCare have agreed to explore the option of a Joint Chair and Joint Chief Executive and consider whether joint senior leadership of the two organisations could strengthen this collaboration and benefit local people. Closer collaboration, enabled by a Joint Chair and Joint CEO, could help integrate pathways between secondary and community care, increase parity between physical and mental health and enable better deployment of resources so people are in the right place at the right time.

The Joint Chair and Joint CEO would provide strategic direction and leadership over the two organisations, enabling even closer collaboration to improve the way we deliver care for patients in Dorset. The proposal does not include any plans, nor is it the intention, to change the way the organisations are structured or to merge. The two Boards would be retained under this proposal, ensuring we do not lose sight of key agendas across the acute, community and mental health sectors. It is also important to recognise that this does not mean we will not, or won't be able to, work closely with our valued system partners and on system wide initiatives - rather, the proposal helps DCH and DHC work better together to work better with the System.

This model, and close variations of it, have been implemented successfully in other parts of the country. Further work is taking place to explore the potential of this proposal prior to both the DCH and DHC Boards making separate decisions at the end of July to proceed or not.

System Pressures
On 30 June 2022, the System moved into escalation level 4 (OPEL 4) due to an increasing trend of patients not meeting the clinical criteria to reside in both acute and community hospitals leading to impact on Emergency Departments resulting in deteriorating waiting times, 12-hour breaches, and ambulance handover delays. In addition, there are pressures within Mental Health and a lack of access to capacity in the community. The increase in COVID cases also has a role to play with increased patients in hospital beds and increased staff absences. Executive escalation calls are taking place to oversee the development and delivery of a de-escalation plan and the Strategic Resilience Group are scheduled to manage the de-escalation and provide senior leadership, direction, and support at operational level.

A letter was sent to the Regional Director, Elizabeth O'Mahoney on 01 July 2022 to notify her of the situation. Following a system wide review of current and predicted data surrounding COVID along with the increasing numbers of staff and patient illness, mask wearing has been reintroduced across all NHS organisations, including within communal areas of Vespasian House and Canford House.

SWAST Chairman
Tony Fox stepped down from his role as chairman of Southern Western Ambulance Service NHS Foundation Trust in May after almost 10 years as a non-executive director and five years as chairman. The Council of Governors appointed Gail Bragg as interim Chair whilst a recruitment process for the long-term position takes place over the coming months.

UHD Chair Appointment
Rob Whiteman, CBE was appointed as the new Chair of University Hospitals Dorset NHS Foundation Trust and commenced on 01 July 2022, replacing David Moss who retired earlier this year. Rob has been Chief Executive of the Chartered Institute of Public Finance and Accountancy for the last eight years and has held many other executive and non-executive roles. Rob brings significant experience of working with the NHS from his time as Chair of North East London Sustainability and Transformation Programme (STP) and as a non-executive director and Chair of audit at Whittington Health NHS Trust and Barking, Havering, and Redbridge University Hospitals NHS Trust

Ambulance Response Times
Nationally there is increased focus on ambulance response times. There are two key performance indicators for ambulance response times. Category 1 calls are where an ambulance is responding to an immediate life-threatening condition, such as cardiac or respiratory arrest. Category 1 calls should be responded to within 7 minutes. Category 2 calls are a serious condition such as stroke or chest pain, which may require rapid assessment and/or urgent transport, should be responded to within 18 minutes.

In June, the mean response time for Category 1 calls in Dorset was 10 minutes, against the 7-minute target. For Category 2, the mean response time in Dorset was 56 minutes, against the 18-minute target. Neither of the standards were achieved for any day in the reporting month of June.

NHS, Social Care and Frontline Workers' Day
On 05 July 2022 it was NHS, Social Care and Frontline Workers' Day, and the 74th birthday of the NHS. Some staff members from DCH attended a ceremony at County Hall in Dorchester with Dorset Council Chairman and Cllr Val Pothecary to say thank you to everyone who works in these areas to keep people safe and remember all those who lost their lives during the coronavirus pandemic. It was great to see frontline health and care workers recognised in this way.

DCH Performance

Impact of 'no reason to reside' (NRTR) Patients
DCH continues to experience significant issues with being able to safely discharge patients who are ready to go home but need some social care support in place before they can leave. NRTR status have increased by almost 400% in the past 2 years.

This results in limited flow of patients which results in theatre cancellations and has an impact at the front door of the Emergency Department, with ambulances unable to hand over their patients in a timely way. As well as the impact on patient care and safety, the Trust faces a significant extra financial cost. Based on the average cost of a ward and current number of NRTR patients, this equates to a cost of around £5.2 million.

Operating Plan for 2022/23
Nationally, Trusts are expected to deliver 104% of the elective activity they delivered in 2019/20 and ensure that they have no patients waiting over 104 weeks for treatment by the end of June, and no-one waiting over 78 weeks by the end of March 2023. Financially Trusts are expected to deliver cost improvements while also sticking to their budgets.

The national priority areas for the operating plan 2022/23 are:

- Investing in workforce and strengthening a compassionate and inclusive culture
- Respond to Covid 19- vaccination programme and meeting the needs of patients with Covid19
- Tackling the elective care backlog- reducing long waits and improve cancer waiting times
- Improve responsiveness of UEC and build community capacity
- Improve timely access to primary care
- Improve mental health services and services for people with a learning disability and/or autism
- Develop approach to PHM, prevent ill health and reduce health inequalities
- Exploit potential of digital technologies
- Make effective use of resources
- Establish ICBs and collaborative system working

The operational plan 2022/23 for DCH has been agreed. We are required to deliver 2.5%, or £5.7million, of cost improvements and currently have identified £2.8million. DCH are also required to deliver a target of no 104 week waits from August 2022, no 78 weeks by end March 2023, significant reduction in 52 weeks by March 2023 and total waiting list will remain static in year.

For the month of June 2022, DCH have delivered a surplus position of £1.837 million, against a planned surplus of £2.324 million, being £0.487 million away from plan. This adverse position is predominantly the result of undelivered efficiencies against plan (£0.641 million), an increase in high-cost agency spend (£0.703 million), additional medical sessions across urology, anaesthetics, gastroenterology and dermatology (£0.200 million), and further increases to inflation for utilities, and an increase in consumables (£0.193 million).

Efficiencies of 2.5% (£5.7 million) must be delivered this financial year in order for DCH to reach the planned break even position, with currently 59% of this full year target identified. £0.433 million of efficiencies have been delivered year to date against a plan of £1.074 million. Urgent plans to accelerate both delivery and further identification are underway, supported by our Transformation Team.

Elective activity performance at DCH is not achieving the national 104% target but is performing well in comparison to both the national and regional average. Nationally, 85%, or 2019/20 activity levels are being delivered, DCH achieved 93.25% in June and 104.28% of clock stops. As a result, the number of patients waiting over 78 and 104 weeks continues to decline and while not at the rate set out in the planning guidance, it is at a sustainable rate.

Cancer performance is being impacted by high referral volumes. While the 62 and 104 day backlog/backstop position remains good, this will increase in the coming months as the impact of the delays at the front of the pathway move through to treatment. Diagnostic waiting list size is an area of concern, with increase demand and staff shortages due to on-going sickness issues relating to COVID. Insourcing options are now being considered for the imaging department.

DCH are providing mutual aid support in Orthodontics for University Hospitals Dorset (UHD). This includes treating patients waiting over 104+ weeks at DCH, providing supervision in the absence of a consultant at UHD and seeing and treating all urgent patients. DCH are also taking a handful of general

surgery patients from the Devon system, for day surgery procedures where we have capacity, to support the wider Region.

Cygnet Homebirth Team Anniversary
On 20 June 2022 Dorset County Hospital's Cygnet Homebirth Team celebrated seven years of success. The team launched in June 2015 and has gone from strength to strength, seeing homebirths in the county soar from 2.3% of the total births to a consistent 8-10% and becoming one of the highest homebirth rates in the country. In 2019, the team received national recognition, winning the Royal College of Midwives Homebirth Team of the Year Award. To celebrate their seventh year, the team returned to where they first launched, Abbotsbury Swannery, inviting families they had supported over the years to join them for an afternoon tea in the sunshine.

Ward Accreditation
In June two more wards completed the Ward Accreditation Programme. The programme offers a framework for clinical teams to demonstrate the quality of care and leadership on the ward. The panel visited the Wards and following consideration of the evidence and presentation the panel were delighted to award Ridgeway Ward a 'GOLD' award and Prince of Wales Ward a 'SILVER' award.

Staff Car Parking Charges
On 23 June we announced an update on staff car parking charges. The Government ended the subsidy for free staff car parking at the end of March - however, we committed to retaining free parking for as long as possible. With the opening of the new car park and our financial position coming under increasing scrutiny it was agreed that we can no longer hold off reintroducing charges.

It was agreed that from 18 July 2022 all staff would need to pay a flat rate of £2 a day, a reduction from the previous £2.50 a day, to park on the hospital site, with an aim to introduce a progressive tiered charging regime aligned to pay scales from September 2022. We have also opted for a system where you pay only for the days when you park on site rather than a monthly 'pay for permit' system.

Unfortunately, due to technical issues, the online Staff Parking Portal where staff are required to enter their details in order to park on site is not available yet, so we have had to delay the opening of the new car park and the reintroduction of staff charges. We are keeping staff updated and ensuring we give them as much notice as possible to enter their details onto the portal and on when parking charges will be reintroduced.

Chief Financial Officer
On 27 June we formally appointed a new Chief Financial Officer, Chris Hearn from Dorset HealthCare, who will be starting with us at the beginning of October.

Chief Nursing Officer
On 01 July 2022 it was announced that our Chief Nursing Officer and Interim Deputy Chief Executive, Nicky Lucey, is leaving DCH to take up the role of Chief Nursing Officer at the newly formed Hampshire and Isle of Wight Integrated Care Board in the autumn. Nicky has been instrumental in maintaining our focus on quality and driving improvements and will be greatly missed at DCH. The process for a replacement will be started shortly.

Rising Stars of 2022 Award – IBS STARS
Congratulations to our Lead Inflammatory Bowel Disease (IBD) Nurse Abby Oglesby who recently received IBD STARS' Rising Stars of 2022 Award! Since being in post, Abby has introduced many service changes to assist the specialist nursing team and improve the rapid diagnoses, management and outcomes for our patients.

Volunteer Summer Tea Party
On 14 July 2022 we were delighted to be able to hold our Volunteer Summer Tea Party to celebrate the incredible and unwavering dedication of our army of volunteers at Team DCH! Volunteers were joined by our Chairman, Mark Addison, and Chief Nursing Officer, Nicky Lucey, to enjoy an afternoon tea at Sunninghill Prep School. The afternoon was filled with lots of fun and games, including a crown making

competition to tie in with the recent celebration of the Queen's Platinum Jubilee. We also held a presentation to recognise those who have completed 3, 5, 10, 15, 20 and 25 years volunteer service at DCH.

Nick Johnson
Interim Chief Executive
20 July 2022

Meeting Title:	**Board of Directors Part One**
Date of Meeting:	**27th July 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)	18th July 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 June 2022 continued to experience patient flow restrictions but an improvement in the no reason to reside patient numbers has resulted in a slight improvement against the 4-hour standard. Ambulance handover delays improved slightly, but remain at high levels, putting pressure on the ambulance response times. Elective activity performance is not achieving the national 104% target but is performing well in comparison to both the national and regional average. Nationally, 85%, or 2019/20 activity levels are being delivered, DCH achieved 93.25% in June and 104.28% of clock stops. As a result, the number of patients waiting over 78 and 104 weeks continues to decline and while not at the rate set out in the planning guidance, it is at a sustainable rate. Cancer performance is being impacted by high referral volumes. While the 62 and 104 day backlog/backstop position remains good, this will increase in the coming months as the impact of the delays at the front of the pathway move through to treatment. Diagnostic waiting list size is an area of concern, with increase demand and staff shortages due to on-going sickness issues relating to COVID. Insourcing options are now being considered for the imaging department. **Escalation Reports** The July Board sub-committees met as follows: Monday 18th July: Finance and Performance Committee and People and Culture Committee Tuesday 19th July: Quality Committee and 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	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Q1	Movement on Previous Period	12 Month Trend
Safe										
Infection Control - MRSA bacteraemia hospital acquired post 48hrs (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	↔	
Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**46**	**4 (0.4)**	**3 (0.2)**	**4 (0.4)**	2 (0.2)	2 (0.2)	**5 (0.6)**	9 (0.3)	↓	
Never Events	**0**	0	0	0	0	0	0	0	↔	
Serious Incidents investigated and confirmed avoidable	**N/A**	0	0	1	0	0	1	1	**N/A**	
Duty of Candour - Cases completed	**N/A**	5	3	4	4	9	10	23	**N/A**	
Duty of Candour - Investigations completed with exceptions to meet compliance	**N/A**	0	1	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)**	**2**	0	**4**	**2**	0	**2**	4	↓	
Number of falls resulting in fracture or severe harm or death (Rate per 1000 bed days)	**0**	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	**1 (0.1)**	1 (0.0)	↓	
Pressure Ulcers - Hospital acquired (category 3) confirmed reportable (Rate per 1000 bed days)	**N/A**	1 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.2)	2 (0.1)	↓	
Emergency caesarean section rate		23.1%	21.7%	19.3%	15.1%	31.3%	20.6%	22.8%	↑	
Sepsis Screening - percentage of patients who met the criteria of the local protocol and were screened for sepsis (**ED**)	**90%**	N/A	N/A	N/A	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%**	100%	**82.4%**	92.3%	**88.9%**	100%	N/A	93.5%	↑	
Sepsis Screening - percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour (**ED**)	**90%**	N/A	N/A	N/A	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%**	100%	**81.3%**	91.7%	**88.2%**	100%	N/A	93.3%	↑	
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')**	2	2	N/A	N/A	N/A	N/A	N/A	**N/A**	**N/A**
SHMI Value (deaths in-hospital and within 30 days post discharge) - Rolling 12 months [source NHSD]	**≤1.12 (ratio between observed deaths and expected deaths)**	1.11	1.11	N/A	N/A	N/A	N/A	N/A	**N/A**	
Mortality Indicator **HSMR** from Dr Foster - Rolling 12 months	**100**	**105.2**	**109.5**	**110.6**	N/A	N/A	N/A	N/A	**N/A**	
Mortality Indicator **Weekend Non-Elective HSMR** from Dr Foster - Rolling 12 months	**100**	**119.2**	**122.0**	**123.1**	N/A	N/A	N/A	N/A	**N/A**	
Stroke - Overall SSNAP score	**C or above**	B			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%**	**83.4%**	**82.0%**	94.8%	75.7%	93.7%	95.0%	88.4%	↑	
Dementia Screening - proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	99.8%	↓	
Dementia Screening - proportion of those with a diagnostic assessment where the outcome was positive or inconclusive who are referred on to specialist services	**90%**	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Caring										
Compliance with requirements regarding access to healthcare for people with a learning disability	**Compliant**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	↔	
Complaints - Number of formal & complex complaints	**N/A**	24	29	35	28	42	27	97	↑	
Complaints - Percentage response timescale met	**N/A**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	↔	
Friends and Family - Inpatient - Recommend	**96%**	**93.6%**	**91.6%**	**92.2%**	**93.1%**	**91.7%**	**92.5%**	**92.4%**	↑	
Friends and Family - Emergency Department - Recommend	**84%**	87.4%	80.4%	82.9%	**82.8%**	**80.5%**	**82.3%**	**81.8%**	↑	
Friends and Family - Outpatients - Recommend	**94%**	94.6%	**93.0%**	94.1%	**93.4%**	**93.1%**	**93.5%**	**93.3%**	↑	

Metric	Threshold/ Standard	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Q1	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%**	**55.8%**	**56.8%**	**58.4%**	**58.1%**	**60.0%**	**59.2%**	**59.2%**	↓	
RTT Incomplete Pathway Waiting List size	**17,603**	16727	17128	17195	**17535**	**17602**	**17751**	**17751**	↓	
Cancer (ALL) - 14 day from urgent gp referral to first seen	**93%**	**52.5%**	**71.0%**	**53.6%**	**51.5%**	**68.3%**	**66.4%**	**62.1%**	↓	
Cancer (Breast Symptoms) - 14 day from gp referral to first seen	**93%**	**65.2%**	**88.7%**	94.1%	**81.5%**	93.1%	**92.3%**	**88.6%**	↓	
Cancer (ALL) - 28 day faster diagnosis standard	**75%**	**66.7%**	75.0%	**73.0%**	**71.1%**	**74.2%**	**73.0%**	**72.8%**	↓	**N/A**
Cancer (ALL) - 31 day diagnosis to first treatment	**96%**	97.1%	97.3%	97.6%	97.4%	97.9%	99.1%	98.1%	↑	
Cancer (ALL) - 31 day DTT for subsequent treatment - Surgery	**94%**	100.0%	**83.3%**	**88.9%**	**88.9%**	100.0%	100.0%	94.4%	↔	
Cancer (ALL) - 31 day DTT for subsequent treatment - Anti-cancer drug regimen	**98%**	**97.5%**	100.0%	**97.2%**	**77.4%**	**96.2%**	**95.0%**	**85.2%**	↓	
Cancer (ALL) - 31 day DTT for subsequent treatment - Other Palliative	**98%**	-	-	-	-	-	-	-	↔	
Cancer (ALL) - 62 day referral to treatment following an urgent referral from GP (post)	**85%**	**58.3%**	**62.0%**	**81.9%**	**70.7%**	**70.8%**	**76.4%**	**72.6%**	↑	
Cancer (ALL) - 62 day referral to treatment following a referral from screening service (post)	**90%**	**61.3%**	**71.4%**	**81.3%**	**62.5%**	**60.7%**	**50.0%**	**58.0%**	↓	
% patients waiting less than 6 weeks for a diagnostic test	**99%**	**82.9%**	**89.5%**	**84.3%**	**77.3%**	**77.1%**	**76.6%**	**77.3%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge	**95%**	**59.8%**	**54.4%**	**54.2%**	**54.4%**	**53.1%**	**52.5%**	**54.4%**	↓	
ED - Maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**69.6%**	**64.7%**	**65.6%**	**67.4%**	**67.8%**	**68.8%**	**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	N/A
Sickness rate (one month in arrears)	**3.3%**	**4.79%**	**4.36%**	**6.10%**	**5.28%**	**4.2%**	N/A	**5.28%**	↑	
Appraisal rate	**90%**	**67%**	**67%**	**66%**	**65%**	**64%**	**63%**	**65%**	↓	
Staff Turnover Rate	**8 -12%**	9.0%	9.7%	10.5%	11.4%	11.28%	11.7%	10.7%	↑	
Total Substantive Workforce Capacity		2,881.6	2,908.1	2,922.3	2,916.8	2,877.9	2,878.7	2,897.4	**N/A**	
Vacancy Rate (substantive)	**<5%**	**6.8%**	**6.6%**	**6.3%**	**6.8%**	**7.2%**	**8.5%**	**7.4%**	↓	
Total Substantive Workforce Pay Cost		**11,497.0**	**12,246.0**	**18,886.6**	**12,382.5**	**12,186.7**	**12,228.5**	**12,284.6**	↓	
Number of formal concerns raised under the Whistleblowing Policy in month	**N/A**	0	0	0	0	0		0	**N/A**	
Essential Skill Rate	**90%**	91%	91%	90%	91%	91%	89%	90%	↓	
Elective levels of contracted activity (activity)	**2019/20 = 30,584 2548/month**	**2,312**	**1,993**	**2,409**	**2,153**	**2,633**	**2,377**	**7,163**	↓	
Elective levels of contracted activity (£) Including MFF	**2019/20 = £30,721,866 £2,560,155/month**	**£2,214,088**	**£2,074,581**	**£2,414,961**	**£2,369,964**	**£2,821,551**	**£2,629,467**	**£7,820,982**	↓	
Surplus/(deficit) (year to date)	**2022/23 = £(0) YTD M3 = £(695)**	**(340)**	(125)	**(402)**	**(1,678)**	**(4,309)**	**(1,737)**	**(1,737)**	**N/A**	**N/A**
Cash Balance	**2022/23 - M3 = 16,684**	16,807	27,061	25,951	23,665	20,522	22,052	22,052	↑	
CIP - year to date (aggressive cost reduction plans)	**2022/23 target - £(5,744) M3 target £(1,074)k**	Yet to be decided	Yet to be decided	Yet to be decided	**(49)**	**(77)**	**(433)**	**(433)**	**N/A**	**N/A**
Agency spend YTD	**2022/23 = £11,000 YTD M3 = £2,751**	**9,995**	**10,959**	**12,086**	853	**2,168**	**3,454**	**3,454**	**N/A**	**N/A**
Agency % of pay expenditure		**7.6%**	**7.6%**	**7.3%**	**6.2%**	**7.7%**	**8.2%**	**8.2%**	↓	

Movement Key

Favourable Movement	↑
Adverse Movement	↓
No Movement	↔

Achieving Standard
Not Achieving Standard

Key Performance Metrics Summary

	Metric	Standard	May-22	Jun-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)	**43**	**4 (0.4)**	1 (0.1)
	Infection Control - C-Diff Hospital Onset Healthcare Associated (Rate per 1000 bed days)	**46**	2 (0.2)	**5 (0.6)**
	Never Events	**0**	0	0
	Serious Incidents declared on STEIS (confirmed)		0	2
	SHMI - Rolling 12 months (Mar-21 to Feb-22)	**<1.12**	1.11	
	Mortality Indicator HSMR from Dr Foster - Rolling 12 months (Apr-21 to Mar-22)	**100**	**110.6**	
Performance	RTT incomplete pathways within 18 weeks (Quarter/Year = Lowest 'in month' position)	**92%**	**60.0%**	**59.2%**
	RTT Incomplete Pathway Waiting List size	**17,603**	**17,602**	**17,751**
	All cancers maximum 62 day wait for first treatment from urgent GP referral	**85%**	**70.8%**	**76.4%**
	Maximum 6 week wait for diagnostic tests	**99%**	**77.1%**	**76.6%**
	ED maximum waiting time of 4 hours from arrival to admission/transfer/ discharge (Including MIU/UCC activity from November 2016)	**95%**	**67.8%**	**68.8%**
Finance	Elective levels of contracted activity (£)	**2019/20 = £30,721,866 £2,560,155/month**	**2,821,551**	**2,629,467**
	Surplus/(deficit) (year to date)	**2022/23 = £(0) YTD M3 = £(695)**	**(4,309)**	**(1,737)**
	CIP - year to date (aggressive cost reduction plans)	**2022/23 target - £(5,744) M3 target £(1,074)k**	**(77)**	**(433)**
	Agency spend YTD	**2022/23 = £11,000 YTD M3 = £2,751**	**2,168**	**3,454**

Rating Key

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Executive / Committee: Finance and Performance Committee

Date of Meeting: Monday 20 June 2022

Presented by: Stephen Tilton

Significant risks / issues for escalation to Committee / Board for action	• Significant reduction in finance performance during May • Lack of delivery against the Cost Improvement Plan • Increase in agency spend, noting that this was 9% of the total pay spend in May • CEDL update regarding the multi storey car park spend, noting that the region and system partners had been kept informed of the situation • An increase in COVID cases in the community and in variants of concern • Concerns relating to patient flow • Good improvement in 52 week waiters but not for 78 and 104 week waits
Key issues / matters discussed at the Committee	• Finance Report and Multi Storey Car Park CDEL update • Operational Plan update, following the presented to the extraordinary Board meeting on 15 June 2022 • Performance Report and COVID 19 Update • Divisional Exception Reporting, including the ambulance handover action plan
Decisions made by the Committee	• Approval of CareFlow Medicines Management Stock Control (PSC) and Electronic Prescribing and Medicines Administration (EPMA) Maintenance Costs but noting that the related revenue and capital costs would be taken to the Senior Leadership Group for approval • Approval of the Finance Sub-Group Terms of Reference noting the amendments requested by the committee
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Risks relating to the challenging targets in the Operating Plan were discussed • Risks relating to the CEDL position in relation to the multi storey car park were discussed
Items / issues for referral to other Committees	• It was noted that monitoring of the delivery of the Cost Improvement Programme should be triangulated between Finance and Performance Committee (performance and financial issues) and Quality Committee (quality issues) via the divisional reports. • The pharmacy staffing position to be escalated to Quality Committee for consideration of the quality issues. The situation is also being discussed by the People and Culture Committee.

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 20th June 2022

Presented by: Margaret Blankson

Significant risks / issues for escalation to Board for action	• High sickness levels and the impact on agency expenditure, in light of the Trust's financial position • Leavers and Retention Report, focusing on a review of fixed-term contracts and high level of HCA leavers

Key issues / other matters discussed by the Committee	The committee received, discussed, and noted the following reports:
	• People Performance Report and Dashboard noting continued high sickness levels and high levels of agency spend
	• Family Services and Surgical Division Escalation Report noting
	  ○ Increased turnover, 33% of which is from the Nursing staff group
	  ○ Reiterating high agency spend
	  ○ Additional report highlighting the highest risks in the service and the mitigations of those risks
	• Leavers and Retention Report
	• Just and Learning Culture Update
	• Apprenticeships and Widening Participation Report
	• Education, Training and Development Report
	• Escalation Reports from the following subgroups:
	  ○ Nil received

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

Escalation Report

Executive / Committee: People and Culture Committee

Date of Meeting: 18th July 2022

Presented by: Judy Gillow

Significant risks / issues for escalation to Board for action	• Staff are reporting an increasingly pressured environment both from patients and families and performance pressures, reflecting a national trend. • Clinical Coding challenges and potential impact on SHMI • The Equality, Diversity and Inclusion Report is recommended to the Board. • The Medical Revalidation Report is recommended to the Board in order that the Statement of Compliance can be signed.

Key issues / other matters discussed by the Committee	The committee received, discussed, and noted the following reports:
	• People Performance Report and Dashboard noting decreased sickness levels in month 2 although this had increased again due to COVID and anxiety, stress and depression. A reduction in appraisal compliance and an increase staff reporting an increasingly pressured environment both from patients and families and performance pressures, reflecting a national trend.
	• Urgent and Integrated Care Division Escalation Report noting
	  ○ Improvements in appraisal compliance
	  ○ Staffing challenges within the Occupational Therapy and Pharmacy services
	• Digital Services Escalation Report noting
	  ○ Challenges to delivery of strategic objectives
	  ○ Interim Chief Information Officer arrangements
	  ○ Clinical Coding challenges and potential impact on SHMI
	• Bank and Agency Usage Report noting that this is an issue across the southwest.
	• Board Assurance Framework noting further work to correlate with milestones within the People Plan.
	• Workforce Planning update.
	• Equality Diversity and Inclusion Report.
	• Medical Revalidation Report.
	• Escalation Reports from the following subgroups:
	  ○ People Recovery Steering Group and a review of the onsite Counselling service.

Decisions made by the Committee	• The Equality Diversity and Inclusion Report was approved and recommended to the Board noting that the latest WRES and WDES Data would be presented to the Board in August prior to publication
Implications for the Corporate Risk Register or the	• The Workforce Risk Report was considered noting the increase in bullying and harassment incidents.

Board Assurance Framework (BAF)	
Items / issues for referral to other Committees	• The outcome of the onsite Counselling service review will be presented to the Senior Leadership Group in August.

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Escalation Report

Committee: Quality Committee

Date of Meeting: 21st June 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Work being undertaken across the Trust, following a deep dive into C.Diff rates • Most recent SHMI within normal range • Scrutiny provided to the Maternity Safety Report • Continued scrutiny of the work with the Blood Sciences team • Annual Complaints and Safeguarding reports received • Positive approach to clinical audits being developed by the divisions

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ SHMI within expected range and positive data on falls
	  ○ Challenges included pressure ulcers and a dip in Family and Friends test and patient experience in the Emergency Department
	  ○ C.Diff deep dive presentation
	• Maternity Safety Report noting
	  ○ Improved staff sickness and staffing on SCBU
	  ○ Two new RCAs and two new complaints
	  ○ Improved compliance with K2 training
	• Research MOU
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division including Blood Science MHRA Response Plan
	  ○ Family and Surgical Services Division
	  ○ Both Divisions Harm review process reviewed
	• Divisional Clinical Audit Plans and Bi-Annual Report
	• Safeguarding Children and Adults Annual Report
	• Paediatric Diabetes Peer Review Update
	• Complaints Annual Report
	• Escalation Reports from
	  ○ Clinical Safety Group
	  ○ Infection Prevention and Control Group

Decisions made by the Committee	• Research MOU supported with query on the ongoing need for this
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Supply chain issues including epidurals equipment
Items / issues for referral to other Committees	• Nil new to note

Escalation Report

Committee: Quality Committee

Date of Meeting: 19th July 2022

Presented by: Judy Gillow / Nicky Lucey

Significant risks / issues for escalation to Board for action	• Potential impact on SHMI of coding issues • Focus on stroke and pressure ulcers • Urgent work underway regarding Entonox levels in Maternity • The BAF is now being presented to each committee on a regular basis • Transition from children to adult services • Impact of the increase in mental health attendances at ED • IPC annual report

Key issues / matters discussed at the Committee	The committee received, discussed and noted the following reports:
	• Quality and Safety Performance Report noting:
	  ○ Development of SPC reporting for relevant metrics
	  ○ Majority of the Trust's quality metrics were holding. Quality Improvement work continued regarding pressure ulcers
	  ○ Challenges included mixed sex accommodation, stroke, and C.Difficile
	  ○ Continued focus on the management of Stroke patients and reduction of pressure ulcers
	• Maternity Safety Report noting:
	  ○ No complaints received in June
	  ○ Challenges included staffing, difficulty arranging inutero transfers due to pressures in the system
	  ○ Estates are working with Maternity to ensure Entonox levels are maintained at a satisfactory in all rooms. This is monitored regularly.
	• Board Assurance Framework
	• Divisional Exception Reports from
	  ○ Urgent and Integrated Care Division
	  ○ Family and Surgical Services Division
	• Escalations to System Quality Group
	• Infection Prevention and Control Annual Report and the achievements of the Trust in this regard. Recommended for Board approval.
	• Patient Survey results – Update on Actions
	• Escalation Reports from
	  ○ Medicines Committee
	  ○ End of Life Care Group
	  ○ Infection Prevention and Control Group

Decisions made by the Committee	• Approval of the escalations report template to System Quality Group • Infection Prevention and Control Annual Report recommended for Board approval
Implications for the Corporate Risk Register or the 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

Executive / Committee: Charitable Funds Committee

Date of Meeting: 13 July 2022

Presented by: Dave Underwood

Significant risks / issues for escalation to Committee / Board for action	• Dorset County Hospital Charity finances impacted by pandemic and economic situation, as per UK charity sector. DCH Charity Financial Review (Q4 21/22) held by Charity Strategy Group (May 2022) and report submitted to Charitable Funds Committee 13.7.22. Next review Q1 22/23 to be held on 17.8.22.
Key issues / matters discussed at the Committee	**DCHC Financial review (Q4 21/22)** • **DCH Charity Financial Review (Q4)** The DCHC 21/22 original budget £675k had been adjusted down to £585k. Actual year-end income was £579k. The Reserves position at the end of Mar 2022 (M12) showed a surplus of £87k above the target of £200k. • **DCH Charity Risk Register review (Q4 21/22)** Reserves policy risk rating revised down from 16 (High) to 12 (Moderate). No other changes to current risk ratings. Next review Q1 22/23 (17.8.22) **DCHC Charitable Funds Committee (13.7.22)** • **DCH Charity Finance/Income 21/22** reports (M12 Mar 2022) received. • **DCH Charity Finance/Income 22/23** reports (M2 May 2022) received. • **DCHC Reserves Policy** reserves level increased from £200k to £210k relating to fundraising costs. • **DCH Charity Governance review** now completed.
Decisions made by the Committee	• **DCHC Reserves Policy** CFC approved £210k reserves level for 22/23; review towards year end.
Implications for the Corporate Risk Register or the Board Assurance Framework (BAF)	• Nil
Items / issues for referral to other Committees	• Nil

Meeting Title:	Board of Directors
Date of Meeting:	27 July 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	18/07/2022	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:** • Ambulance handover delays continue to be a challenge at both University Hospitals Dorset (UHD) sites with Dorset County Hospital (DCH) also experiencing some challenges. • Delays in response times to Category 2 calls continues to exceed the 18 minutes national performance target. • High numbers of no criteria to reside (NCTR) patients is impacting on flow through ED and the hospital. • At the end of June 2022, there were 48 patients who have been waiting 104+ weeks and 381 patients who have been waiting 78+ weeks at DCH. • Diagnostic performance waiting list increased by 589 in April, with over 6 week waits rising by 1,030. • UHD's Patient Tracker List (PTL) continues to be above 3,000 and ranks 22nd when compared nationally, however Dorset has the third lowest backlog in England by % of PTL. • Workforce challenges within community mental health teams continue, linked to increased demand and recent surges in COVID-19 infection rates. **Quality:** • Throughout May outbreaks of COVID-19 continue to reduce among the providers within Dorset. • Both Trusts have reported their position against the 7 Immediate and Essential Actions (IEAs) identified in the initial Ockenden report. DCH are mostly compliant (>90%) with UHD 87% compliant. • NHS England's insight visits to maternity units in Dorset will take place in early September. • The ongoing delays in completing the Initial Health Assessments for Dorset resident children coming into care has now been escalated to contract leads to performance manage. • The national requirement for NHS Trusts to move from the current National Reporting and Learning Service to Learning from Patient Safety Events (LFPSE) has been confirmed as end of March 2023. Due to financial impact of system upgrades there is a risk that the national deadline will not be met.							

	Finance: • Work has been underway in the Finance Teams for the Clinical Commissioning Group (CCG) to close-down their position and to update the Operational Plan. • As at May 2022 the current reporting is showing a £2.8M under delivery of Cost Improvement Programmes (CIP) for providers. • Organisations are priortising a deep dive into rapid spend and usage analysis for Agency costs.
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	27 July 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 23 June 2022.

2.0 Performance

At the end of April 2022, emergency attendances were close to being in line with April 2021, albeit overall 2022 levels are higher. However, 2020 data (which it had previously been in line with) continues to be significantly lower. 999 activity has fallen in line with 2019/20 levels. South West Ambulance Service Foundation Trust (SWASFT) have been at their highest alert level (REAP Black) since June 2021.

Ambulance handover delays continue to be a challenge at both University Hospitals Dorset (UHD) sites. Dorset County Hospital (DCH) have also experienced some challenges with handover delays at times of surge. Reports of ongoing high levels of acuity and trauma are being raised on Operational Delivery Group calls together with increases in mental health presentations. This, together with high numbers of no criteria to reside (NCTR) patients, is impacting on flow through ED and the hospital with resulting impacts on ambulance handover delays.

Delays in response times to Category 2 calls, patients who often require time critical clinical care, continues to exceed the 18 minutes national performance target. SWASFT continue to utilise options to mitigate against harm, particularly within this patient group, and Clinicians within the Hub are manually reviewing cases within the call stack to identify those patients considered most at risk in order to prioritise an ambulance response.

Hospital bed occupancy remains consistently above 95% due to a high proportion of patients who do not meet the clinical criteria to reside. The Discharge & Flow Cell meets twice weekly and complex discharge meetings/huddles are now taking place at all the providers to support the delivery of this new model, including review of patients within interim, intermediate and reablement services.

The referral to treatment waiting list increased by 5,580 in April, predominantly on the non-admitted pathways (such as treatment delivered through outpatient appointments). The system saw an increase of 298 patients waiting over 52 weeks in April. The PAS merger at UHD has duplicated entries which has artificially inflated the waiting lists numbers and therefore impacted on all measures relating to waiting lists. UHD are working to validate duplicate pathways as soon as possible.

At the end of June 2022, there were 48 patients who have been waiting 104+ weeks and 381 patients who have been waiting 78+ weeks at DCH. This has seen a continuous reduction in numbers over the last 6 weeks.

In diagnostic performance the waiting list increased by 589 in April, with over 6 week waits rising by 1,030. Those waiting more than 13 weeks has increased by 55 patients to 373 overall. It is anticipated as UHD complete the move to a single PAS it will impact the Diagnostic waiting list. However, Dorset continues to be the strongest Diagnostics (DM01) performance regionally.

Faster diagnosis standard and 62-day performance has been largely maintained, albeit below standard. The rate of two week wait referrals for UHD in March were at similar levels when compared to March 2021, with a slight reduction in April due to the Easter bank holidays. However, the two week wait referrals for DCH have seen an increase compared to the 2021 figures. Referral rates that had notable increases were Colorectal, Gynaecology, Head & Neck, and Upper GI.

In April UHD's patient tracking list (PTL) continues to be above 3,000 and ranks 22nd when compared nationally. DCH's PTL has remained static and therefore is a positive reflection of patient flow. Dorset has the third lowest backlog in England by % of PTL.

The backlog of patients waiting over 62 days remains a challenge for both Trusts, however the backlog position for April 2022 was just above the trajectory by 4. For the 104 days backstops, of the 30 trusts with the largest Patient Tracker List's (PTL's) nationally, UHD has the 2nd lowest % of backstop patients with DCH's position remaining static at 1.9% of the total PTL.

There continues to be Workforce challenges within community mental health teams linked to increased demand and recent surges in COVID-19 infection rates. Out of area placements remain above target and are linked to increase in pressure and reduced capacity due to infection control requirements, estates work, staff sicknesses and delayed discharges. Perinatal mental health access has ongoing concerns regarding Mental Health Services Data Set (MHSDS) reported position which remains below locally reported access rate. A meeting is being arranged with Regional Lead and National Team to review, potentially to be linked to coding error of video calls at national level.

Access time for Children & Young People Mental Health continue to be exacerbated by staffing issues related to recruitment & absence and increase in referrals from November 2021 – February 2022 along with a backlog of assessments waiting to be screened and assessed. Overall access rates remain below trajectory

3.0 Quality

Throughout May outbreaks of COVID-19 continue to reduce among the providers within Dorset, in both acute and community hospital settings. Outbreaks in care homes continue to decline in number, size and length of outbreak. Supportive IPC visits and IMTs (incident management team) continue when required, however very few have been held due to the decline in prevalence.

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. Both Trusts have reported to the respective Boards their position against the 7 Immediate and Essential Actions (IEAs) identified in the initial Ockenden report. DCH are mostly compliant (>90%) with some work ongoing to provide assurance of risk assessments at every contact through audit. UHD reported 87% compliance with actions taking place regarding the Maternity dashboard, maternal medicine networks and ongoing audits. NHS England's insight visits to maternity units in Dorset will take place in early September to provide assurance against these actions.

In Infection Control, NHSEI have set a new trajectories for infections in Dorset, including thresholds for the CCG as a system, Dorset County Hospital and University Hospital Dorset. These thresholds are set for C. Difficile and Gram-negative bloodstream infections such as Klebsiella spp., Pseudomonas aeruginosa and E. coli bloodstream infections. These trajectories are significantly lower compared to last year, posing a particular challenge for this financial year, especially with a consistent picture of increased infections across England and Southwest.

In safeguarding, work continues alongside social care to prepare for the implementation of the draft Liberty Protection Safeguards (LPS) and Mental Capacity overarching Code of Conduct. A Regional LPS Lead has been appointed to support all CCG/ICB in the South-West. Clarity has been sought from NHSE regarding the collation of the minimum data set and coding within current IT systems. The ongoing delays in completing the Initial Health Assessments for Dorset resident children coming into

care has now been escalated to contract leads to performance manage. UHD have increased capacity to undertake more IHA's to address the backlog, however further work is required to ensure a more sustainable long-term plan.

The national requirement for NHS Trusts to move from the current National Reporting and Learning Service to Learning from Patient Safety Events (LFPSE) has been confirmed as end of March 2023. Dorset Trusts have reported that the current version of Local Risk Management Systems in use are not yet supported by the software companies (Datix and Ulysses) to ensure the switch to LFPSE. There could be considerable extra cost to upgrade the Datix system in two trusts and another is currently in procurement for a new system, therefore there is a risk that the national deadline will not be met.

4.0 Finance

Work has been underway in the Finance Teams for the Clinical Commissioning Group (CCG), now NHS Dorset, to close-down their position and to update the Operational Plan. Non-recurrent funding had been utilised to achieve a breakeven position which created difficulties going forward, particularly with the forthcoming cessation of the COVID-19 funding.

As at May 2022 the current reporting, based on April 2022 plan submission, is showing a £2.8M under delivery of Cost Improvement Programmes (CIP) for providers, with the CCG reporting a breakeven. Full reporting to commence from July 2022 following agreement of operational plans.

Progress has been made on understanding COVID-19 costs within providers. All providers were undertaking a detailed review of expenditure by 14 June 2022. DCH are reviewing a number of costs which have the potential to be removed.

For Agency costs organisations are priortising a deep dive into rapid spend and usage analysis. There is a need to understand the current position in relation to agency rates, incentives etc. for each organisation and plot visually initial analysis, led by the Dorset Workforce Collaborative Group.

Meeting Title:	Board of Directors, Part 1
Date of Meeting:	27 Jul 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	30 Jun 2022	BAF discussed, recommendations: - proposed new risk PA4.2 be removed, dealt with separately - feedback from AT, AH, SS missed for this EMT, be added for RAC - discussion supporting PA2.1 being re-scored at 16 (from 20) - Add a summary of risk trend and success in mitigation – to Front Sheet
People and Culture Committee	18 July 2022	
Quality Committee	19 July 2022	
Risk and Audit Committee	19 July 2022	

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 4 risks scored >20: PE1.2, PL1.1, PL1.3, PL1.5* *Risk PA2.1 has been lowered in risk score from 20 to 16, owing to the system finding a breakeven position for FY22/23.* *Proposed Risk 4.2, relating to CSR as a cross cutting, agreed by EMT to deal with this off BAF. (removed as proposed new risk from BAF)* *Summary Trends - since BAF first draft Dec-21.* *2 risks have been mitigated completely and removed:* *PL1.7 and PL1.8 in Jan-22* *3 new risks have been added since first BAF* *PL1.11, PL3.2, PL3.3 in Jan-22* *Of 35 risks on the BAF, 4 have seen **risk score improve**, owing to mitigations put in place:* *- PL2.1 (not committing sufficient resources to NHP). Risk lowered from 20 to 15 in Mar-22. Full program structure and dedicated team in place, with Gov Board.* *- PL3.1 (achieving a Dorset wide Integrated Care Record). Risk lowered from 9 to*							

	3 in Mar-22. Full project structure and resourcing agreed, under ICS Digital Portfolio Director. *PA2.1 (achieving financial break even). Risk lowered from 20 to 16 in Jun-22. System summit has been progressing transformation recovery actions, with a plan to get back to balance in FY22/23.* *PA3.3 (investing in and supporting Services identified as CoE). Risk lowered from 16 to 12 in Jun-22. Clinical Strategy in place which prioritizes CoE, joint working with ICS is starting.* *Of 35 risks on the BAF, 2 have seen **risk score worsen**, owing to mitigations put in place:* *- PE3.2 (operational pressure stifle innovation needed). Risk increased to 15 from 12 in Jan-22. Divisional meetings have been tasked with Innovation focus, Research Plan has been republished, QSIR training re-energised.* *- PL1.11 (delivery of timely and accurate Coding). New risk at score 16 added in Mar-22. Recruitment efforts underway in Coding Dept, refocused team has addressed distorted SHMI previously being reported. Overall a Coding backlog still persists, and the staffing problems have not been resolved.*
Action recommended	The Board is recommended to: 1. **NOTE** the changes this month, made in Red within the BAF, which update on mitigations and delivering lower risk. 2. **APPROVE** the final BAF

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

Risk Heatmap

		1
CONSEQUENCE SCORE		Rare
5	Catastrophic	5
4	Major	4
3	Moderate	3 PL3.1
2	Minor	2 PL1.9
1	Negligible	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	Mitigations - 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	Jun -22 All mitigations in place.	
								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	Jun -22 All mitigations in place.	
								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	Jun -22 All mitigations in place.	
								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 - Target date: in place (Complete) and ongoing feeding into respective sub-board or group • Ward accreditation framework - Target score: implemented process/ complete first round by April 2023 • Incident reporting -Target score: in pace and reports to Quality Committee and in turn to Board	• People performance Dashboard - PCC • PCC workplan - FTSU report, review of whistleblowing arrangements • Implementation of just & learning culture • Inpatient surveys • Datix	Good	Good	4	Jun -22 All mitigations in place.	
								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	Jun -22 All mitigations in place.	
								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	Mitigations - 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 (Integration 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 foreseable 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 achivement which will be tracked through EPMG and reported up through both Divisional governance and EPMG to FPC/Quality ctees. Target date: completed and reporting through to FPC/Board as planned • Quality improvement plans within Divisions and key work streams to support delivery of key KPIs supporting quality improvement. Target date: 6 specilties enrolled in CWT System work (complete), 6 specialties enrolled for system 70wk focus (completed), Theatre program established • Elective Performance Management Group - workstreams aligned to operational planning guidance. Performance Framework - lessons for **Gaps in Control and Actions:** National Elective Recovery Plan sets out a 3 year plan towards achievement of NHS Constitutional Standards. Trajectories agreed for achivement 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	All monitoring in place, 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. Target date: framework in place and enacted • Redesign through ED15 to increase estate and flow within current dept including commitment to increased workforce. Target date August 2022 dept alterations completion date • Increase to 7 day SDEC offer across medicine and surgical specialties. Target date - 7 day service completed. Surgical element November 2022. • Clinical and People Strategies addressing emergency flow. Target date: strategies established with/individual delivery timeframes - most significant is Em Zone - delivery phased from 23/24. Home First Board work streams. Target date: winter 23/24 for full delivery of **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 H2P funding and the full implementation of the integrated OH 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 call in place and a refresh of the Patient Flow Program underway - mapped to the interim arrangements. Focus on Pathay 0 patients and first door (ED/Rchester) 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 RDI reporting against investment in ED15 model to UECB ED15 Steering Group through to FPC updates	Good	Good	12	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
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 pathways, then patients will have unnecessary and lengthy hospital stays leading to poorer outcomes and therefore the objective of high care that is safe and effective will not be met. Similarly the above concern would mean we are not contributing to a strong, effective Integrated Care System, focussed on meeting the needs of the population	3	4	12	• Home First Board membership • Urgent and Emergency Care Board - COO membership • Investments in ED capacity, SDEC 7-day working, 7-day discharge services, increased Acute Hospital at Home capacity. Target date: SDEC and Discharge 7 day services completed. Increased Hospital at Home - November 2022 • Home First (DCH) Steering Group - PAT, redesign of discharge support, CCTR, MDT working, strengthened front door multi-agency response. Completion date: via Patient Flow Program Winter 2022 • WSCE support front door and discharge response. Pilot in place (completed) Central and Inner Streams for front door response. Target date: **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 RDI reporting to UECB on investments into patient flow schemes Home First (DCH) Steering group papers.	Requires Improvement	Requires Improvement	9	Internal mitigations in place for winter 22/23 External mitigations through Home First delivery in 23/24	
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). Target date: Improvement Program established. PAS patch implemented in June 22. Full roll out of virtual offer by March 23 **Gaps in Control and Actions:**	• Reports to SLG and through to Board via Strategy updates	Good	Good	2	Internal transformation plan full delivery by March 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 though KPI's such as the Summary Hospital-level Mortality Index.	4	4	16	The coding department is attempting to recruit a new full-time manager (2 yr 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 18/5/22. **Gaps in Control and Actions:**	Vacancies versus establishment Coding backlog Improvement in SHMI	Requires Improvement	Requires Improvement	6	?	
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, OBC submitted June 2022	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	31/03/2023	
PL 2.3	FPC	CFO	CFO	**Risk Description:** If we do not work to improve our sustainability as an organisation then we will increase our environmental impact and so we will not improve the environmental, social and economic well-being of our communities, populations and people.	3	3	9	• Sustainability champions & Sustainability Travel Working Group in place at DCH to encourage long term improvements and sustainability • Sustainability Programme in development in line with the Kings Fund Sustainability Theory bringing together Social, Environmental and Economic factors • Social Value Pledge and Action Plan in place emphasising the commitment to improving the wellbeing of the population • Green plan published and monitored annually • Planned revision of annual report to support triple bottom line reporting **Gaps in Control and Actions:**	• Regular reporting to Strategy and Transformation SLG • Annual reporting on Green Plan to FPC and Board	Good	Good	9	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 Mak - 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- Target date: complete process in place and ongoing (reports to PEG and then QC) • Maternity Voices Partners as part of the Local Maternity & Neonatal System - Target date: in place and ongoing (Reports to QC and ICS SOG) • Communication and Engagement lead for estate development to support further engagement with local population: target date: in place and ongoing (reports via project Board) • Learning Disability Adviser linked activity with independent groups of service users- Target date: in place and ongoing (reports to QC) • Engagement roadmap with leadership from Head of patient Experience and Engagement. Target date: in place and ongoing reports to PEFG and QC • Networked links with external engagement partnerships such as Healthwatch Dorset, CCG/ICS team, Dorset Council. Target date in place and ongoing, feeds into QC • Council of Governors links into community coordinated by Trust Secretary • Quality Improvement methodology includes service user engagement. Target date: In place • 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 +engagement of population May-Jun 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 independant 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 Mak - Patient feedback CMO - AHSN CEO/Director of Strategy - ICS	**Risk description:** If we fail to utilise population health data in a meaningful way to inform service development then services will not meet the needs of the population in ways that means an improvement in health and wellbeing	3	4	12	• DIS dataset • 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	

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	Mitigations - 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 decsion-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:** Many Clinical Leads have never had leadership/management training. ACTION: Appropriate training to commence September 2022 - Julie Doherty.	• 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 GAP:** Waiting list recovery is hampered by NCTR patients. ACTION: Joint working with DHC and Dorset Council to improve patient flow.	• 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	4	16	• ICS Financial framework and Financial Strategy. • Current operating plan delivers a breakeven and does not require external financing, but are heavily reliant on non recurrent funding and 2.5% CIP. **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 and increasing dedicated workforce resource. • 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. Target date: completed • Commitment to be engaged fully in ICS 'Provider Collaborative' - Target date: December 22 for effective delivery South Walks initiative with system partners including Local Authority and community provider. Target date: initial phase completed. Second phase dependedint on funding stream - 23/24 completion date if funded **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	Provider collaborative effectively working Dec 22 South walks - phased throughout 23/24	
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** GAP: Centres of Excellence need to be identified across all Dorset Trusts and developed jointly. ACTION: Joint working within the ICS will support development.	• Monitoring of clinical strategy via S&T SLG and divisional performance • Business Planning processes	Good	Good	8	?	
Partnership Objective 4 Through partnership working we will contribute to helping improve the economic, social and environmental wellbeing of local communities														
PA 4.1	FPC	CEO	Head of Social Value	**Risk description:** If the Trust does not recognise the impact of it's decisions on the wider economic social and environmental well-being of our local communities then our impact will not be as positive as it could be and so the health our populations will be affected	3	3	9	• Social Value Programme. • Social Value Impact Assessments against decision • Reporting of social value programme progress and impact against social value plan to SLG and Trust Board. **Gaps in Control and Actions:**	• Social Value reporting to SLG and Board • SV Dashboard • SV reporting in annual report	Good	Good	6		

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

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

0 - 4	Very low risk
5 - 9	Low risk
10 -14	Moderate risk
15 – 19	High risk
20 - 25	Extreme risk

Likelihood score (L)

The Likelihood score identifies the likelihood of the consequence occurring.

A frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur 1 in 3 years	Do not expect it to happen/recur but it is possible it may do so 1 every year	Might happen or recur occasionally 1 every six months	Will probably happen/recur but it is not a persisting issue 1 every month	Will undoubtedly happen/recur,possibly frequently 1 every few days

Identifying Risks

The key steps necessary to effective identify risks from across the organisation are:

a) Focus on a particular topic, service area or infrastructure
b) Gather information from different sources (eg complaints, claims, incidents, surveys, audits, focus groups)
c) Apply risk calculation tools
d) Document the identified risks
e) Regularly review the risk to ensure that the information is up to date

Scoring & Grading

A standardised approach to the scoring and grading risks provides consistency when comparing and prioritising issues.
To calculate the Risk Grading, a calculation of **Consequence (C)** x **Likelihood (L)** is made with the result mapped against a standard matrix.

Consequence score (C)

For each of the five main domains, consider the issues relevant to the risk identified and select the most appropriate severity scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column. This provides five domain scores.

DOMAIN C1: SAFETY, QUALITY & WELFARE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality /audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Gross failure to meet national standards

DOMAIN C2: IMPACT ON TRUST REPUTATION & PUBLIC IMAGE

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Complaints	Informal complaint/inquiry	Formal complaint (stage 1) Local resolution	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Multiple complaints/ independent review	Inquest/ombudsman inquiry

DOMAIN C3: PERFORMANCE OF ORGANISATIONAL AIMS & OBJECTIVES

	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

DOMAIN C4: COMPLIANCE WITH LEGISLATIVE / REGULATORY FRAMEWORK

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

Risks	RAC Dates: Nov-21	11-Jan-22	15-Mar-22	10-May-22	12-Jul-22	Trend
PE 1.1	16	16	16	16	Pending	Unchanged
PE 1.2	20	20	20	20		Unchanged
PE2.1	12	12	12	12		Unchanged
PE 3.1	8	8	8	8		Unchanged
PE 3.2	12	12	15	15		Worsening
PE 3.3	12	12	12	12		Unchanged
PE 3.4	6	6	6	6		Unchanged
PL 1.1	20	20	20	20		Unchanged
PL 1.2	16	16	16	16		Unchanged
PL1.3	16	20	20	20		Unchanged
PL 1.4	6	6	6	6		Unchanged
PL 1.5	20	20	20	20		Unchanged
PL 1.6	12	12	12	12		Unchanged
PL1.7	12					Unchanged
PL1.8	16					Unchanged
PL 1.9	2	2	2	2		Unchanged
PL 1.10	16	16	16	16		Unchanged
PL 1.11			16	16		Worsening
PL 2.1	15	20	15	15		Improving
PL 2.2	16	16	20	16		Unchanged
PL 2.3	9	9	9	9		Unchanged
PL 3.1	6	9	3	3		Improving
PL 3.2		12	12	12		Unchanged
PL 3.3		12	12	12		Unchanged
PL 4.1	12	12	12	12		Unchanged
PL 4.2	12	12	12	12		Unchanged
PA 1.1	8	8	8	8		Unchanged
PA 1.2	9	9	9	9		Unchanged
PA 1.3	6	6	6	6		Unchanged
PA 1.4	12	12	12	12		Unchanged
PA 2.1	20	20	20	16		Improving
PA 2.2	12	12	12	12		Unchanged
PA 2.3	6	6	6	6		Unchanged
PA 3.1	8	8	8	8		Unchanged
PA 3.2	8	8	8	8		Unchanged
PA 3.3	16	16	16	12		Improving
PA 4.1	9	9	9	9		Unchanged

Meeting Title:	Board of Directors Part 1
Date of Meeting:	21 July 2022
Document Title:	**Corporate Risk Register**
Responsible Director:	Nicky Lucey, Chief Nursing Officer Reviewed by Emma Hoyle, Deputy Chief Nursing Officer
Author:	Mandy Ford, Head of Risk Management and Quality Assurance

Confidentiality:	*n/a*
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Relevant staff and executive leads for the risk entries	Various	Risk register and mitigations updated,
Risk and Audit Committee	19 July 2022	

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 • 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	

Board of Directors
Corporate Risk Register as at 06.07.2022

Executive Summary
The Board 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 06.07.2022 unless otherwise stated and is reflective of the operational risks.

1.2 This report is to provide the Board 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 Board 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. Top Themes:

2.1 **Covid 19**

- 919 – Covid 19 (Extreme 20 (down from 25))

4.1.1 As discussed at the previous Committee in May, the Trust was looking to reduce the risk score for this risk as the National alert level had been lowered.

4.1.2 Since the National alert level was lowered, we have seen a significant increase in infection rates, with significant numbers of Covid patients in hospital (64 as at 08.07.2022) and we have a significant number of staff absent from work due to contracting Covid. None of the cases are related to the Trust and are all community related. This appears to have happened since all of the Government restrictions were lifted and large outdoor events have taken place, such as the Jubilee celebrations and Glastonbury festival.

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 continue to be 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 and staff from the Divisions.
- Reintroduction of mask wearing in non clinical areas
- Action cards revised

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 15.06.2022)
- 464 – Mortality Indicator (Moderate 12) (update as at 15.06.2022)

4.3.1 Both of these items are discussed and reviewed regularly at the Hospital Mortality Group (HMG) chaired by the Chief Medical Officer.

4.3.4 Discussion at the HMG noted :-

- The latest SHIMI is inside the expected range following the reduction in backlog of the coding of patient notes.

- The percentage of invalid of symptom / sign diagnosis which are effectively blank on the submitted forms has also reduced from 31.8% to 23%.
- Our mean depth of coding has also improved from the third worst in the country and is slowly recovering.
- Chief medical Officer is hopeful a further substantial drop in the SHIMI will occur when the latest codding is updated on the rolling 12-month period and should improve substantially from autumn onwards.
- Following review and discussion, it was determined that the risk score for Clinical Coding should remain as high and mortality as moderate. However, we will review the SHIMI data for next month and if the SHIMI continues to fall we could then reduce the risk.

4.4 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.

5 UPDATES:

5.1 461- High volume of patients with no reason to reside (Extreme (20))

5.1.2 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 08 July 2022, the figure stands at 77 patients.

5.1.3 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.

5.1.4 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.

5.2 1252 – Financial Sustainability 2022/23

5.2.1 The final plan for 2022/23, submitted in April, reflects a £17m deficit which threatens the financial sustainability strategic objective. However, since then NHSI requested all deficit systems to resubmit operational plans for the 20.06.2022 demonstrating how they would achieve a break even position.

5.2.2 The Dorset system have submitted a plan to reach breakeven, however, it contains significant risk in delivery and requires a full delivery of cost improvement programmes and financial improvement programmes.

5.2.3 There are a number of workstreams in progress across the Dorset system which should improve the position. Ongoing working across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan. Robust CEO and CFO support is in place via regular meetings to discuss the financial rigor governance and delivery of cost improvements.

5.3 474 - Review of Co-Tag system and management of issuing/retrieving tags to staff (High(16))

5.3.1 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.

5.3.2 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.

5.4 1251 – Critical Failings in hospital blood bank (Extreme 20)

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.

5.4.2 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

5.4.3 Mitigations currently in place:

- Divisional meetings occurring daily following daily huddle within HBB. Any concerns are escalated and action plan formed.
- Weekly meeting to progress the very urgent findings of the May MHRA audit. This meeting covers a recovery plan specifically looking at capacity and demand, recruitment trajectory and a training plan. Weekly progress report is submitted to the Executive meeting with divisional attendance.
- A locum Blood Bank manager has been appointed for a 6 month tenure and a manager returning from maternity leave (who is a qualified BMS) has joined the department for a year's secondment to help recover the Quality Management System.
- All plans are currently on track

5.5 **Family Services and Surgical Division**

5.5.1 There are no new emerging risks from the Division which the Board 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.

7. Recommendation

The Board is recommended to:

- review the current Corporate Risk Register; and
- note the Extreme and High-risk areas and actions
- consider overall risks to strategic objectives and BAF
- request any further assurances

Name and Title of Author:
Mandy Ford, Head of Risk Management and Quality Assurance
Date: data correct as at 12.07.2022
Appendices

- Heat Map (Appendix 1)
- Corporate Risk Register detail (Appendix 2)

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** (919,1251)	**25**
	4 Major	**4**	**8**	**12** (450, 690)	**16** (474)	**20** (472, 840,1221,1252)
	3 Moderate	**3**	**6**	**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.**			
	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 449 - (Moderate) Financial Sustainability 21/22 979 - (Low) Removal/reduction of education funding from HEE commencing April 21.				

Corporate Risk Register **Appendix 2**

The Risk Items on the Corporate Risk Register have been reviewed by the appropriate risk leads and the Executive Team.

Movement on Risk Register: 	Risk Statement Added to Risk Register 01/04/2022	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:12.07.2022
1252	**Financial Sustainability year 2022/23**	Previous Rating	Extreme
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. However since then NHSI requested all deficit systems to resubmit operational plans for the 20.06.2022 demonstrating how they would achieve a break even position. The Dorset system have submitted a plan to reach breakeven, however, it contains significant risk in delivery and requires a full delivery of cost improvement programmes and financial improvement programmes.		Local Manager	Claire Abraham
Current position As at 12.07.2022(data correct as at 12.07.2022)		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. Ongoing working across the divisions and corporate services to explore all opportunities to contribute to achieving the financial plan. Robust CEO and CFO support is in place via regular meetings to discuss the financial rigor governance and delivery of cost improvements.		Next review date **ACTIONS ONGOING TO MANAGE FINANCES**	31.07.2022

Movement on Risk Register: 	Risk Statement Added to Risk Register 05.05.2022 Escalated to Corporate Risk Register 12.05.2022	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed:05.07.2022
1251	Critical failings in hospital blood bank	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** – 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	Andrew Miller Sonia Gamblen
Current position As at 05.07.2022(data correct as at 05.07.2022)		TARGET RATING Target date:	Low (9) Consequence: Moderate Likelihood: Possible 31.03.2023
Mitigation: • Action plan which is being reviewed currently • Recruitment plan in place • Training plan in place • Training resources in place for the systems • Digital plan around resolution. **Update:** • Divisional meetings occurring daily following daily huddle within HBB. Any concerns escalated and action plan formed. • Weekly meeting to progress the very urgent findings of the May MHRA audit. This meeting covers a recovery plan specifically looking at capacity and demand, recruitment trajectory and a training plan. Weekly progress report is submitted to the Executive meeting with divisional attendance. • A locum Blood Bank manager has been appointed for a 6 month tenure and a manager returning from maternity leave (who is a qualified BMS) has joined the department for a year's secondment to help recover the Quality		Next review date	14.07.2022

Management System. • All plans currently on track.		

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: 05.07.2022
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 05.07.22 (data correct as at 08.07.2022)		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, 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 and fluid resistant surgical masks • Eye and face protection and disposable aprons, gowns and gloves • Outpatients and visitors required to wear masks on site, unless they are exempt. (• FFP3 lead has been appointed and will be supported by the Health, Safety and Security manager and staff from the Divisions. **Update:** • Since the National alert level was lowered, we have seen a significant increase in infection rates, with significant numbers of Covid patients in hospital and we have a large number of staff absent from work due to contracting Covid.		Next review date **All actions constantly reviewed following national and IPC guidance.**	31.07.2022

• Reintroduction of mask wearing in non clinical areas • Action cards revised		

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		Next review date **ACTION RE APPOINTMENT COMPLETED** **OTHER ACTIONS ONGOING TO MANAGE WAITING LIST.**	30.06.2022 (OVERDUE FOR REVIEW _ CHASED WITH SERVICE)

providers and local authorities on the next steps		

Movement on Risk Register: 	Risk Statement **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 08.07.2022 (data correct as at 13.06.2022)		TARGET RATING Target Date:	Very Low Risk (4) Consequence: Minor Likelihood: Unlikely 01.12.2023
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:** • Out to advert for Band 8b Paediatric Diabetes Clinical Psychologist. Advert closes on 19/06/22. Third time advertising the role. • PEER review action plan - subject to regular review overseen by Chief Operating Officer Anita Thomas. • Majority of action plan relates to staffing of service.		Next review date **TARGET DATE EXTENDED DUE TO RECRUITMENT PROCESS.**	13.06.2022

Movement on Risk Register:	Risk Statement **Date added to Risk Register 22.02.2022**	CURRENT RISK RATING (Following review and mitigations)	Extreme (20) Consequence: Major Likelihood: Certain Reviewed: 05.07.2022
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 05.07.2022 (data correct as at 05.07.2022)		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:** • Mutual aid to UHD meant that DCH reported 55 over 104 wk waiters at the end of June – in line with most up to date figures reported to region but above original forecast of 0 – Dorset came in on plan however as a consequence of the mutual work to support • Shared 78 wk plan to cross support throughout the year in development • Request from Region for mutual aid for other Systems will further complicate recovery plan if patients passed through to Dorset, displacing Dorset patients from available capacity		Next review date	31.07.2022

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

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: 15.06.2022
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 15.06.2022 (data correct as at 15.06.2022)		TARGET RATING Target Date:	Low (6) Consequence: Minor Likelihood: Possible 31.12.2023
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. • The latest SHIMI is inside the expected range following the reduction in backlog of patient notes. • The percentage of invalid of symptom / sign diagnosis which are effectively blank on the submitted forms has also reduced from 31.8% to 23%. The average is 13% so still some work to do. • Our mean depth of coding has also improved from the third worst in the country and is slowly recovering.		Next review date: **ACTIONS ONGOING AND CURRENTLY ON TARGET**	31.07.2022

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 local review**	**Target rating following completion of all actions**

1060 ED Footprint not fit for purpose 1061 Workforce requirements for new ED 709 – Failure to achieve constitutional standards (now closed).	Low risk Moderate risk	Very Low risk Very Low risk

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:15.06.2022
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 15.06.2022 (data correct as at 15.06.2022)		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:** • The latest SHIMI is inside the expected range following the reduction in backlog of patient notes. • The percentage of invalid of symptom / sign diagnosis which are effectively blank on the submitted forms has also reduced from 31.8% to 23%. • If the SHIMI continues to fall in the next month, the risk score will be adjusted to reflect improvement		Next review date **SHOULD BE READ IN CONJUCTION WITH RISK 641**	31.07.2022

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

Meeting Title:	Board of Directors Part 1
Date of Meeting:	21 July 2022
Document Title:	**Responsible Officer Annual Board Report (Medical Revalidation)**
Responsible Director:	Professor Alastair Hutchison
Author:	Dr Julie Doherty

Confidentiality:	*No*
Publishable under FOI?	*Yes*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
People and Culture Committee	18 July 2022	

Purpose of the Paper	The Board is recommended to approve the report prior to submission to the Board. Statement of Compliance to be signed by CEO once approved by Board in preparation for submission to NHSE/I.							
	Note (✓)		*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	*x*
Summary of Key Issues	The Trust continues to meet all statutory duties in relation to medical revalidation & RO regulations. Our main risk for the 2022-23 appraisal year relates to reaching & maintaining target appraisal rates. We continue to have a large number of locally employed doctors (LED). In 2021-22 appraisal year we held a successful pilot for an ARCP style Panel for LED appraisal and in June 2022 held further Panels. This Panel relies on the LED meeting with an educational supervisor (ES). We shall only be able to maintain the ARCP equivalent Panel for our large numbers of LEDs if these doctors have a trained allocated & funded educational supervisor (ES). The LED lead has submitted a bid for the ES for LEDs. A cost saving has been identified when comparing the time taken for the LED Panel appraisal versus an appraisal with a consultant medical appraiser. Divisions still need to be mindful of the need to put forward suitable candidates to take on the role of medical appraisal. The GMC Regional Liaison Service offers training to support Revalidation and may be something the Board would wish to consider for one of their development days. (GMC Handbook Principle 1a)							
Action recommended	The Board is recommended to: 1. **APPROVE** the report prior to its submission to the Board. Statement of Compliance to be signed by CEO once approved by Board in preparation for submission to NHSE/I							

Governance and Compliance Obligations

Legal / Regulatory	Y	Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I
Financial	N	
Impacts Strategic Objectives?	N	
Risk?	Y	The main risk for the 2022-23 appraisal year relates to reaching & maintaining target appraisal rates. We shall only be able to maintain the ARCP equivalent Panel for our large numbers of LED if these doctors have an allocated & funded educational supervisor (ES). The LED lead has submitted a bid for the ES for LED.
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	**18 July 2022**
Report Title	**Responsible Officer Annual Board Report (Medical Revalidation)**
Author	**Dr Julie Doherty, Responsible Officer**

Designated Body Annual Board Report covering period 1 April 2021 – 31 March 2022.

Completed using the required template issued by NHSi / NHSe

Section 1 – General:

The board / executive management team of Dorset County Hospital NHS FT can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> Comments: Dr Julie Doherty is the RO for DCHFT
>
> Comments: DCHFT has a split Chief Medical Officer (CMO) / RO role. This is managed by good communication and regular 1:1 meetings between the CMO and RO.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> Yes
>
> Comments: We have seen a turnover of medical appraisers. We continue to request that Divisions look within their Care Groups to identify appropriate and interested consultants and SASG (now termed Specialist grade) doctors to take on the role of medical appraiser. Departments would need to find 0.188PA per appraiser within the job plan from their budgets.
>
> Action for next year: Bid in progress for funding of sufficient educational supervisors for LED to support their appraisal via ARCP equivalent panel (where appropriate)

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Compliant

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Comments: The Medical Appraisal Policy has been reviewed during 2021/22 to include updates on appraisal process for LED

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Comments: DCHFT had an external visit from the HLRO NHSEI South West on 9 July 2019. Formal written feedback is not provided from the review, verbal feedback was provided at the time of the review Action for next year: See Action Plan at Appendix 3

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To strengthen governance and QA processes for locum's / Short – term contract (>3months) holders via 1. Introduce requirement for contract holder to meet with clinical lead and engage in local educational & clinical governance programme – via a 'contract of expectations. This will support the doctor in gaining evidence for appraisal and revalidation whilst also supporting systems for patient care & safety. (GMC handbook Principle 1b) 2. Introduce locum exit forms to provide doctors without a prescribed connection to DCHFT with feedback on their performance. NHSE & NHSI contacted for templates to share

Comments: 1. Contract of expectations discussed at Revalidation & Appraisal Governance Group (RAGG) on 3 November 2021 and decided against the introduction. Drs will be supported to engage in departmental governance & educational meetings. 2. Internal Scope of Practice form being adapted for use to support provision of feedback for locums

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Comments: All Drs with a prescribed connection are offered an annual appraisal. Many Drs have chosen to use the Appraisal 2020 model with variable feedback; others continue to use the template on our RMS (PReP IT). We are reviewing our RMS as the contract is due for renewal. There has been more emphasis on reducing the written contribution to appraisal in preference for verbal reflection, promoting professional development and well-being. Action for next year: Promote the use of the Appraisal 2020 model at quarterly appraiser meetings Awaiting further updates from NHSEI regarding appraisal templates for 2022

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Liaison with Clinical Directors to discuss & review how Care Groups and departments monitor medical appraisal rates. Consider introduction of published RAG table to identify doctors nearing their appraisal anniversary and aid scheduling of their appraisal Comments: Departments appear to monitor appraisal rates as a combined reporting. Further work needed to facilitate ownership by departments of medical appraisal rates according to grade.

The administrator for medical appraisal & revalidation monitors appraisal rates for those with a prescribed connection to DCHFT. Compliance with annual appraisal monitored and reviewed at the monthly appraisal meetings attended by the RO / CMO and appraisal lead. QA and governance overseen at RAGG.

Action for next year:

Ongoing liaison with divisional directors and clinical leads to facilitate a move towards departmental ownership & monitoring of appraisal rates

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Compliant.

Medical Appraisal Policy updated 2022. Awaiting hyperlinks addition and then for discussion & ratification at LNC – Ratification expected 13/07/22

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

Explore the introduction of ARCP equivalent process for LED (in training grade equivalent posts) with a prescribed connection to DCHFT.

Comments:

Pilot process introduced following liaison with DME and discussion at LNC.

Further ARCP type Panels successfully held in June 2022.

Many LED have an educational supervisor (ES) for face to face meetings. LED lead has submitted a bid for funding for educational supervisors for those LED who have not yet been allocated an ES. The ES is an essential part of the appraisal process for LED. For those LED without an ES, their appraisal is via a trained consultant or specialist grade appraiser

Action for next year:

Facilitate the provision of an ES for all LED in a training grade equivalent role

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year:

1. Appraisal lead to present audit of 'quality of inputs to appraisal' to the appraisers at the next quarterly appraisers meeting

Comments:

1. Outcome from audit (submitted June 2021): Good compliance with documentation of CPD, essential skills updates, research, supervision/teaching roles, feedback and SUI. Areas for improvement in documentation for appraisal input forms include QI activities, incident reporting, job plan & scope of practice forms. It is likely that these areas were discussed within the appraisal itself – this would be evidenced by audit of appraisal output forms (ASPAT scores).

Conclusions: Engagement with the appraisal process is essential and can be maintained by ensuring the process of collecting evidence is as easy as possible. Aides' memoir, checklists and templates are very helpful. The resources on the intranet have been shown to help a great deal. Introduction of the Appraisal summary template was well received and has improved the output summaries and ASPAT scores significantly.

The findings & recommendations from the audit were discussed at the Quarterly appraisers' meeting & at the Revalidation & Appraisal Governance Group (RAGG) on 03/11/21

Action for next year:

The appraisal lead recommended repeating the audit (2022-2023) to look at trends and identify areas of improvement.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: 1. Evaluate the functioning and outcomes of RAGG Comments: RAGG meetings were held on 07/07/21 and 03/11/21. Minutes are available from the meetings. The scheduled RAGG meeting of 02/03/22 needed to be deferred due to competing priorities. The group have self-assessed against Principle 1 of 'Effective Clinical Governance for the Medical Profession'. RAGG is exploring the development of a lay members forum with regional Trusts. Members of RAGG are also exploring ways in which IT may further support inputs to appraisal. Inputs and outputs from Appraisal are quality assured as noted above. The Board receive an annual report on medical appraisal and revalidation. Action for next year: 1. Repeat audit of quality of inputs to appraisal planned 2. Continue to monitor quality of appraisal output via ASPAT and feedback to appraisers 3. Self-Assessment (at RAGG) against Principles in 'Effective Clinical Governance for the Medical Profession' and make progress with actions from RAGG

Section 2b – Appraisal Data

+See AOA for 2021/22 (at Appendix 1)

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	**DCHFT**
Total number of doctors with a prescribed connection as at 31 March 2022	**246**

Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**220 (+29 leavers)**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**26**
Total number of agreed exceptions	**6**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Nil

Comments:

86 doctors revalidated this year.

There were 9 recommendations to defer revalidation due to insufficient evidence – mostly relating to patient feedback not having been completed. Of the 9 deferral recommendations (regarding 8 doctors), 5 doctors subsequently revalidated, 1 was deferred for a second time (and discussed with the GMC ELA), 1 left the Trust to work elsewhere and 1 is due for a recommendation to be made beyond 31 March 2022.

There were no recommendations for non-engagement in appraisal & revalidation.

There was 1 late submission (RO recommendation made 1 day after due date) as the RO was awaiting further information prior to making a recommendation. The RO makes the recommendation directly to the GMC via GMC Connect or PReP IT.

Reminders have been issued to doctors to better ensure that patient feedback collection is started in good time to facilitate it being complete & available for reflection at their pre- revalidation appraisal.

Following a reminder issued previously by the RO to clinical & divisional directors / managers that the CMO and RO must be notified if a doctor's contract is terminated early due to concerns about their practice / competence there has been an improvement in such notifications. Appraisers do contact the RO if there is anything from appraisal they need to bring to the attention of the RO.

Potential / actual FtP concerns are discussed at the quarterly RO / GMC ELA meetings and in between these as necessary.

Action for next year:

Aim to reduce the number of recommendations for deferral due to insufficient evidence.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Nil

Comments:

Doctors are informed of RO recommendations via email to the Doctor at the time of submission via GMC Connect.

Recommendations to defer are discussed with the doctor either face to face or via email well before that recommendation is submitted.

Deferrals may be a joint agreement between Dr and RO depending on the reason for deferral. Reasons for deferral and actions the doctor needs to complete to enable a recommendation to revalidate to be made are set out clearly and provided in writing (usually via email).

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Nil

Comments:

We engage in self-assessment (with lay member challenge at RAGG) against the Principles set out in 'Effective Clinical Governance for the Medical Profession'.

Copies of self – assessments available.

Action for next year:

Continue self -assessment at RAGG and take steps to complete actions identified

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Revisit whether there is a need for an annual (performance) review for all SASG / Consultants at DCHFT in addition to their annual appraisal and the job planning process currently in existence.

Comments: Discussions restarting about reintroducing annual review linked with job planning and appraisal for specialist grade and consultants. This would better ensure completion of internal scope of practice forms for appraisal as well as better linking PDPs to job plans. Relevant information is available to doctors for their appraisal but can be time consuming to collate. We are exploring whether there are any digital solutions to better facilitate collation of incident reporting and complaints information to doctors Action for next year: Update on progress for annual reviews

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Nil Comments: Maintaining High Professional Standards is the approved policy used for responding to concerns. Fitness to Practice issues are discussed at the RO / CMO / GMC ELA meetings which are held quarterly. The GMC ELA is available for informal / formal discussion by MS Teams / telephone between meetings. Practitioner Performance Advice (PPA) service is an additional support for the CMO / deputy CMO (RO). Regular meetings are scheduled with the Trust's allocated advisor from PPA.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year:

1. HR (with RO & CMO support) Audit of case investigation and management against standards in MHPS and GMC governance handbook
2. Contact neighbouring Designated Bodies (Yeovil, Bournemouth, Poole) to consider sharing of resources for case investigation and management and make links for peer support.

Comments:

Audit not yet commenced due to other priorities and workforce capacity.

Case investigation and case management training rescheduled and will link with UHD (University Hospitals Dorset).

Contact made with UHD and the RO is to attend their case investigators peer group meeting in September 2022 with a view to introducing similar at DCHFT for peer learning and support.

Analysis of 'Responding to Concerns' cases for 2021/22: See appendix 2

Action for next year:

Carry over action 1.

Evaluate progress of establishing a peer support group for case investigators at DCHFT

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: Nil Comments: MPIT forms (national process) are used. Telephone conversations or virtual meetings via MS Teams have occurred where there were higher level concerns potentially likely to impact on patient safety / outcomes. There is documented evidence of discussions and decision making / outcomes.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Nil Comments: HR policies include an Equal Opportunities Impact Assessment & statement. We are working through self -assessment of the Principles in the GMC handbook as outlined above at RAGG Processes could be further strengthened by implementing actions in 4 above. There is discussion and challenge at the RO/CMO/ GMC ELA meetings.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: Nil

Comments:

In addition to pre-employment check there are systems to share information once a doctor has been offered a contract with DCHFT:

Sharing of information regarding new doctors entering employ occurs via MPIT forms from RO to RO.

Such forms are also used to share concerns (RO to RO) which arise during employment at DCHFT of any doctors who also practice elsewhere (e.g locum doctors; doctors with private practice)

HPANs (Health Professional Alert Notices) may also be used to share significant concerns about a doctor who has disconnected from DCHFT and not yet made a connection to a new Designated Body.

GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns.

Information sharing processes adhere to Caldicott principles. RO and CMO share the role of Caldicott guardian and attend relevant update training. (GMC handbook Principles 4e & f).

Doctors in training posts and their equivalent LED have clinical supervision and in most instances (for LED / all for those with a national training number) educational supervision.

Section 6 – Summary of comments, and overall conclusion

We have made good progress during 2021/22 with the following actions:

1. Appraisal rates reaching 89.43% for those doctors with a prescribed connection to DCHFT at 31 March 2022. This is despite the workforce issues with covid and recovery from covid. We hope to see further improvements with a target of >92% for 2022/23.

2. Improved clinical governance and lay member challenge for appraisal & revalidation process as RAGG now established and regular meetings occurring. Self -Assessment against the Principles set out in the GMC handbook 'Effective Clinical Governance for the Medical Profession' has been positive.

3. There is effective information sharing when responding to concerns about doctors at DCHFT. There are appropriate support mechanisms in place for doctors when concerns arise.

Actions still outstanding:

1. Liaison with divisional directors and clinical leads to facilitate a move towards departmental ownership & monitoring of appraisal rates. This could free up some time for the revalidation administrator to support LED appraisal. We also hope it will support

our aim to further improve appraisal rates by raising the priority & benefits of annual appraisal.

2.To establish a peer support group for case investigators (medical and non-medical) at DCHFT.

3. HR (with RO & CMO support) audit of case investigation & management against standards in MHPS and GMC governance handbook

New Action:

1. LED lead is seeking funding (via bid) for all LED in training grade equivalent posts to have an Educational Supervisor. This in turn will allow suitable LED to be appraised via an ARCP equivalent Panel. This will reduce the pressure to seek further medical appraisers and will better mirror the process of their peers as many of these doctors will re-enter training posts.

2. To complete updates (i.e. hyperlinks) to the Medical Appraisal Policy and present to LNC for approval.

Overall conclusion:

The Trust continues to meet all statutory duties in relation to medical revalidation & RO regulations.

The GMC Regional Liaison Service offers training to support Revalidation and may be something the Board would wish to consider for one of their development days. (GMC Handbook Principle 1a)

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman)

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Name of Organisation	Name of Responsible Officer	TOTAL Number of Revalidations due in Period 1st April 2021 to 31st March 2022	Number of positive recommendations made	Number of initial deferrals	Reasons for deferrals	Number of doctors for which no positive recommendation was made (non-engagers/performance concerns etc)	Reason for NOT being recommended
eg. DB England South West	Dr AN Other	201	199	7	No PSQ/MSF x3, performance concern x2, Revalidated by previous organisation as newly appointed to own organsation x1	1	Suspended by GMC
Dorset County Hospital NHS FT	Dr Julie Doherty	89	86	8	No PSQ/MSF x6, Insufficient appraisal data / other supporting info x2	1 (second deferral)	Performance concern within previous employ and awaiting outcome x1
Weldmar Hospice	Dr Julie Doherty	1	1				

Annual Report Appendix 2

Audit of concerns about a doctor's practice

(NB Within the numbers included, there is some cross over between categories such that the same Dr may be included in more than one section of the report. Drs may be substantive or employed as a locum. Data relates to 4 doctors in total)

Concerns about a doctor's practice	Total
Number of doctors with concerns about their practice in the last 12 months leading to formal case investigation & case management (MHPS or equivalent) Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	
Capability concerns (as the primary category) in the last 12 months	
Conduct concerns (as the primary category) in the last 12 months	3
Health concerns (as the primary category) in the last 12 months	
Some Other Substantial Reason (as the primary category) in the last 12 months	
Remediation/Reskilling/Retraining/Rehabilitation	
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2022 who have undergone formal remediation between 1 April 2021 and 31 March 2022 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*	
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)	
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)	
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)	
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies	
TOTALS	
Other Actions/Interventions	
Local Actions:	

Number of doctors who were suspended/excluded from practice between 1 April 2021 and 31 March 2022: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	2
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	 1 1
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	Number
Were referred by the designated body to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	2
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	
Were erased from the GMC register between 1 April and 31 March	
Practitioner Performance Advice Service actions:	Number
Number of doctors about whom the Practitioner Performance Advice Service (PPAS) has been contacted between 1 April and 31 March for advice or for assessment	2
Number of PPAS assessments performed	0

Revalidation ACTION PLAN

Area for development for DCHFT as RO service provider	Action	Responsibility	Timescale	Assurance	Progress (as at July2022)
1. Improve appraisal rates (in line with peers)	i) Liaison with DD's, CD's and DM's to identify potential appraisers with agreed remuneration & resourced time for appraisers. ii) Meeting to be scheduled between RO / MD and Director of HR / Deputy Director HR to discuss contract for doctors at DCHFT (relating to appraisal requirements) iii) Review arrangements for acceptance of a prescribed connection and appraisal scheduling for short term contract / As &When Drs iv) Liaison with Care Group leads to improve their	RO with DD & DM RO / MD / Director HR RO / Revalidation administrator with HR advisor Appraisal Lead / CDs and service managers with HR admin support	i)Quarterly monitoring in line with NHSE returns ii)Complete iii)Complete iv)Partially complete as some departmental monitoring of appraisal rates include medical staff. Revised date Dec2021	Appraiser to doctor ratio nearer 1:6 Improving appraisal rates	i)Liaison with DD's & DM's ongoing to try to recruit more appraisers. New appraisers have undertaken training, however a similar number of appraisers have relinquished this role. Business case for LEDs access to ES/ CS ARCP equivalent Panels in place for specified LED following successful pilot. ii &iii)Meeting held and medical appraisal & revalidation policy updated. Discussions affirmed the contractual requirement for annual appraisal. No agreement or decision to take forward at

		monitoring of medical appraisal rates – with proposal to introduce RAG table				DCHFT at this time the action implemented at some other Trusts to withhold pay if appraisal not completed within 28 days of appraisal anniversary. iv)To be scheduled. Proposal to meet with business / service managers and clinical leads (as gaps in care group leads)
2. Strengthening the clinical governance and QA arrangements for locum and As & When contract holders	i) ii) iii)	Appraisal lead with RO and HR to explore the use of locum exit forms. Introduce requirement for contract holder to meet with clinical lead and engage in local educational and clinical governance programme- e.g. via 'contract of expectations' Review of contract to consider introduction of a minimum period	i) RO & Appraisal lead making enquiries within Regional RO network. ii) DD's and DM's with CD's / clinical leads iii) HR (deputy director and medical HR advisor)	i) Oct 2019- Partially complete; revised date June 2021 ii) Oct 2019- Partially complete; revised date June 2021 iii)Jan 2020- completed	Locum exit form in use Agreed & signed contract of expectations at start of post Attendance records at educational / CG sessions Employment contract update Medical Appraisal & Revalidation	MPIT generally RO to RO whereas we would like a form signed by a consultant or clinical supervisor that the locum can use within their portfolio. MPIT to be used if significant concerns arise. Awaiting template locum exit forms from NHSE/I- not received thus in house development.

	of work per 6 or 12 month contract to support revalidation			Policy	Likely to adapt the scope of practice forms for use. ii) Contract of Expectation to be drawn up. Discussion held at Quarterly Appraiser meeting. Requires reminder at Care Group CG meetings to embed- Decided against CofE at RAGG 3 Nov 2021 iii)Updated medical appraisal & revalidation policy complete
Strengthen the governance & QA processes for appraisal & Revalidation	Introduction of a Revalidation & Appraisal Governance Group (RAGG)at DCHFT. TOR for such groups available via Regional network.		RO with Board / HR support	Jan 2020 Partially complete; revised date Dec 2020	RAGG TOR / minutes	RO & Exec team agreed expenses reimbursement for lay member. TOR written. First quorate meeting held 3 March 2021.
Consider how to improve the QA of case investigation and peer support to case investigators and case managers when responding to concerns about doctors	i) Review the QA processes & support for case investigation & management in place at DCHFT ii) Compile a list of		Deputy Director HR	June 2020 Partially complete; revised date June 2021	Audit of case investigation & management Buy in to NHS Resolution	HR team compiling list of trained case investigators & case managers The Trust had

	trained case investigators and managers iii) Liaise with neighbouring RO to determine interest in sharing resources and peer support	RO		(PPAS) resources	commissioned PPA (formally NCAS) to provide some onsite Case Investigator training in March 2020. Training postponed due to Coronavirus. Awaiting new date. 2 staff attended UHD training. RO to attend UHD case investigators peer group meeting Sept 2022 To formulate audit of case investigation & management against MHPS
I confirm that the action plan above has been discussed and agreed with my Board or equivalent		*Responsible officer - Signature & Date*			

Meeting Title:	Dorset County Hospital Board of Directors
Date of Meeting:	27th July 2022
Document Title:	**Research Strategy Refresh 2022-25**
Responsible Director:	Alastair Hutchison, Chief Medical Officer and Executive Lead for Research
Author:	Zoë Sheppard but co-produced with staff and patients

Confidentiality:	**Internal circulation only due to content included e.g. finances**
Publishable under FOI?	No

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Wide consultation through various meetings e.g. Staff Networks	Various	Incorporated
Senior Leadership Group Working Group	4th May 2022	Incorporated
Senior Leadership Group	22nd June 2022	Incorporated e.g. ordering, targets, and shorter version

Purpose of the Paper	To obtain endorsement for the research strategy refresh 2022-25 as well as financial and cultural investment from the Trust.						
	Note (✓)		*Discuss (✓)*	✓	*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	The research strategy refresh 2022-25 presents: 1. A summary of the current position with strengths, weaknesses, opportunities, and threats. 2. The mission, vision, and objectives with six priorities for 2022-25: a) Workforce plan. b) Increasing focus on income generation through West Dorset community research hub(s). c) Integrating research into services and embedding research into the culture of the organisation. d) Embedding patient and public involvement and engagement as well as equality, diversity, and inclusion to ensure inclusive research that is patient-centred. e) Increasing digital and 'green' ways of working to facilitate research opportunities and efficiencies. f) Measuring the impact of research for increased accountability. 3. An action plan with key performance indicators to be operationally reported through Care Group/Division with strategic oversight via Research Strategy Committee. 4. An appendix providing an overview of research and its benefits along with the national, regional, and local position including how the strategy was co-produced – the strategy is strongly aligned with the Trust strategies including people, place, and partnership, the clinical and people strategies, as well as social value and the green plan.						

Action recommended	The Board is recommended to: 1. **DISCUSS** the content of the strategy. 2. **ENDORSE** the proposed strategy.

Governance and Compliance Obligations

Legal / Regulatory	N	
Financial	Y	Continued financial support from Trust required but priority to increase income generation.
Impacts Strategic Objectives?	Y	Strongly aligned with the Trust strategies including people, place, and partnership, the clinical and people strategies, as well as social value and the green plan.
Risk?	Y	Continued financial support from Trust required but priority to increase income generation
Decision to be made?	Y	To endorse strategy refresh
Impacts CQC Standards?	Y	Research now has increased prominence within new Care Quality Commission strategy
Impacts Social Value ambitions?	Y	Under-served communities; champion equality, diversity, and inclusion; be green and sustainable
Equality Impact Assessment?	N	Consulted with Staff Networks
Quality Impact Assessment?	N	

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Research Strategy

Refresh 2022-25

Short version

For internal circulation only

Quality and relevant research to deliver outstanding care for people in ways which matter to them

Preface

The pandemic has brought its many challenges including pausing the majority of research studies. However, research became centre stage on the international agenda and led to the identification of life-saving treatments, diagnostic tests, and vaccines. It also meant different ways of working within research and the team really pulled together to deliver important COVID-19 research that has been recognised regionally and nationally.

The 2022-25 research strategy refresh hopes to build on this success by integrating research into services within the hospital. A culture change is required to move from a perception of research being 'optional' to being truly embedded and valued within the fabric of the organisation given research is the route to evidence-based practice.

Thank you to everyone who fed into this strategy (including our patients) to ensure it was co-produced. With this is mind, the mission remains ***'quality and relevant research to deliver outstanding care for people in ways which matter to them.'*** *We look forward to working with you all to deliver the ambitions set out in the following slides.*

Professor Alastair Hutchison

Executive Lead for Research

Dr Zoë A. Sheppard

Head of Research (2017-22)

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Research Strategy

Refresh 2022-25

Vision

Quality and **relevant** research to deliver outstanding care for people in ways which **matter to them**

Mission

Working with our research and health and social care partners, will be at the heart of improving the wellbeing of our communities

Objectives

1. To deliver **outstanding** relevant research
2. To **integrate** research into services at the Trust
3. To **collaborate** with patients, staff, and research partners
4. To **enable** staff to engage in research
5. To be a **sustainable** department

Priorities

1. Develop departmental **workforce plan**
2. **Service development** increasing focus on **income generation**
3. **Integrate** research into services and **embed** research into the culture
4. Embed **patient and public involvement** as well as **equality, diversity, and inclusion**
5. Increase **digital** and **green** ways of working
6. Measure **impact** of research

Quality and relevant research to deliver outstanding care for people in ways which matter to them

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

To deliver outstanding relevant research

Action	Owner	Timescale	Key Performance Indicator
Continue to deliver high quality research answering important clinical questions	Clinical Lead	2022-23	Number of participants
Measure impact of research	Research Managers through Business and Quality meeting	2024-25	Descriptive impact story narratives
Collect high quality data including monitoring and audit of equality, diversity, and inclusion indicators as well as centralised storage for deviations, breaches, and data queries	Governance Lead	2022-23	Percentage compliance with equality, diversity, and inclusion monitoring data
Produce research outputs to contribute to evidence-based care through publications etc	Chief Investigator (Project Lead)	2022-23	Number of publications
Ensure participants feel valued	Clinical Lead	2022-23	% participants responding that they feel valued on Participant Research Experience Survey

Quality and relevant research to deliver outstanding care for people in ways which matter to them

To integrate research into services

Action	Owner	Timescale	Key Performance Indicator
Integrate with clinical services to increase opportunities for patients e.g. Department Links/Research Champions, attend meetings and ward rounds, newsletters etc	Clinical Lead	2022-23	Descriptive research environment narrative
Work closely with Patient Advice and Liaison Service, Audit, and Transformation through Patient, Audit, Research, Transformation, and Innovation group to share information of relevance to the other departments	Governance Lead	2022-23	Descriptive research environment narrative
Incorporate research into routine staff and patient data collection	Governance Lead	2024-25	Descriptive research environment narrative
Nurture clinical academic careers	Head of Research	2022-23	Number of internships/ fellowships/ studentships/ posts etc

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

To collaborate with patients, staff, and research partners

Action	Owner	Timescale	Key Performance Indicator
Embed patient and public involvement and engagement to ensure research is patient-centred	Head of Research	2022-23	Descriptive research environment narrative
Build on successes with engaged staff to deliver clinical research to inspire others	Clinical Lead		
Work with Higher Education Institutions e.g. student placements, studentships, collaborative research projects	Head of Research		
Collaborate with system partners including Dorset Healthcare, General Practice, and non-NHS e.g. through Research Active Dorset including social care	Head of Research		
Work with National Institute for Health and Care Research organisations e.g. Clinical Research Network, Research Design Service, Applied Research Collaboration	Head of Research		
Partner with charities and local organisations to pursue common goals	Head of Research		
Work with reputable commercial companies to develop West Dorset community research hub(s)	Clinical Lead		

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

To enable staff to engage in research

Action	Owner	Timescale	Key Performance Indicator
Ensure staff have **capacity** to do research e.g. through recruitment, job descriptions, job planning, appraisals, and career progression etc	Executive Lead	2024-25	Descriptive research environment narrative
Ensure staff have research **capability** through training and support e.g. Good Clinical Practice, inductions, continuing professional development, increased knowledge/skills of practitioners	Governance Lead /Head of Research	2022-23	Percentage of Trust staff compliant with Good Clinical Practice training
Ensure research as easy as possible with research delivery support and embedding research into the patient pathway	Clinical Lead	2022-23	Descriptive research environment narrative
Encourage early career researchers and research funding applications for research led by the hospital	Head of Research	2022-23	Descriptive research environment narrative
Harness space for research as well as taking research to communities to ensure inclusion e.g. South Walks House/The Atrium, Weymouth Hub, Research Buses	Clinical Lead	2022-23	Descriptive research environment narrative

To be a sustainable department

Action	Owner	Timescale	Key Performance Indicator
Develop local people plan for the department including wellbeing; kindness and compassion; equality, diversity, and inclusion; social value; training such as in numeracy and using data; efficiencies and resilience and career progression e.g. investment appraisal of roles, Clinical Trial Assistant/Practitioner led studies, time allocation tools, career progression, Governance Assistant and Deputy Clinical Lead	Operational Lead	2023-24	Descriptive research environment narrative
Diversify income streams balancing clinical value with income generation e.g. moving away from COVID-19 research to increased focus on commercial research through West Dorset community research hub(s), working across Dorset, fundraising, funding applications led by the hospital with associated Research Capability Funding	Clinical Lead/ Head of Research	2022-23	Increased income
Increased feasibility assessment of studies including financial elements	Governance Lead	2022-23	Descriptive research environment narrative
Improved financial systems through sharing of good practice at Wessex wide Finance Network	Management Accountant/ Operational Lead	2022-23	Increased income and descriptive research environment narrative
Increase digital and 'green' ways of working to facilitate research opportunities and efficiencies as well as trust e.g. Dorset Intelligence and Insight Service, technology compatible with clinical systems	Operational Lead/ Governance Lead	2022-23	Descriptive research environment narrative

Quality and relevant research to deliver outstanding care for people in ways which matter to them

Monitoring Progress

Key Performance Indicators and evidence for narratives to be collated during monthly Business and Quality meetings (feeding into Care Group and Division)

Regularly review progress towards strategy at four monthly **Research Strategy Committee** reporting to **Quality Committee**, and onto **Trust Board**

Annual report/ newsletter to be produced at the end of each financial year to share progress, celebrate success, and raise awareness of research

Strategy will continue to evolve – essential to be reviewed annually and refreshed every three years

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Strategic Dashboard

Key performance indicator*		Year		
		22-23	23-24	24-25
Research outputs	Number of research participants *(Target: 1000 each year, aligned with **engagement** and **income** pillar)*			
	Number of publications *(Target: 50 each year, aligned with **engagement** pillar)*			
	Percentage of participants responding that they feel valued on Participant Research Experience Survey *(Target: 80%, aligned with **engagement** and **governance** pillar)*			
Research environment	Research income *(Target: increase by £100k each year, aligned with **income**)*			
	Percentage compliance with equality, diversity, and inclusion monitoring data *(Target: 80%, aligned with **governance** pillar)*			
	Percentage of Trust staff compliant with Good Clinical Practice training *(Target: 80%, aligned with **governance** and **engagement** pillar)*			
	Number of internships/ studentships/ fellowships/ posts *(Target: 3 each year, aligned with **engagement** pillar)*			
	Descriptive research environment narrative *(aligned with all four pillars including **people**)*			
Research impact	Descriptive research impact story narratives			

*Incorporating outputs, environment, and impact similar to the Research Excellence Framework

Quality and relevant research to deliver outstanding care for people in ways which matter to them

Meeting Title:	Quality Committee
Date of Meeting:	27 July 2022
Document Title:	**Urgent & Integrated Division Exception Report**
Responsible Director:	Anita Thomas – Chief Operating Officer
Author:	Sonia Gamblen

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	21 June 2022	

Purpose of the Paper	To provide assurance to the DCHFT Board of Directors of the actions being taken within the hospital's blood bank following MHRA audits in January and May 2022.							
	Note (	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	The response plan provides a detailed action plan articulating clear timeframes and responsibilities. The response plan is divided into two workstreams which relate to the findings and associated actions of the January and May audits. Workstream One responds to the urgency required to mitigate the May MHRA findings and workstream Two represents the actions for the January audit findings. Matters highlighted following the MHRA audit in May have resulted in three defined areas: 1. Embedded escalation pathways from "work bench to Board". Specific actions relating to this have been: ○ Daily morning Blood Bank Huddles ○ Daily HBB Touch Point meeting following morning Blood Bank Huddle with Divisional Management ○ Weekly escalation of Blood Bank developments to Executive meetings. 2. Training & Recruitment of staff specifically relating to blood bank – a training plan is in place and is running to schedule and a recruitment campaign has resulted in various appointments which are now documented demonstrating a trajectory of staff leaving and commencing within the department. The training plan is then linked to this. 3. Demand & Capacity – a detailed piece of work has been undertaken to identify staffing deficits. This resulted in an additional requirement of a Band 7 (appointment made) and a Band 6 – recruitment underway. In addition fixed term contracts have been provided to oversee the Quality Management System and for the position of Head of Blood Bank. Both of these positions have been successfully appointed into and are having significant positive impact. The Gantt chart attached provides further detail for both of the audit workstreams Monthly submissions are being sent to the MHRA to :- • provide an overview of staffing (including recruitment and training) • detail progress with outstanding non-conformities and SOPs							

	• confirm operational staffing levels and how these have been addressed when in escalation The MHRA have asked the Trust to report unexpected changes in staffing to the services without delay and the corrective actions. This is monitored through daily staffing huddles and escalation meetings.
Action recommended	The DCHFT Board is recommended to: 1. **NOTE** the report

Governance and Compliance Obligations

Legal / Regulatory	Y	To provide safe standards of care in line with best practice
Financial	Y	Possibly if a claim resulted in a finding against the Trust
Impacts Strategic Objectives?	Y	Linked to the Trusts' vision to provide outstanding care in ways which matter to them. Collaborative: Recognising that we have much to learn from the patients that use our services and the staff that deliver those services Outstanding: To ensure practice is up to date using the best possible evidence Sustainable: To monitor any change that we make to ensure that it is productive, effective and efficient and meets the desired aim without adverse effect on other services, systems, processes or people. Integrated: To ensure that patients receive a safe continuum of care regardless of clinical setting by working collaboratively with our community partners using pathways and digital technology to aid seamless transitions of care. Enabling: To ensure that staff are included in service redesign and developments and provided with opportunities to learn, train to enable them to deliver best practice care and treatments.
Risk?	Y	To undertake risk assessments and provide mitigation where risk is identified
Decision to be made?	N	
Impacts CQC Standards?	Y	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Respect Integrity Teamwork Excellence

"Pathology Programme" Gantt Chart

Please use the example and legends (shown below at the bottom of the sheet) to complete your Gannt Chart

NHS Dorset County Hospital NHS Foundation Trust

Status	Under Action	Mile-stone
Planned		◆
Completed		◆
In Progress		
Off Track		◆

Project Plan Gannt Chart						Quarter 1					Quarter 2												
Action #	Corrective Actions	Owner	CA Ref #	Description	Status	May	Jun				Jul				Aug				Sep				
Workstream 1 - May 22 Re-Inspection																							
M1.1.1 - Resource issues were not being communicated to Executive Management in sufficient detail to allow adequate understanding of the issues.																							
1	A workforce tracker is in place to show changes to staffing within the Blood Bank Team (including Locums, Flexibly Employed staff) and the subsequent risks/mitigations.	Service Manager	CA01	Workforce Tracker	Already in Place	◆																	
2	Escalation Flowchart is in place for immediate use at HTT huddle to guide safest staffing in place for the service on the day	Head of Pathology	CA02	Escalation	Already in Place	◆																	
3	A full safe staffing Standard Operating Procedure detailing how wider staffing risks are identified, assessed and escalated, aligned to service need	Head of Pathology	CA03	Safe Staffing	Active					◆													
4	One Dorset Pathology Business Continuity Plan is being updated to show the course of action if HBB minimum staffing levels are not achieved in the medium term, despite best efforts	Head of One Dorset Pathology	CA04	Business Continuity	Active						◆												
5	Interim arrangement in place for immediate discussion between DCH and One Dorset Pathology regarding sharing of staffing resources and/or transfer of activity to another site	Head of One Dorset Pathology	CA05	Activity Transfer	Already in Place	◆																	
M1.1.2 - The number of blood transfusion competent staff had reduced significantly since the January inspection. There was no assessment of the impact of these staff losses.																							
1	A safe staffing Standard Operating Procedure detailing how staffing risks are identified, assessed and escalated will be in place	Head of Pathology	CA03	Safe Staffing	Duplicate	This is being actioned as part of M1.1.1																	
2	Escalation Flowchart is in place for immediate use at HTT daily huddle to guide safest staffing in place for the service on the day	Head of Pathology	CA02	Escalation	Duplicate	This is being actioned as part of M1.1.1																	
3	One Dorset Pathology Business Continuity Plan is being updated to show the course of action if HBB minimum staffing levels are not achieved	Head of Pathology	CA04	Business Continuity	Duplicate	This is being actioned as part of M1.1.1																	
4	Interim arrangement in place for immediate discussion between DCH and One Dorset Pathology regarding sharing of staffing resources and/or transfer of activity to another site	Head of Pathology	CA05	Activity Transfer	Duplicate	This is being actioned as part of M1.1.1																	
5	A Demand and Capacity plan is in place to determine the number of staff needed to inform recruitment above the established level, which will be built upon with a further detailed analysis to support a final version of the Demand and Capacity profile	Service Manager	CA06	Demand & Capacity	Active			◆															
6	The Roster building process, roster review and huddle meetings already in place to identify and resolve issues with HTT competent staff, will be used to underpin the full analysis	Service Manager	CA07	Roster	Already in Place	◆																	
7	A full Training plan to identify and ensure there is a robust system in place for all staff to achieve competencies	Head of Pathology	CA08	Training	Active					◆													
8	Final competency sign-off for a Band 6 BMS will enable a ringfenced suitably trained HTT colleague to provide training, supervision and general support.	Head of Pathology	CA09	Compentency	Active						◆												
9	Interim provision is being mitigated by current pool of qualified Blood Bank staff	Head of Pathology	CA10	Interim provision	Already in Place	◆																	
M1.1.3 - Although several positions had recently been filled there were no start dates fixed for the majority. In addition, several of the new starters would require substantive training in UK blood transfusion systems and an assessment of the resource requirements for this had not been documented.																							
1	Training plan to identify and ensure there is a robust system in place for all staff to achieve competencies	Head of Pathology	CA08	Training	Duplicate	This is being actioned as part of M1.1.2																	
2	Final competency sign-off for a Band 6 BMS will enable a ringfenced suitably trained HTT colleague to provide training, supervision and general support.	Head of Pathology	CA09	Compentency	Duplicate	This is being actioned as part of M1.1.2																	
3	Interim provision is being mitigated by current pool of qualified Blood Bank staff	Head of Pathology	CA10	Interim provision	Duplicate	This is being actioned as part of M1.1.2																	
4	Rolling recruitment for BMS to be put in place to mitigate delays in the recruitment process (this will include visas, training lead-in times)	Head of Blood Science/HR Business Partner	CA11	Recruitment	Already in Place	◆																	
5	Departmental Establishment Plan (DEP) will be enhanced to provide an assessment of the current workforce and risks, once the full analysis of demand and capacity has been completed	Service Manager	CA12	DEP Update	Awaiting Planned Start Date				◆					◆									
6	The Departmental Establishment Plan is in place, showing the staffing structures of the team and vacancies	Service Manager	CA12	DEP	Already in Place	◆																	
M1.1.4 - There was no capacity plan, or similar document, in place to allow a clear determination of the numbers of personnel required to maintain the transfusion laboratory operations and the Quality Management System.																							
1	A safe staffing Standard Operating Procedure detailing how staffing risks are identified, assessed and escalated will be in place	Head of Pathology	CA03	Safe Staffing	Duplicate	This is being actioned as part of M1.1.1																	

Respect Integrity Teamwork Excellence

"Pathology Programme" Gantt Chart

Please use the example and legends (shown below at the bottom of the sheet) to complete your Gannt Chart

NHS Dorset County Hospital NHS Foundation Trust

Status	Under Action	Mile-stone
Planned		◆
Completed		◆
In Progress		
Off Track		◆

Project Plan Gannt Chart						Quarter 1			Quarter 2		
Action #	Corrective Actions	Owner	CA Ref #	Description	Status	May	Jun		Jul	Aug	Sep
2	Interim Escalation Flowchart is in place for immediate use at HTT daily huddle to guide safest staffing in place for the service on the day	Head of Pathology	CA02	Escalation	Duplicate	This is being actioned as part of M1.1.1					
3	A further workforce skill-mix review to be undertaken to future proof the service provision	Head of Blood Science/HR Business Partner	CA13	Skill Mix	Active			◆			
4	A Demand and Capacity plan is in place to determine the number of staff needed to inform recruitment above the established level	Service Manager	CA06	Demand & Capacity	Duplicate	This is being actioned as part of M1.1.2					
5	Roster building process, roster review and huddle meetings are in place to identify and resolve issues with HTT competent staff	Service Manager	CA07	Roster	Duplicate	This is being actioned as part of M1.1.2					
M1.1.5 - There was no procedure in place that described the steps to take should there be no blood transfusion competent staff available to carry out transfusion activities. Ad hoc arrangements that had been used were over reliant on staff good will and not sustainable.											
1	A safe staffing Standard Operating Procedure detailing how staffing risks are identified, assessed and escalated will be in place	Head of Pathology	CA03	Safe Staffing	Duplicate	This is being actioned as part of M1.1.1					
2	Interim Escalation Flowchart is in place for immediate use at HTT huddle	Head of Pathology	CA02	Escalation	Duplicate	This is being actioned as part of M1.1.1					
3	Dashboard to be introduced to show core staffing and safety metrics to support planning and mitigation of risks over time	Deputy Head of Business Intelligence	CA14	Dashboard	Active					◆	
4	In liaison with One Dorset Pathology, redivert tests to UHD; concentrate on urgent activity to ensure safe service provision e.g. cease all non-urgent GP requests.	Head of One Dorset Pathology	CA05	Activity Transfer	Duplicate	This is being actioned as part of M1.1.1					
M1.1.6 - The Trust had brought in an interim system for paper-based blood collection in light of issues with the implementation of blood 360. The system was designed to address interruption of laboratory staff, however, there was insufficient evidence that the risks associated with this system had been adequately assessed and mitigated.											
1	A project team and plan to be put in place for the implementation of Haemonetics at DCH	Deputy CIO, Head of ODP, Head of Pathology	CA15	Haemonetics	Active			◆			
2	An ongoing evaluation of the paper-based system in use until the introduction of Haemonentics, to monitor and assess any risks and mitigations needed for a safe service	Quality Manager	CA16	Blood 360	Active			◆			
Workstream 2 - Jan 22 Inspection											
J1.1.1 - There was inadequate resourcing of the quality system:											
J1.1.1.1	A Capacity and Demand plan will be developed to determine the resource required to maintain the transfusion laboratory operations and the Quality Management System.	Hospital Blood Bank Manager/ Quality Manager	CA06	Demand & Capacity	Duplicate	This is being actioned as part of M1.1.2					
J1.1.1.2	1. Trust IT, MSoft & Clinisys to remediate the challenges identified within Blood360. Blood360 will be ready for full validation in test environment week commencing 24/01/2022.	Alex Davies & Quality Manager/ Pathology IT Support	CA16	Blood 360	Closed	Requirements for validation has been overtaken by events. ODP has made the decision to move to Haemonetics.					
J1.1.1.2	2. Training of Porters to be completed 01/03/2022. This will remove blood collections from the laboratory area.	Service Manager/ Transfusion Nurse Practitioner	CA17	Porters	Closed	The 'go-live' date for the porters transporting the blood components was the 1 Jun 22					
J1.1.1.2	3. All short-term solutions are to have an Impact Risk Assessment completed to mitigate the risk until the training of porters is complete.	Hospital Blood Bank Manager/ Quality Manager	CA17	Porters	Closed	The 'go-live' date for the porters transporting the blood components was the 1 Jun 22					
J1.1.1.3	Review and implement internal processes to identify and escalate appropriate issues within the service. This will provide an agreed pathway in place for escalation from the Transfusion Laboratory Service through Divisional Governance Management structures and Governance Committees through to sub–Board Committees. The executive will support the resource requirements that are identified as required for the Blood Bank.	Head of Laboratories & Hospital Blood Bank Manager	CA02	Escalation	Duplicate	This is being actioned as part of M1.1.1					

Respect Integrity Teamwork Excellence

"Pathology Programme" Gantt Chart

Please use the example and legends (shown below at the bottom of the sheet) to complete your Gannt Chart

NHS Dorset County Hospital NHS Foundation Trust

Status	Under Action	Mile-stone
Planned		◆
Completed		◆
In Progress		
Off Track		◆

Project Plan Gannt Chart						Quarter 1					Quarter 2												
Action #	Corrective Actions	Owner	CA Ref #	Description	Status	May		Jun			Jul				Aug					Sep			
J1.1.1.4	All escalations will be recorded and tracked through each management meeting until the point of closure. This will be supplemented by the organisational risk management system (Datix) via incident reporting and the recording of the risk on the risk register. These actions will be included within the requirements of the Capacity plan. Action trackers and minutes recorded will ensure that feedback and appropriate escalation takes place following the Trust escalation process.	Head of Laboratories & Hospital Blood Bank Manager	CA02	Escalation	Duplicate	Escalations are being actioned as part of M1.1.1 and the Demand & Capacity Plan is being actioned as part of M1.1.2																	
J1.1.2 - Change control and validation procedures were deficient:																							
J1.1.2.1	Review change control procedure, identify and implement plan for maintaining URS as a live document. Revalidation procedure will ensure URS is kept up to date with any major changes being reviewed at the Hospital Transfusion Team meeting.	Hospital Blood Bank Manager & Quality Manager.	CA16	Blood 360	Closed	Requirement for a Blood360 URS has been overtaken by events. ODP has made the decision to move to Haemonetics. M1.1.6 also refers.																	
J1.1.2.2	All new risk assessments to go onto Q-Pulse for sign off by the Head of Laboratories, after review by the Head of Blood Bank and the Quality Manager. Risks will be regularly reviewed at appropriate Departmental and Care Group meetings to ensure that risks, plans and mitigations are accurate. Further escalations will be made without delay	Hospital Blood Bank Manager & Quality Manager	CA18	Risk	Already in Place	◆																	
J1.1.2.3	Management will support further QMS training for all operational staff in the HBB. This will be part of the regular training plan and subject to re-training at minimum every 2 years or significant changes to operational requirements.	Departmental Training Officer & Quality Manager	CA08	Training	Duplicate	This is being actioned as part of M1.1.2																	
J1.1.3 - The site failed to adequately manage the remediation commitments to the inspection carried out in March 2019 regarding actions taken to improve deviation management and accurately report progress to the inspector:																							
J1.1.3.1	The revised capacity management plan will include the workload associated with the QMS, and mitigations where appropriate using impact risk assessments. The implementation of effective RCA and CAPA and or documented justification where this cannot be achieved will be adequately supported	Hospital Blood Bank Manager & Quality Manager	CA06	Demand & Capacity	Duplicate	This is being actioned as part of M1.1.2																	
J1.1.3.2	The Policy for the management of non-conformances will be revised to include actions to be taken when named individuals cannot or have not completed the required action by the deadlines specified and included in the capacity plan. Monthly pre-Business & Quality one to one meetings with the Head of Blood Bank and the Quality Manager to cover quality reports in addition to overdue non-conformities.	Hospital Blood Bank Manager/ Quality Manager	CA19	Non-conformance Policy	Active									◆									
J1.1.3.3	The Policy for the management of non-conformances will be revised to include actions to be taken when an investigation requires an extension, including any associated risk assessments appropriate to the stage of the outstanding investigation.	Hospital Blood Bank Manager & Quality	CA19	Non-conformance Policy	Active									◆									
J1.1.3.4	The revised capacity management plan will include the workload associated with the QMS.	Hospital Blood Bank Manager & Quality	CA06	Demand & Capacity	Duplicate	This is being actioned as part of M1.1.2																	
J2.1.1 - The control of user access to the WinPath LIMS system enabled users to access the account of other colleagues if they did not log out of both the LIMS application and remote portal access area:																							
J2.1.1.1	We have removed the generic logons wef 28 Apr 22 which has removed the root cause and resolved the issue.	Hospital Blood Bank Manager, Quality Manager & IT Pathology	CA20	Logins	Closed	Completed																	
J2.1.2 - There was a lack of Service Level Agreements (SLA) or similar documents for key IT functions and services:																							
J2.1.2.1	A Trust IT Operational Level Agreement is in place to ensure security and systems are maintained with effective response times for actions. This is being forwarded to the Laboratory Department. To ensure effective communication, Pathology IT to be included each month at a Change Advisory Board meeting. The communication link between the Laboratory Department and the Trust IT Department is the responsibility of Pathology IT Manager.	Service Manager / Pathology IT Manager	CA21	IT OLA	Active													◆					
J2.1.2.2	All identified agreements are to be reviewed with any outstanding agreements being identified and addressed by Interim Pathology Service Manager with input from Trust IT and procurement.	Service Manager	CA21	IT OLA	Active													◆					

Respect Integrity Teamwork Excellence

"Pathology Programme" Gantt Chart

Please use the example and legends (shown below at the bottom of the sheet) to complete your Gannt Chart

NHS Dorset County Hospital NHS Foundation Trust

Status	Under Action	Mile-stone
Planned		◆
Completed		◆
In Progress		
Off Track		◆

Project Plan Gannt Chart						Quarter 1					Quarter 2												
Action #	Corrective Actions	Owner	CA Ref #	Description	Status	May		Jun			Jul				Aug				Sep				
J2.1.2.3	A Trust-wide Change Control process is in place to ensure regulatory requirements are met, which is to be embedded within Pathology. Any changes are subject to the Change Advisory Board which meets weekly. Pathology IT to be included each month at a Change Advisory Board meeting. The Change Control document is being forwarded to the Laboratory teams from the Trust IT Department. The Change Control Process will then be reviewed by Head of Laboratories, Pathology Quality Manager and Pathology IT Manager.	Head of Laboratories & Head of Digital Technology	CA22	Change Control	Active												◆						

Meeting Title:	Board of Directors Part 1
Date of Meeting:	21 July 2022
Document Title:	**Equality Diversity and Inclusion (EDI) Annual Report**
Responsible Director:	Dawn Harvey, Chief People Officer
Authors:	Ebi Sosseh, Inclusion Lead 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	18 July 2022	

Purpose of the Paper	To note and approve the Equality Diversity and Inclusion (EDI) Annual Report. Additionally, to note and approve the EDI Plan (Appendix Two). The report summarises the action we have taken over the past year towards our strategic aims. All public authorities have a legal requirement to publish their EDI activities on an annual basis as part of their Public Sector Equality Duty, as set out in the Equality Act 2010.							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	✓
Summary of Key Issues	DCH continues with its firm commitment to provide a supportive environment where our staff, patients, visitors and service-users can all feel that they belong. This is the first full ED&I Report since July 2020. There have been separate reports provided to PCC during 2021 on key equality frameworks to ensure legal compliance. In April 2021, the Trust's EDI roadmap was rooted in a number of initiatives aimed at developing inclusive behaviours and practices. Good progress has been made with the Dignity & Respect at Work Programme (initially aimed at B2-6) and this is now being offered to all grades as originally intended. It will be integrated into other programmes such as Management Matters and Inclusive Leadership to support our culture change journey. The Inclusive Leadership Programme (for B7+) has been delivered by external consultants to 8 cohorts of leaders. Evaluation has been undertaken, the programme content is currently being reviewed and refreshed and will move to in-house delivery from Autumn 2022. The Reciprocal Mentoring Programme originally intended to be delivered by the NHS Leadership Academy early in 2022 was withdrawn due to national funding issues but is being replaced by an in-house version from August onwards. A cohort of staff from ethnic minority communities							

	participated in a pilot of a system-wide Beyond Difference Programme in 2021. A refreshed version of the programme will be accessible later in 2022. Our Staff Networks have increased in number. Focused engagement activities and communication plans have strengthened the way the networks operate and how they support staff from under-represented groups. The ED&I Plan (& Actions) has been refreshed and included as Appendix B.
Action recommended	The Board is asked to: 1. **NOTE AND APPROVE** the Equality Diversity & Inclusion Annual Report 2021/22 and ED&I 2022-25 Plan (Appendix B).

Governance and Compliance Obligations

Legal / Regulatory	Y	The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful: discrimination, harassment and victimisation. The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
Financial	N	
Impacts Strategic Objectives?	Y	People, Place, Partnership – The Trust strategy signals our intention to truly value our staff. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.
Risk?	Y	Non-compliance with the PSED would create risks for the organisation in terms of reputation and potential fines.
Decision to be made?	Y	NOTE AND APPROVE the Equality Diversity & Inclusion Annual Report 2021/22 and ED&I 2022-25 Plan
Impacts CQC Standards?	Y	Development of fair and inclusive leadership, practice and culture contributes to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains
Impacts Social Value ambitions?	Y	Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge.

Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Equality, Diversity and Inclusion (EDI) Annual Report 2021-22

Executive Summary

At Dorset County Hospital Foundation Trust (DCHFT) we believe that equality, diversity and inclusion (EDI) is everybody's business and sits at the heart of the organisational culture and is considered in all that we do. All public authorities have a legal requirement to publish their EDI activities on an annual basis as part of their Public Sector Equality Duty, as set out in the Equality Act 2010. This report summarises the action we have taken over the past year towards our strategic aims. It outlines where we have had success and how we recognise there is more to do. The Committee is asked to note and approve the Equality Diversity and Inclusion (EDI) Annual Report including our next steps, and to note and approve the EDI Plan which is shown at Appendix 2.

1. Introduction

1.1 At DCHFT we continue to strive to ensure a culture of inclusion, understanding, kindness and respect sits at the heart of our People agenda. We have a firm commitment to provide an inclusive and supportive environment where our staff, patients, visitors and service-users feel that they belong and matter.

1.2 During 2021/22the COVID-19 pandemic continued to impact and we recognise this has been a particularly difficult time for our people. The on-going listening and learning from staff experiences is critical as we move forward.

1.3 This is the first full ED&I (Annual) Report since July 2020. There have been separate reports provided to PCC during 2021 on key equality frameworks: Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap. Those reports are referenced within this Annual Report as high-level overviews of our national reporting requirements.

1.4 In April 2021, the Trust's EDI roadmap was rooted in a number of initiatives aimed at developing inclusive behaviours and practices. Good progress has been made with the Dignity & Respect at Work Programme (initially aimed at B2-6) and this is now being offered to all grades as originally intended. It will be integrated into other programmes such as Management Matters and Inclusive Leadership to support our culture change journey.

1.5 The Inclusive Leadership Programme (for B7+) has been delivered by external consultants to 8 cohorts of leaders. Evaluation has been undertaken, the content is currently being refreshed and will move to in-house delivery from Autumn 2022. The Reciprocal Mentoring Programme originally intended to be delivered by the NHS Leadership Academy early in 2022

was withdrawn due to national funding issues but is being replaced by an in-house version from August onwards. A cohort of staff from ethnic minority communities participated in a pilot of a system-wide Beyond Difference Programme in 2021. A refreshed version of the programme will be accessible later in 2022.

1.6 Our Staff Networks have increased in number. Focused engagement activities and communication plans have strengthened the way the networks operate and how they support staff from under-represented groups.

1.7 Our 'Transforming People Practices' initiative commenced in April 2021, resulting in our Discipline Policy being re-written with a 'Just & Learning' approach. A refreshed Appraisal process launches in July 2022 and values-based recruitment practices have been implemented.

1.8 This report summarises the action we have taken over the past year towards our strategic aims. The ED&I Plan (& Actions) has been refreshed and included as Appendix B.

1.9 Progress on ED&I activity is monitored by the Trust's Equality, Diversity & Inclusion Steering Group (EDISG). The Terms of Reference for this group have been updated to clarify the purpose and membership of the group.

1.10 The Committee is asked to note and approve the EDI Report 2021/22 and ED&I 2022-25 Plan.

2. Training and Staff Development

2.1 Our Inclusion Lead has reviewed mandatory online EDI training modules and contributed to improved content, providing practical scenarios for staff which have a stronger reference to the inclusion agenda.

2.2 Training on Gender Awareness, Disability Awareness and International Communications have contributed to a rich programme of ED&I learning.

2.3 A cohort of staff from ethnic minority communities participated in a pilot of a system-wide Beyond Difference Programme in 2021. A refreshed version of the programme will be accessible later in 2022.

2.4 A basic Management Toolkit was developed and located on the Staff Intranet during the summer of 2021. Managers will be further supported by a new Management Matters Programme launching in October 2022.

2.5 Whilst an initiative to qualify line managers as Mental Heal First Aid Champions did not get off the ground, there has been a re-focus on utilising existing Mental Health First Aiders to become Health & Wellbeing Coaches (HWCs), with CPD routes planned to include suicide awareness training. The first cohort of HWCs has been launched in April 2022, with more cohorts planned. Line managers will be accessing a session on how to have 'Safe & Effective Wellbeing Conversations' as part of a new Management Matters Programme. The session is based on a national NHS Health & Wellbeing Framework.

3. Staff Support Networks

3.1 Four staff support networks are fully active within the Trust. They are the Ethnic Diverse, Overseas Staff, Pride (LGBTQ+) and Without Limits (Disability & Carers) Networks. All Staff Networks have Communication and Action Plans in place to engage more effectively with staff. The Armed Forces Staff Network is currently in the process of rebranding their purpose.

3.2 The networks have used the recent National Staff Network Day to engage wider across the organisation. The networks have acted as critical friends to the Trust with suggestions around making communication more accessible and embedding inclusive recruitment practices.

3.3 Some of the network chairs have also shared the need for more protected time to better support their members. A proposal will be shared with the Senior Leadership Group (SLG) in August for consideration and discussion.

3.4 Staff disclosure of disabilities and long-term health conditions remains low on our ESR system and does not match the figures disclosed via the Staff Survey. Work is ongoing to encourage staff to disclose their status on ESR so we have more accurate data to work with.

4. Inclusive Leadership Programme

4.1 The Inclusive Leadership Program commenced in June 2021 with 8 cohorts running up to June 2022. Each cohort comprised approx. 20 managers (Band 7+ with line management responsibilities) and was designed and facilitated by two external consultants.

4.2 The programme consisted of 6 sessions covering 3 over-arching themes: Seeing Differently, Responding Differently and Leading Differently. The programme was aimed at supporting our managers to develop their ability to integrate a ‘pro-equity’ approach into the teams they lead, manage & supervise.

4.3 Participants were invited to complete a baseline questionnaire at the start and end of the programme to enable self-assessment and measurement of impact. Evaluation has proved mostly positive, with individuals committing to practical actions following the programme.

4.4 The on-going delivery of the programme has now transferred to the OD Team who are currently reviewing feedback before re-launching a refreshed in-house version later this year.

5. Reciprocal Mentoring

5.1 The original programme delivered by NHS Leadership Academy, due to commence in 2021 was cancelled due to a re-direction of funds. Our own in-house version commences in August 2022. The initial focus will be for staff from under-represented groups to partner with senior staff who have participated in the Inclusive Leadership Programme.

5.2 A key focus of the mentoring relationships will be identifying opportunities for making change to support the inclusion agenda. Most of the mentors are from the cohorts of the Inclusive Leadership (IL) programme who want to progress their inclusive leadership journey. Members of our staff networks will be partnered with the IL Mentors.

6. ED&I Frameworks (WRES, WDES and GPG)

Workforce Race Equality Standard (WRES)

6.1 The Workforce Race Equality Standard (WRES) is the national framework through which Trusts measure their performance against nine key indicators around race and ethnically diverse staff.

6.2 Four of the Staff Survey questions are used as indicators within the WRES. Three indicators show positive trajectories including less staff reporting harassment and bullying from staff (down 11%).

6.3 In last year's WRES report, the high percentage of staff believing that the Trust provides equal opportunities for career progression and promotion resulted in the Trust being ranked as one of the best performing Acute Trust's for this Indicator. This year we have seen a decline from 84.3% to 67.2%. Whilst this is 5.3% below the national average for BME staff, last year the figure was 10.2% above the national average. This year's figures indicate an increasing disparity between White and BME staff, being 23.3% (in comparison with 7.5% last year).

Workforce Disability Equality Standard (WDES)

6.4 The Workforce Disability Equality Standard (WDES) is similar to the WRES, but looks at the experiences of staff with disabilities or long term health conditions (LTCs).

6.5 Nine of the Staff Survey questions are used as indicators within the WDES. Six indicators show positive trajectories including more staff saying they would report experiences of bullying and harassment (up 7%). The staff engagement score has remained static at 6.9 but is higher than the national average for staff with LTCs.

6.6 The percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, states that despite not feeling well enough to perform their duties The data shows a decrease for Disabled staff of 3.4% resulting in 30.8% saying they have felt pressurised to come to work, which is unacceptably high.

WRES & WDES

6.7 The ED&I Staff Survey results indicate we are heading in the right direction, but we also recognise there is more work to do. More detailed information is available on our Equality Diversity and Inclusion page of the DCHFT website.

6.8 Actions to address some of the findings include: mentoring opportunities, career conversations, talent development and encouraging the reporting of bullying and harassment.

Positives	Could Improve
Higher positive score of ethnically diverse staff saying that they were looking forward to going to work (64%)	Experiencing harassment from patients up by 9% from 2020 for staff with disabilities
(76%) feel empowered to make suggestions to improve their work (ethnicity)	(54%) (ethnically diverse) reported a negative score having worked extra hours on top of their normal contracted hours compared to white staff (35%)
(75%) feel that their line manager is encouraging at work 71% for white staff) (ethnicity)	(Bullying and Harassment in terms of ethnicity) the numbers that had negative experiences was still higher than white staff (34% to 25%)
Equal opportunities for career opportunities up by 17% and 11% above average (ethnicity)	Figures are down by 1% on previous year on reasonable adjustments (Disabilities) but still high at 75%
Equal opportunities for career opportunities up by 4% (staff with Disabilities)	
Pressure for staff with disabilities to come to work when unwell are down by 3%	

Gender Pay Gap (GPG)

6.9 Across our entire workforce our mean gender pay gap is 26%. This means that the average hourly pay rate for men is 26% higher than for women. This is a 5% improvement on the pay gap recorded in 2020. Our overall median gender pay gap is 9%. This means that the mid-point hourly rate for men is 9% higher than for women. This is significantly lower than in 2020 where the overall median gender pay gap was 22%.

6.10 Our proportion of male and female staff should be taken into account when looking at our gender pay gap, as should the age range of our male and female workforce, as members of staff who have enjoyed long careers in the NHS can often be higher up the pay point scales than those who are just starting their careers.

6.11 Plans to narrow the gender pay gap includes:

- Further flexible working options. Allowing employees to fulfil their roles and their personal commitments at home.

- Deliver on our commitment to quality appraisal for all staff to support talent management and succession planning. Support the development of female employees through mentoring and leadership development. Give focus to our female employees in the lower bands to equip them with the skills and to give them the confidence to apply for our more senior posts.

- To review the Equality Impact Assessments around recruitment and promotion processes in case of any hidden barriers to women staff progressing.

For more details about the WRES, WDES and the Gender Pay Gap report, see Appendix A on page 7.

7. Communication and Engagement

7.1 Numerous opportunities have been created to increase the levels of communication and engagement about our Inclusion agenda at DCHFT. The introduction of the weekly Organisational Development bulletin has ensured that inclusive topics, information and guidance is featured on a weekly basis for all staff. Our OD roadshow secures slots at existing Team Meetings to cover the wider work of the OD department.

7.2 'Let's Talk Inclusion' lunchtime conversations have been a very useful forum for discussing inclusion. These sessions have attracted interest at system, regional and national level with colleagues from other parts of the NHS joining regularly.

7.3 The 'inclusion' Twitter handle has also created a focal point for information to share with staff, other parts of the NHS and the public.

7.4 To increase networking opportunities and peer support across our staff networks, all networks have their own MS Teams channel. Bespoke WhatsApp groups aimed at overseas doctors and nurses, which include staff from India, Nigeria and the Philippines, have been successful in increasing the sense of belonging.

8. Overseas Staff Support

8.1 Over the past year we have continued to make progress in terms of our inclusive support to staff from overseas. The Education Department has a team of preceptorship staff who undertake a range of training and pastoral care to support new staff. Our Inclusion Lead and Overseas Staff Network Chair have been actively supporting individuals and groups of staff

8.2 Support ranges from helping to source accommodation, providing advocacy and networking opportunities. The Accommodation Team provide guidance and support materials for new staff seeking non-Trust rented properties and the recent decision to issue letters of guarantee has been a major step forward in reducing anxiety levels.

9. Equality Diversity and Inclusion (EDI) Plan

9.1 The ED&I 2022-25 Plan & Actions (see Appendix A page 8) have been refreshed, with a Trust-wide focus incorporating staff, service delivery and external engagement issues. The aims of the refreshed plan align with the DCH People Plan.

10. Conclusion

10.1 Despite the challenge of the ongoing pandemic, absence of an Inclusion Lead for much of 2021 and shifting work demands and priorities, the Trust had remained steadfast in ensuring that the inclusion agenda remains central to what we do.

10.2 We recognise that much still needs to be done to ensure respectful and inclusive behaviour across the Trust as well as continue to raise awareness of ED&I including wider health inequalities issues.

10.3 The ED&I Plan and actions provide the direction and focus needed to coordinate and monitor progress. The renewed push to strengthen our Staff Networks will enable staff to have their diverse needs recognised and enable their voices to be heard. Our inclusive leadership, recruitment and retention approaches will pave the way towards Dorset County Hospital being an employer of choice.

10.4 Our next steps include:

- Embedding Inclusive Recruitment practices within the workplace
- Expanding support services for overseas staff around accommodation issues
- Embedding career conversations for all staff, with pilots for Staff Network members, to recognise talent and support progression.

11. Recommendations

The People and Culture Committee is recommended to note and approve the Equality Diversity and Inclusion report 2021/22 and Appendix B (ED&I Plan) for submission & publication.

12. Appendices

Appendix A:

Workforce Race Equality Standard (WRES) Report 2021
https://www.dchft.nhs.uk/wp-content/uploads/2021/09/WRES-Report-2021.pdf

Work Disability Equality Standard (WDES) Report 2021
https://www.dchft.nhs.uk/wp-content/uploads/2021/10/DCHFTWorkforceDisabilityEqualityStandard2021.pdf

Equality Delivery System 2
https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Public Sector Equality Duty (PSED)
https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

Gender Pay Gap Report 2021
https://www.dchft.nhs.uk/wp-content/uploads/2022/03/Gender-Pay-Gap-Report-2021.pdf

Appendix B

Equality, Diversity and Inclusion Plan

2022-25

Photo source: unsplash.com

Placing diversity and inclusion at the heart of our culture

Foreword

The last two years has been challenging on many fronts, for our staff and society at large, as we grappled with the pandemic whilst aiming to delivery top class healthcare to our communities. We also recognise the fact that Equality Diversity and Inclusion issues have to be a major priority in terms of wellbeing and creating a culture where everyone feels respected and valued.

We are delighted to introduce the Dorset County Hospital (DCH) Equality, Diversity and Inclusion (EDI) three year Plan (2022-25). The Plan will build on the current EDI roadmap for a pro equity and inclusive culture, whilst aligning to our wider people Plan. Our approach will setout how will continue to deliver our ambition to be the best place for patient care and experience and the best place to work, reflecting our commitment that everyone who works at, or comes into contact with DCHFT feels welcomed, respected and included.

We have made great strides with our inclusive Leadership training programme, recruiting a Freedom to Speak Up Guardian and establishing staff support networks, but we recognise that more needs to be done.

We believe equality, diversity and inclusion is everybody's business and sits at the heart of the organisational culture and is considered in everything we do.

As leaders, we recognise that more needs to be done to ensure an inclusive culture, proactive leadership and an adherence to our values of Integrity, Respect, Teamwork & Excellence, at all levels throughout the organisation. We remain aspirational in ushering in a culture of kindness, mindfulness and where every individual can feel that they can maximise their potential within a safe environment.

Culture is set from the top, middle and roots of any organisation and it is vital that all staff adopt the principles of the plan and embrace inclusive behaviours.

To achieve the aims and objectives set out in this plan we also recognise that we have a duty to provide the best care possible to our patients and to also contribute towards keeping our communties healthy. In this regard, our approach will be to equip our staff with diverse insights about our local population as well forge closer links with the communities that we serve.

Our refreshed approach recognises that we have made significant progress in our journey towards an inclusive environment where all sections of the Trust feel engaged, feel that they belong, feel valued and fulfilled and that everyone is able to bring their best self to work.

(Signed by CEO & Board Chair)

1. Vision, values and strategic objectives

Reflecting on our message of 'placing diversity and inclusion at the heart of our culture', this approach has arose from the following principles:

For patients

Improved patient access, safety and experience

The Trust will create a culture of care based on positive attitudes towards welcoming the diversity of patients, their families, carers and service users and meeting diverse needs. The Trust will be an organisation that continually improves by embedding inclusion principles and standards into everyday practice and placing them at the heart of policy and planning

For staff

A diverse, valued and supported workforce

The Trust will be an employer of choice that recruits and develops staff fairly, taking appropriate action whenever necessary so that talented people choose to join, remain and develop within the Trust. Strong equality, diversity and inclusion at all levels will underpin consistently good patient care across all services

Inclusive and compassionate leadership

The Trust will ensure that our leaders are equipped to achieve and create an increasing and sustainable legacy of inclusion, ensuring a Trust-wide culture where everyone is seen, heard and valued. We will challenge inequality in all its forms and promote dignity, respect and understanding within the Trust and our diverse communities.

2. How will be achieve this

- To develop the culture where staff can be their best selves, feel fulfilled in their work environment and maximise their potential;
- To cultivate an environment of learning, reflection and growth in terms of an inclusive approach to staff retention and patient care delivery;
- Promoting and supporting inclusive leadership at the Board, Senior Management Team and across the organisation at all levels.

3. Drivers

At Dorset County Hospital (DCH) we aspire to providing outstanding care for people in ways which matter to them. Our vision to look after and invest in our staff, developing our workforce to support outstanding care and equity of access and outcomes aligns to our EDI objectives where everyone feels they belong, they matter, and their voice is heard.

There are also a number of legal requirements, national standards and contractual obligations that the Trust must meet to eliminate discrimination and advance equality of opportunity and community cohesion apart from the Equality Act 2010 and the Public Sector Equality Duty (PSED):

- Equality Delivery System (EDS) 3 which has has four goals:
    - Better health outcomes
    - Improved patient access and experience
    - A representative and supported workforce
    - Inclusive Leadership
- Workforce Race Equality Standard (WRES);

Which is a mandatory requirement embedded within the NHS Contract to ensure effective collection, analysis and use of workplace data to address the under-representation of staff from minority communities, their representation per pay band and access to development and promotion opportunities across the NHS.

- Workforce Disability Equality Standard (WDES);

  A set of ten specific measures (metrics) that enable NHS organisations to compare and better understand the experiences of disabled and non-disabled staff. It will support positive change for existing employees and enable a more inclusive environment for disabled staff working in the NHS

- Gender Pay Gap (GPG);

  Introduced in 2018. All employers with 250 or more employees are required to comply with reporting and action planning each year on seven metrics including, mean gender pay gap; median gender pay gap; the proprtion of men and women in each quartile pay band to readdress inequity in pay.

- The National Staff Survey provides the opportunity for benchmarking against the above frameworks.

See appendix one (page 8) for more information about the frameworks.

We are also driven by the desire to tackle known inequalities when it comes to the experiences of diverse members of staff and patients. Through national studies, research and publications, we are aware of the disparities facing various staff groups in terms of opportunities in the workplace, feelings of isolation, experiences of discrimination, lack of maximising ones' potential sometimes mostly directly or indirectly related to their protected characteristics.

Patients from different ethnic backgrounds have varying levels of outcomes for example in maternity services, People with learning disabilities are 4 times more likely to die of preventable causes and Older people report receiving poorer levels of care than younger people with the same conditions.

Evidence has also shown that fair treatment of staff is linked to a better experience of care for patients. Moreover, the NHS is amid a workforce crisis and improving its performance on diversity and inclusion will play an important role in the NHS becoming a better place to work and build a career.

4. Progress so far

As we emerge from the pandemic, acknowledging the challenges that our service and staff have faced, we are also mindful about recognising and celebrating some of the progress made over the last few years, examples of which include:

- Being a Disability Confident Employer;
- Establishing five Staff Support network groups namely;
    - Armed Forces Network;
    - Ethnic Diversity Network;
    - Overseas Staff Support Network;
    - Pride (LGBTQ) Network;
    - Without limits Network (disability).
    - Rollout of a trust—wide Inclusive Leadership training programme;
    - Appointment of a Freedom to Speak Up (FTSU) Guardian;
    - Establishing a network of staff wellbeing Coaches;
    - Creation of welcome packs for overseas workers;
    - Adapting fire alarms systems to suit those with hearing loss.
    - Collecting feedback from recently recruited staff on their experience of the recruitment process
    - The new Disciplinary policy which was ratified via Partnership Forum in November is now in use. A soft launch approach is supporting the introduction of the new policy; this involves training and advising managers as individual situations arise.
    - A values-based recruitment approach for Healthcare Support Workers has been rolled out. The long-term aim, captured within the people plan, is to include an element of valued based recruitment in all selection processes.

5. From Plan to Practice

1. **To further develop the culture where staff can be their best selves, feel fulfilled in their work environment and maximise their potential;**

- Co-create Development programmes with the Staff Network Leads to become sustainable with increased visibility, membership, wider reach and impact;
- Implement programme of Talent Development within the organisation with the emphasis on unearthing hidden talents;

- Develop a Reciprocal Mentoring offer between members of our staff networks and the attendees of the Inclusive Leadership Programme;
- Create a project around 'Career Conversations' with targeted members of our diverse workforce.

2. **To cultivate an environment of learning, reflection and growth in terms of an inclusive approach for staff retention and patient care delivery;**

- Offer and facilitate bespoke training programmes (Inclusion) to trust staff;
- Embed Inclusive Recruitment practices across the trust;
- Create 'Curious Conversations and 'Information Sharing' events around diverse topics;
- Ensure that there is equity of access to the 'Freedom to Speak Up' Guardian across the protected characteristics.
- Review other existing people policies, following the same approach taken with the Disciplinary policy. The expectation is the next set of policies to review will be the Probationary policy, Grievance policy, and Performance Management policy.

3. **Promoting and supporting inclusive leadership at the Board. Senior Leadership Group and across the organisation at all levels.**

- To be the lead sponsor of new Inclusive initiatives across the trust;
- To translate personal 'Inclusive' Pledges into work-based action;
- To be an ambassador for sharing ED&I good practice across the organisation.

Equality	Equality doesn't mean treating everybody the same – it means being fair and ensuring everyone is treated individually and in a way that is appropriate for them. At DCHFT we offer one to one sessions around assessing the impact of our major plans, strategies and policies.
Diversity	For DCHFT diversity means being inclusive of all our differences and including everyone. We actively encourage the recognition and celebration of diverse events such as Black History Month, LGBTQ History Month and work closely with our catering manager to ensure that our offer to staff and patients is diverse.

Inclusion	Inclusion means valuing and celebrating differences and encouraging an open culture for staff and patients. We encourage all of our staff networks to determine their own direction in terms of supporting each others needs.

6. Moving Beyond compliance- Our Vision for EDI

Our vision for EDI at the Trust is that it becomes the 'golden thread', running through everything we do. EDI will inform the way we think and work and be woven into all of our policies, procedures and behaviours.

EDI will be mainstreamed, with Board members and senior leaders championing equality and diversity and applying a consistently inclusive approach and EDI objectives will be integrated into business plans.

Our EDI Steering Group will be actively involved in setting the direction of travel for EDI, providing views and comments on proposals and signing off reports before submission to Boards and Committees.

7. Measures of Success

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

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

- Board members and leaders at all levels will routinely demonstrate their commitment to equality, diversity and inclusion
- Board and Committee papers will identify equality-related impacts and how they are mitigated and managed
- When at work staff are free from abuse, harassment, bullying and physical violence from any source *(SOS, Quarterly staff survey, ER data)*
- Staff believe the Trust provides equal opportunities for career progression and promotion *(shortlist to hire data)*
- Staff recommend the Trust as a place to work and receive treatment *(SOS, Quarterly staff survey)*

- Greater diversity in our senior management and leadership structures *(workforce demographic by band, improvements at 8a and above via a goal-oriented trajectory of progress)*
- People report positive experiences of Trust services *(FFT)*

Appendix A (Links to EDI frameworks)

Workforce Race Equality Standard (WRES)
https://www.england.nhs.uk/wp-content/uploads/2014/10/wres-indicators-april-16.pdf

Work Disability Equality Standard (WDES)
https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/#:~:text=The%20Workforce%20Disability%20Equality%20Standard,and%20publish%20an%20action%20plan.

Equality Delivery System 2
https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Public Sector Equality Duty (PSED)
https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

Meeting Title:	**Board of Directors**
Date of Meeting:	**27th July 2022**
Document Title:	**Well Led Review Action Plan Update**
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	16th March 2022	Consider involvement of non-clinical divisions in the action plan Meetings with divisional triumvirate on Divisional and Care Group Governance actions. SLG members to input to the draft action plan Return an update in 6 weeks' time
Trust Board	30th 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.
Executive Management Team and Management Action leads	Monthly	Monthly updates to actions and assurances obtained and reported to Board Bi-monthly.

Purpose of the Paper	This paper provides updates to Action Plan in response to the Well Led review undertaken in Quarter 3 2021/22 by PriceWaterhouseCoopers received from identified action leads, divisional teams and the Executive Team.						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The Action Plan outlines the planned responses and timescales to the nine action recommendations arising from the Well Led review and is presented to the Board of Directors for assurance and information. Key action progress areas are: **1 Leadership** – financial scrutiny meetings established between CEO, CFO and budget leads **2 Board Development** – Board debriefs following Myers Briggs Type Indicator review **3 System Working** – Progressing development of Management Matters training. On schedule for October Launch. - Progressing plans for first bi-annual leadership summit in September - Further operational performance and financial challenge - Communication and Stakeholder Engagement Plan in early development **5 Performance Management** – further development of the Balanced Scorecard and implementation of SPC reporting **6 Care Group Governance** – Management Matters moving to design phase						

	- Care Group meetings audit in planning **7 Leadership Visibility** – Team Briefing reviewed and relaunched
Action recommended	The Board of Directors is invited to note the updated 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 Objectives?	N	Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust Strategy.
Risk?	N	
Decision to be made?	N	
Impacts CQC Standards?	Y	Foundation Trusts are required to commission an independent external review of their Well Led arrangements every three years.
Impacts Social Value ambitions?	Y	Ensuring that the Trust is Well Led is a fundamental requirement to ensuring delivery of the Trust's social value ambitions.
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Dorset County Hospital
NHS Foundation Trust

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, with CEO and CFO Financial scrutiny meetings being held with all Divisional and Corporate Budget leads.
					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.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
Responsible Committee:		Finance and Performance Committee								
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		Individual 1-1 debriefs took place during March & April. Board Development session introduced MBTI Team Map, to highlight potential blindspots. Facilitated discussion showcased insights. MBTI App distributed post-session, to support effective communication utilising insights & learning about self and others. To be used as a springboard for further development.
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.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
		• Ensuring DCH is communicating in a way that is impactful - consider who is giving the messages and in what forum.	September 2022	**Medium**	2. Stakeholder Messaging Strategy to be developed. Develop regular key messages for sharing. Agree with Trust Board key messages & positives relating to ICS/ICB		Nick Johnson	Phil Davis		ICB formed by July 22, processes being put in place to support communications: 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. **Management Matters** – focus groups completed, at design stage. On target for October launch. Bi-annual **Leadership Summits** agreed, first one 5th September. Agenda covering: (1) Strategic oversight, ICS, DHC & collaborative working. (2) Operational Finance & Performance, financial

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										challenges/thinking & working differently (3) How we do Assurance at DCH – difference between reassurance & assurance, environment more focused on finance & performance
		• 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		Work in progress to develop the Trust narrative and commence plan.
Responsible Committee:		Board								
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		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.

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					Performance, Strategic Change and Leadership / Improvement Capability.					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) Work underway to develop Balanced Scorecard and Strategic Dashboard, pending BI Team approval of an SPC solution.
					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 –		Anita Thomas	OD Team		Management Matters focus groups completed. Moving to design stage. Divisional Leadership development likely to be aligned with Intro session for

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					consider Myers Briggs or 4OD.					Management Matters, as a self- discovery/reflective session underpinned by EQ & assessment tool. Exec Lead proposed cohorts could use either psychometric tool to pilot different benefits e.g. clinical leads to use MBTI. Decision to be made in August.
					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 Governance meetings		Anita Thomas	Divisional Managers		
					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		Anita Thomas	Corporate Governance Team		Audit currently in planning phase with a view to completing over the summer. Assurance report presenting outcomes anticipated in September 2022

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
					covering score card domain subjects					
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
					3. Review of Team Brief.		Dawn Harvey	Susie Palmer		Team briefing has been reviewed and re-launched as a hybrid meeting in response to feedback from attendees. The number of slides and speakers had been reduced and the meeting is open to all staff who wish to attend. A new addition is the Hospital Hero certificates being presented at the end of the meeting.
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

No.	Area	Recommendation	Timescale	Priority	Action	Action Progress Status	Responsible Executive	Management Lead	Assurance	Evidence
										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 Quality Committee		Alastair Hutchison	Stuart Coalwood & Andy Miller		See minutes of meeting
Responsible Committee:		Quality Committee.								

Meeting Title:	Board of Directors Part 1
Date of Meeting:	27 July 2022
Document Title:	**Maternity Safety Report July 2022**
Responsible Director:	Nicky Lucey, CNO
Author:	Jo Hartley, Director of Midwifery & Neonatal Services

Confidentiality:	No
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	19 July 2022	

Purpose of the Paper								
	Note (✓)		*Discuss*	✓	*Recommend*		*Approve (✓)*	✓
Summary of Key Issues	This report sets out to the Trust Quality Committee the quality and safety activity covering the month of June and where relevant, quarter two. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board. • Data from Power BI provided • No complaints in June • Staffing has been very challenging with delayed IOLs increasing • Maternity staffing remains challenging although workload has been reduced on some shifts. • New risk submitted to Risk Register concerning the difficulty in arranging inutero transfers because of cot and LW bed scarcity • Guidelines for continuity of care, women choosing to birth of guideline and escalation of professional disagreement published or in production • A new RCA investigating a woman who did not agree to an emergency LSCS despite clear indication that her baby was deteriorating • Actions agreed with Chief Pharmacist following on from the CD incidents • Caesarean section rates remain at nearly 40% - this is no longer a KPI following specific instructions from NHSE • ATAIN update (Avoiding Term Admissions into Neonatal Services). • Governance and Transformation lead for Maternity appointed • Update provided about SBLCB (Saving Babies' Lives Care Bundle) • Compliance has improved with K2 training and multi professional emergency training • Sickness rates have increased •							
Action recommended	The Trust Board is recommended to: 1. **DISCUSS** the report 2. **APPROVE** the contents							

Governance and Compliance Obligations

Legal / Regulatory	Y	Several national regulatory reports govern and guide maternity services
Financial	Y	MIS generates a 10% rebate if all objectives met.
Impacts Strategic Objectives?	Y/N	
Risk?	Y	There are risks around safe staffing levels and mandatory training.
Decision to be made?	N	
Impacts CQC Standards?	Y	As above
Impacts Social Value ambitions?	Y/N	
Equality Impact Assessment?	Y/N	
Quality Impact Assessment?	Y/N	

Dorset County Hospital
NHS Foundation Trust

Maternity Quality and Safety report

July 2022 (June data)

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Nicky Lucey, CNO

.

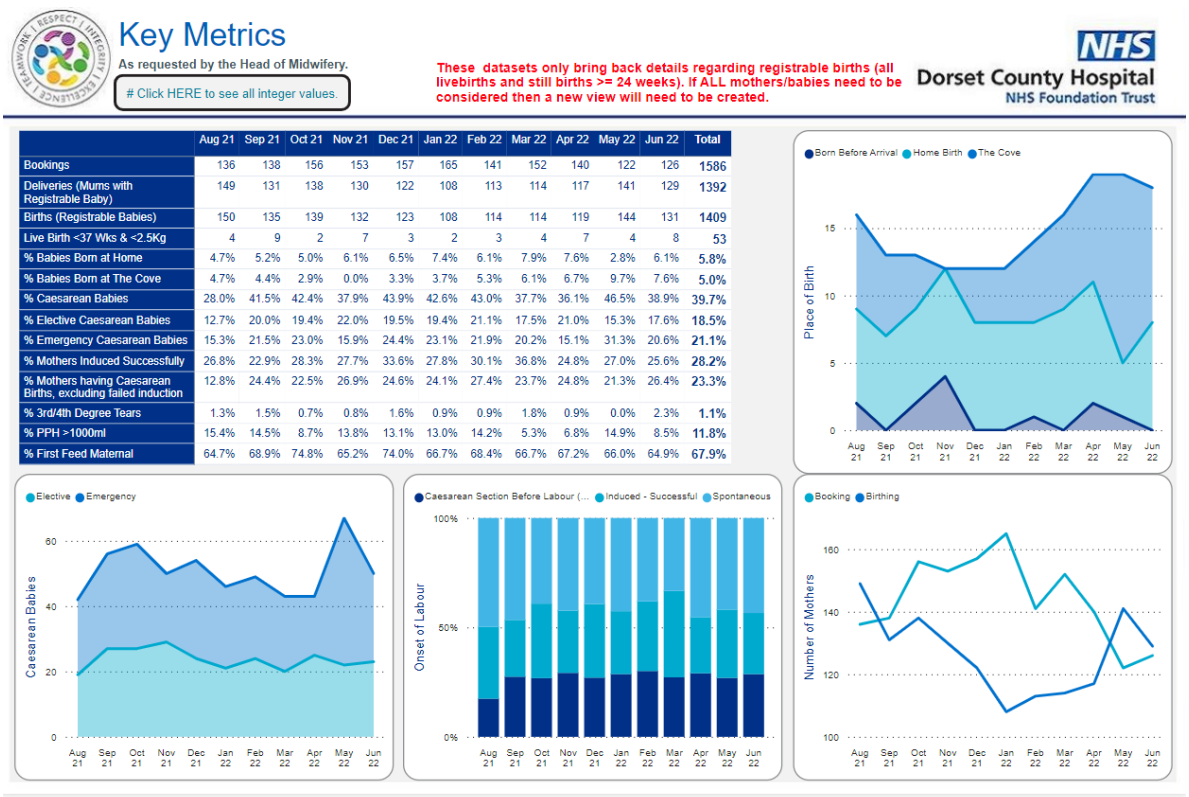
Executive Summary

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of June and where relevant, quarter two. This is to provide assurances of maternity quality and safety and effectiveness of patient care with evidence of quality improvements to the Trust Board.

- Data from Power BI provided
- No complaints in June
- Staffing has been very challenging with delayed IOLs increasing
- Maternity staffing remains challenging although workload has been reduced on some shifts.
- New risk submitted to Risk Register concerning the difficulty in arranging inutero transfers because of cot and LW bed scarcity
- Guidelines for continuity of care, women choosing to birth of guideline and escalation of professional disagreement published or in production
- A new RCA investigation
- Actions agreed with Chief Pharmacist following on from the CD incidents
- Caesarean section rates remain at nearly 40% - this is no longer a KPI following specific instructions from NHSE
- ATAIN update (Avoiding Term Admissions into Neonatal Services).
- Governance and Transformation lead for Maternity appointed
- Update provided about SBLCB (Saving Babies' Lives Care Bundle)
- Compliance has improved with K2 training and multi professional emergency training
- Sickness rates have increased

Activity and incidents reported.

Activity



	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Total
Bookings	136	138	156	153	157	165	141	152	140	122	126	1586
Deliveries (Mums with Registrable Baby)	149	131	138	130	122	108	113	114	117	141	129	1392
Births (Registrable Babies)	150	135	139	132	123	108	114	114	119	144	131	1409
Live Birth <37 Wks & <2.5Kg	4	9	2	7	3	2	3	4	7	4	8	53
% Babies Born at Home	4.7%	5.2%	5.0%	6.1%	6.5%	7.4%	6.1%	7.9%	7.6%	2.8%	6.1%	5.8%
% Babies Born at The Cove	4.7%	4.4%	2.9%	0.0%	3.3%	3.7%	5.3%	6.1%	6.7%	9.7%	7.6%	5.0%
% Caesarean Babies	28.0%	41.5%	42.4%	37.9%	43.9%	42.6%	43.0%	37.7%	36.1%	46.5%	38.9%	39.7%
% Elective Caesarean Babies	12.7%	20.0%	19.4%	22.0%	19.5%	19.4%	21.1%	17.5%	21.0%	15.3%	17.6%	18.5%
% Emergency Caesarean Babies	15.3%	21.5%	23.0%	15.9%	24.4%	23.1%	21.9%	20.2%	15.1%	31.3%	20.6%	21.1%
% Mothers Induced Successfully	26.8%	22.9%	28.3%	27.7%	33.6%	27.8%	30.1%	36.8%	24.8%	27.0%	25.6%	28.2%
% Mothers having Caesarean Births, excluding failed induction	12.8%	24.4%	22.5%	26.9%	24.6%	24.1%	27.4%	23.7%	24.8%	21.3%	26.4%	23.3%
% 3rd/4th Degree Tears	1.3%	1.5%	0.7%	0.8%	1.6%	0.9%	0.9%	1.8%	0.9%	0.0%	2.3%	1.1%
% PPH >1000ml	15.4%	14.5%	8.7%	13.8%	13.1%	13.0%	14.2%	5.3%	6.8%	14.9%	8.5%	11.8%
% First Feed Maternal	64.7%	68.9%	74.8%	65.2%	74.0%	66.7%	68.4%	66.7%	67.2%	66.0%	64.9%	67.9%

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 July 2021 to June 2022:

July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
60	60	65	98	91	87	64	43	55	70	93	79

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	7 for maternity, 4 for SCBU
RF2	Missed medication	1
RF3	Delay in providing or reviewing an epidural in labour	0
RF4	Delay of more than 30 minutes between arrival and admission in ANDAU -	
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	10
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	0
RF10	Delay of time critical activity	0

Incidents in the last 6 months requiring RCAs

	Jan	Feb	Mar	Apr	May	June
Incidents requiring RCAs	0	0	1	2	2	1

Incidents of interest without RCA required (updated and new)

reference	detail
DCH74370	Delayed screening test of a 5 day old baby
DCH74201	A premature baby at DCH due to a lack of cots in the network .
DCH74276	Patient with a bedsore after caesarean section

Update in relation to CD drugs on the Maternity Unit, On the 4th July, the DoM and Divisional Direcor of Nursing met with the Chief Pharmacist (NJ) and colleague (AB)

Wide ranging discussion covering increased safety measures for provision of CDs, alternative medication and more efficient dispening measures

RCAs round-up and update

reference	detail	Ongoing action
June 2022 DCH73734	Management of a deteriorating CTG during labour	Baby returned to DCH and discharged with parents. Currently unable to clearly foresee impact on baby's development but will be followed up in clinic
DCH73197	Intrauterine death	This case will be presented and reviewed at the Perinatal Mortality Review Panel. Currently, no care concerns identified
DCH72942	Intrauterine death	This case will be presented and reviewed at the Perinatal Mortality Review Panel. Currently, no care concerns identified
April 2022 DCH72663	Baby collapsed after birth	This case will be investigated by HSIB. **Update:** HSIB have interviewed staff and family
March 2022 DCH71346	Intrauterine death with a fetal abnormality	. **Update:** case presented at Perinatal Mortality Review Committee. No learning identified. Case can be closed
DCH66427	Intrauterine death	**Further update:** parent's concerns passed to PALS to be managed as a complaint, alongside review of the case

Risk Register

ID	Title	Risk Statement	Open	Risk	Risk Level
1456	lack of capacity within the neonatal network, impacting on in-utero transfers	**New risk** As a level one SCBU, we have to transfer all women who may need delivery, under 32 completed weeks of pregnancy. There is increasing difficulty to identify a neonatal unit with a cot available and then the corresponding bed on labour ward. Most transfers take between 2-4 hours phoning around hospitals, taking the time of a midwife and often a consultant obstetrician. Some transfers have been miles outside of the network and a midwife must travel with the woman, hence diminishing staff on LW. Cotline, which is meant to assist with the search, is usually unable to help, and at times isn't available.	14/07/2022	moderate	Care group
1227	Provision of the smoking cessation service to pregnant women	All pregnant to be tested for their CO levels at booking, at 36 weeks and ideally at any opportunity. Referral is then made to the smoking cessation service. Currently, there is a shortage of the cardboard tubes that are required for the test. Furthermore, although the recent audit of CO testing was positive, there is evidence that women are not always screened - sometimes due to lack of access to the monitor. The smoking cessation lead midwife is on LTS and the service is being managed (very well) by a band 4 MSW. However, this is not a sustainable model and is required for SBLCB and therefore for Ockenden and MIS. **Initial action** Consideration of a significant increase in monitors and MSWs being trained to do the test so women are screened whenever they are admitted. Funding identified for a public health lead midwife as well. **Update July 2022:** currently being audited in relation to SBLCB. Guidance doesn't allow for women who decline screening – this is being addressed through the MIS requirements, by the Governance Lead Midwife	17/03/2022 Quarterly review	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 July 2022** Four datix linked to staffing – vacant shifts due to sickness and unable to fill through bank or agency.	18/12/2019 Quarterly review	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 **Apr 2022** – audit completed. Containers packaged to be collected by courier – not collected so resent to cairns for analysis **Update July 2022** Results from analysis are disappointing with two rooms failing the acceptable levels. The matron has asked for an urgent review of the rooms that have failed, with Estates as currently, unclear of next actions.	24/12/2019	High	Division
1127	Maternity Staffing	**Update:** staffing remains challenging. Recruitment continues with interviews soon for band 5 &6 posts. but there is a high number of midwives retiring. However, sickness rates have improved considerably (see end of paper). The mitigation remains the same - reallocating staff, asking staff to work extra shifts, utilising bank staff. **Update July 2022** Staffing remains very challenging. New staff appointed, both MWs and MSW but recruitment and OH processes protracted. Recent recruitment was problematic due to an error in the Trac system, resulting in several candidates accepting job offers elsewhere. Number of bank staff has reduced to less than 50% of pre-pandemic numbers and staff disinclined take extra shifts. DoM and matrons as well as staff not usually allocated clinical shifts, have been working clinically which, whilst it is the right response, impacts other duties and responsibilities.	20/07/2021 Quarterly review	high	division

Learning from Claims and from NHS Resolutions early Notification Scheme

Complaints

Month	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Formal	1	3	1	0	0	0	0	0	0	0	2	0
Informal	3	3	4	1	0	2	0	1	1	2	0	0
Total	4	4	5	1	0	2	0	1	1	2	2	0

May 2022 Care during labour was “brilliant” other than her interaction with one midwife.	**Update** Incident discussed with the midwife who immediately expressed a heartfelt apology. We also discussed how to manage these interventions in a sensitive manner, and those colleagues who role-model this behaviour. Apology sent to the patient and a mentor identified for the midwife.
This mum was very upset about the care provided to baby by one member of the team.	**Update** Reflection provided by the nurse – very apologetic and this will be passed to the patient.

Mortality, Morbidity, Serious Investigations, External Reporting & Learnin

Mortality MBRACE (Mothers and Babies Reducing Risk through Audit & Confidential Enquiries) reportable cases

Neonatal Deaths for quarter two

Ref	Description
	Two neonatal deaths both occurring at tertiary units as babies very premature

Perinatal mortality reviews

Cases pending review at Perinatal Mortality Review panel as of date of report

Number of cases pending review at PMR panel	**2**
TOTAL cases requiring review completion	2

Morbidity including M&M meetings

Date of Meeting: June 2022

Learning and Actions

- Badgernet documentation could be improved.
- The time between decision for CAT 2 section and delivery of baby <30mins
- TOF difficult to diagnose in the antenatal period.
- X3 significant desaturations episodes in the first 36 hours post transfer back, x1 requiring 2222 call and IPPV none prior to t/f.
- Discussion re should he have had a SALT referral and assessment in Southampton.
- Baby has needed further surgical treatments.

Learning and Actions

- Patient received steroids and MgSO4 prior to delivery
- Should this patient have been on Aspirin? First pregnancy. Mother had PET (but this was not disclosed at booking, so would not have been advised Aspirin).
- Baby LISA (less invasive surfactant administration)
- Persistent base excess corrected with medication.
- Parenteral nutrition considered but not required.

Current Maternity Safety Guidelines and SoPs in Development

Conflict of Clinical Opinion	**Guideline currently be completed then circulated for comment**
SoP for Continuity of Care provision	**published**
Guideline for the management of women who choose to birth off-guideline	**Guideline currently being completed then circulated for comment**

HSIB quarterly review meeting

- New case reported as detailed above

Safety suggestions from staff

No updates this month

Safety Champions action plan

Action Plan

No update this month

Service User Feedback

No update this month

Training

MATERNITY STAFF COMPLIANCE for MANDATORY TRAINING
JUNE 2022
(covering the period up to and including 30th June, 2021-30th June, 2022)

Training	Staff grade	Percentage of attendance
PROMPT (Practical Obstetric Emergency Procedure Training)	**Obstetric Anaesthetists**	92.8%
	Obstetric Consultants	87.5%
	Doctors (Reg/SHO)	100%
	Midwives	91%
	MSW	57%
BLS	**Obstetric Anaesthetists**	81%
	Obstetric Consultants	75%
	Doctors (Reg/SHO)	82.5%
	Midwives	76%
	MSW	41%
NLS (4 yearly accredited course)	**Senior Midwives/Homebirth Midwives**	96%
NLS (yearly update)	**Midwives**	82%
K2 – Fetal monitoring	**Doctors** **Midwives**	80% 98%

Maternity and medical staffing

Maternity Staffing

Sickness absence	May 2022
midwives	6.5%

Sickness absence	May 2022
MSW	8.1%

Medical cover has been managed effectively with only one episode of a consultant acting down for a shoft during the day. This was due to short term sickness. For night shifts where midwifery staffing is 3 midwives or less, two doctors work overnight instead of one, to assist with caesarean sections (this role is usally provided by a midwife).

Maternity incentive scheme Year 4

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

Gestation	REASON FOR ADMISSION	ADMITTED FROM	TOTAL DURARION	DAYS ON SCBU	RESPIRATORY DAYS	IV FLUIDS DAYS	IV ANTIBIOTIC DAYS	TRANSFERRED OUT	ONSET OF LABOUR	JAUNDICE	HYPOGLYCAEMIA	HYPOTHERMIA
Jan-22												
37+1	RDS	Theatre	5	4	4	1	2	N	EILSCS	N	N	N
40+4	HIE	PNW	3	1	2	0	2	N	IOL	N	Y	N
40+4	RDS	Theatre	6	4	2	2	5	N	Spont	N	N	N
38+0	RDS	Theatre	1	1	1	1	1	Y	EILSCS	N	N	N
41+6	Suspected sepsis	PNW	3	1	0	0	2	N	IOL	N	N	N
39+4	RDS	Theatre	1	1	1	1	1	N	IOL	N	N	N
Feb-22												
39+1	Suspected sepsis	Theatre	3	1	1	1	2	N	IOL	N	N	N
39+0	RDS	Theatre	3	1	1	1	2	N	IOL	N	N	N
38+3	Poor condition	Theatre	8	1	2	1	7	N	IOL	N	N	N
37+2	RDS	Theatre	5	2	1	2	2	N	IOL	N	Y	N
Mar-22												
39+1	Hypoglycaemia	PNW	2	1	0	1	0	N	IOL	N	Y	N
37+4	Hypoglycaemia	PNW	11	6	0	4	2	N	EILSCS	N	Y	N
39+0	RDS	PNW	3	2	1	1	2	N	EILSCS	N	N	N
40+3	HIE	PNW	3	2	1	2	2	N	Spont	N	N	N
38+5	Monitoring	PNW	4	1	0	0	0	N	IOL	N	N	N
Apr-22												
37+0	Hypoglycaemia	PNW	5	1	0	1	0	N	EILSCS	N	Y	N
37+3	RDS	PNW	6	3	3	3	5	N	EILSCS	N	N	N
37+4	HIE	Theatre	1	1	1	1	1	Y	EmLSCS	N	N	N
37+0	Hypoglycaemia	PNW	14	4	0	2	0	N	EILSCS	N	Y	N
37+4	Hypoglycaemia	PNW	8	4	0	3	2	N	IOL	N	Y	Y
39+1	RDS	Theatre	2	1	1	1	2	N	IOL	N	N	N
37+2	Suspected sepsis	PNW	5	2	2	2	2	N	Spont	N	Y	N
May-22												
37+3	Hypoglycaemia	PNW	4	2	0	2	2	N	IOL	N	Y	N
40+2	HIE	Labour	3	2	1	2	2	N	Spont	N	N	N
38+3	RDS	Labour	3	1	1	1	2	N	Spont	N	N	N

Thoughts and themes provided by ATAIN lead

- Increase in admissions from the postnatal ward. Exacerbated by a lack of staff on the postnatal ward
- Increase in hypoglycaemia admissions
- In April 85% of admission were 37/40 infants, (all but 1 of the term admissions)
- In March and April, 75% of admissions were either from an induction of labour or elective LSCS. However, given the increasing numbers of both IOL and elective LSCS, this is not necessarily a correlation.

- There are examples of good use of the HIE proforma and no cases where it should have been used and not been used.

- Poor paediatric documentation on maternity BadgerNet when a baby is admitted, this continues to be an issue. Reminder emails have been sent to all responsible for admitting babies to SCBU and the importance of documentation.

New actions to be addressed

- Update the ATAIN presentation that the midwives receive during their update day. Instead of discussing the numbers and improvements, it would be beneficial to focus on essential elements of care, troubleshooting problems and what guidance there is available.
- The postnatal lead midwife will also promote and remind staff of the normothermia guideline for neonates, to ensure all staff are empowered to commence appropriate actions and care for infants

when they are hypothermic. Recognizing that paediatric referral is not necessarily the most appropriate course of action

- Ensuring PROMPT covers how to give supplementary oxygen and not just resuscitation, as we have had a case where an infant had significantly low saturations, but no action was taken (or documented) until paed review when the baby was taken straight to SCBU.

Review of SBLCB v2

Provided by the newly appointed Maternity Governance, Quality Improvement and Transformation Lead

Element	Current concerns	Challenges and concerns
Increasing smoke free pregnancy by offering CO monitoring at booking and referring to smokestop services	4942 - Audit to assess the quality of data capture **during 2019** (pre pandemic whereby CO monitoring ceased) for CO monitoring at booking and at 36 weeks (sample audit from the year) **findings 90% at booking, 78% at 36/40** **Badger Statistics for June 2022:** Women asked about smoking status at booking – 100% CO monitoring recorded at booking 31% This data discrepancy is due to the Badger system default being set to only recognise a CO reading taken within 3 days of the booking appointment. Bookings are primarily undertaken virtually or by phone then an appointment arranged to attend a 'booking clinic' for the face to face (F2F) investigations; bloods, Blood pressure, CO monitoring etc. If this appointment is outside the 3 day window then the BadgerNet system will not record this as CO at booking despite the other F2F booking investigations being within the acceptable KPIs for screening. There is a 'back door' solution the BI are working on to enable the true percentage of CO monitoring at booking. The 31% in June accounts for bookings undertaken F2F (homebirth/Continuity teams/BAME/Learning disabilities etc.) – Sample audit to assess CO	CO monitoring was ceased nationally during the C-19 pandemic due to it being deemed aerosol generating – during this period women self-reported smoking status as per the C-19 SBLCBv2 revised guidance. MIS was paused nationally in recognition of the pandemic. When CO monitoring was reintroduced CO monitoring tubes were in demand and became temporarily unavailable from the supplier (supply chain issues) so a previous inferior model was sourced (single use cardboard tubes). These are now available and being used but were superseded by the unavailable superior model which has a filter and the woman can have her own to use throughout pregnancy. Given the rise in C-19 cases currently ideally the filters would be used instead of the cardboard tubes but midwives are using PPE for all patient contacts (alongside other strategies) so the risk of C-19 transmission is mitigated. National guidance from SBLCBv2 wording states women should be ***offered*** CO monitoring however NHSR MIS stipulates for trusts to pass safety action 6 (SBLCBv2 compliance) then an 80% monitoring rate ***MUST*** be achieved. Further, an action plan is required for trusts achieving <95% - there is concern nationally that this does not take into account women declining monitoring for various reasons; being a non-smoker; religion etc. The national Ockenden Midwives have composed a letter to send to Mathew Jolley requesting the rewording of the MIS specification to reflect SBLCBv2 and request further to this that the requirement to include the number of women declining CO monitoring within the data submission, is in direct opposition to our duty to provide women with informed choice around any aspect of the care that they are offered and may or may not choose to accept.

	referrals to smokestop (completed) – **findings 100% referral rate** – fully compliant	
Identification and surveillance of pregnancies with fetal growth restriction (FGR)	100% of pregnancies are risk assessed for FGR at booking and stratified into a low, moderate or high-risk pathway – this field is mandated on BadgerNet At the 20 week anomaly scan if FGR is suspected the woman is sent to the Antenatal Day Assessment Unit (ANDAU) for review and plan of care by an obstetrician	Moderate and High risk FGR pathways involve commencing Aspirin as early as possible, ideally between 12-16 weeks gestation. There is no internal mechanism to dispense/administer aspirin so the GP is asked to prescribe – sometimes this causes a delay in the woman receiving it, some GPs won't write a prescription so the woman is asked to buy it herself. There is a national PGD for aspirin in pregnancy which DCH are trying to adopt as a QI initiative. All guidelines align with the SBLCBv2, the Perinatal Institute &/or NICE guidance or a workaround has been agreed and established; babies stratified as high risk require a uterine artery doppler performing prior to 24 weeks gestation however there are no trained practitioners at DCH to undertake his, the workaround constitutes a higher level of ultrasound surveillance during the third trimester. The Maternity Incentive Scheme stipulates a quarterly review of a minimum of 10 cases where babies are born with FGR. At DCH we had 6 in the last quarter – our birth numbers do not allow for this amount per quarter therefore all cases are reviewed each quarter
Raising awareness of detection and management of reduced fetal movement (RFM)	100% of pregnant women have the Kicks Count leaflet pushed out at varying touchpoints throughout the pregnancy continuum. Discussing fetal movements is a mandated field within every routine antenatal appointment within BadgerNet	The data collection and audit function (backend) within Badgernet currently doesn't pull correctly and the system demonstrates a low compliance of distributing Kicks Count leaflets. Front end interrogation is able to demonstrate 100% compliance when each individual record is checked. This is being investigated by our digital midwife, Clevermed and BI team to identify the issue
Effective fetal monitoring during labour	Staff attend a minimum of 2 online interactive CTG sessions facilitated by the Fetal Monitoring Lead. Sessions are multidisciplinary and cover local (anonymised) cases bringing a contextualised approach to learning. Human factors is an integral feature within sessions. Compliance with K2 training as above	Currently no concerns other than continuing to ensure compliance with training
Reducing preterm birth - Criteria for DCH level 1 SCBU unit is babies over 32 weeks gestation. Threatened preterm labour <32 weeks	10.9% preterm (24-36 weeks gestation) birth rate during June. National average is 8% 5527 – audit for administration of corticosteroids (in progress) BadgerNet June data: 98.5% of babies born in appropriate care setting 2 babies born <32 weeks	•Numbers of preterm deliveries at DCH are so minimal that the percentage swings on the process indicators are vast. This makes it very difficult to achieve minimum 80% for MIS criteria. •Often women present in advanced labour which prevents a full dose of steroids being administered (doses are 12 hours apart) Increasingly challenging to identify cot and LW bed to facilitate inutero transfer

gestation at DCH would necessitate an inutero transfer to a tertiary unit.	gestation •neither received a full course of corticosteroids <7 days of birth 2 babies born <30 weeks gestation (same 2 babies as above) •1 received PReCePT magnesium sulphate (MgS04) prior to delivery	

Meeting Title:	Board of Directors Part 1
Date of Meeting:	27 July 2022
Document Title:	**Safeguarding Annual Report**
Responsible Director:	Nicky Lucey
Author:	Sarah Cake

Confidentiality:	no
Publishable under FOI?	*No*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Safeguarding Group Quarterly Meetings	2021-2022	Assurance and governance requires Annual report / activity to be sent through Quality Committee.
Quality Committee	21 June 2022	

Purpose of the Paper	*Offer assurance of the process for Safeguarding Supervision programme*							
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	*A review of the activity for the Safeguarding team through 2021-2022 , to include activity in relation to adults , children, maternity , learning disabilities and the Mental Capacity Act .* .							
Action recommended	The Board are asked to : 1. Approve the Report 2. Approve the Strategy and Work plan for 2022-2024.							

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	
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*

Title of Meeting	**Quality Committee**
Date of Meeting	**21/06/2022**
Report Title	**Annual Safeguarding Report**
Author	Sarah Cake Head of Safeguarding Joanne Findlay Learning Disability and Mental Capacity Act Lead; Hanna Wellman Specialist Nurse for Safeguarding Children; Sarah True Safeguarding Lead Special Care Baby Unit.
Responsible Executive	Nicky Lucey – Chief Nursing Officer/Interim Deputy Chief Executive Officer.

Purpose of Report

The purpose of this annual report is to inform and assure members of the Quality Assurance Committee the Safeguarding activities within Dorset County Hospital during 1st April 2021 – 31ST March 2022

Foreword

Dorset County Hospital Foundation Trust (DCHFT), its Executive Team, Safeguarding Leads / Practitioners and Managers are committed to ensuring that the mental capacity and safeguarding of our patients, their families, our staff and our communities is at the foundation of our Trust values and is embedded within our day-to-day practice.

DCHFT recognise that one of the most important principles of safeguarding is that it is 'everyone's responsibility'. Safeguarding children, young people and adults can only be effective when we work collaboratively with our partner agencies and respectively with those who need protecting from the risk of harm, abuse or neglect. The Trust gives due regard to ensuring all its services protect individual human rights, treat individuals with dignity and respect and safeguards them against abuse, neglect, discrimination, or poor treatment.

Safeguarding is increasingly multifaceted, challenging, and poses a balancing act for practitioners when ensuring the rights and choices of an individual with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm.

The annual Safeguarding report aims to:

- Provide assurance of compliance with the local multi agency guidelines for safeguarding adults (Dorset Adults Safeguarding Board / Dorset Clinical Commissioners Group, Pan Dorset Children's Safeguarding Partnership).
- Provide assurance of compliance with the Care Quality Commission Registration Standards: Regulation 13 (safeguarding service users from abuse and improper treatment), fundamental standard 5 (safeguarding from abuse) and Safe Domain (safeguarding arrangements).

- Inform the Board of safeguarding adults activity including progress against the annual work plan.
- Provide assurance of compliance with the local multi agency guidelines for safeguarding children (Dorset Children's Safeguarding Board / Dorset Clinical Commissioning Group and County Council).
- Provide assurance of compliance with the Section 11 of the Children Act (1989, 2004)

Safeguarding Policies

Policy Name	**Available**	**Last updated**
Safeguarding Adult Policy including links to Safeguarding Partnership websites	☒	Within the past 3 months
Safeguarding Children Policy including links to Safeguarding Partnership websites	☒	Within the past 6 months
MCA and DoLS Policy	☒	Within the past 3months
Safer Recruitment Policy	☒	HR
Allegations Against Staff Policy	☒	HR
Whistleblowing Policy	☒	HR
Supervision Policy	☒	Safeguarding guidance available to supplement this policy
Was Not Brought (adults and children)		Updated April 2021
Domestic Abuse Policy and Guidance	yes	Updated in March 2021
PREVENT	Yes	Due review
Learning disability Framework & Supporting adults & children with learning disability / autism policy	yes	1 month

Paper Previously Reviewed By

This paper is a summary of the Safeguarding Group; therefore, the content has been discussed and reviewed via that Group, which has the delegated responsibility for safeguarding governance.

Strategic Impact

All providers have a legal responsibility to safeguard the welfare of adults under Care Act 2014, Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DOLS) 2009.

All providers that deliver services to children have a legal requirement to meet Section 11 of the Children Act (1989, 2004).

Domestic Abuse and violence against woman has been widely covered in both local and National media and remains an area of focus politically

Safeguarding Children is still on the political agenda with increased focus on Modern Slavery, Child sexual exploitation, Criminal exploitation, County Lines sexual abuse within education and increasing knife crime by teenagers.

Risk Evaluation

Key Risks for the service

1. **Activity and Demand –** increasing safeguarding activity Trust wide.
2. **Training –** training compliance, specifically for level 3 children's compliance Requirement to align with the intercollegiate guidance for adult Safeguarding at level 3 & maintaining supervision during COVID restrictions
3. **Information Sharing –** to ensure information shared with community services in a timely and robust manner following the attendance of a child at DCHFT.
4. **Talent Management –** ensuring that the DCH Safeguarding Team has the correct people with the capabilities to deliver outstanding care, now and going forward.
5. **Mental Health –** increasing need for Mental Health provision in an acute physical environment, specifically for children and young people.
6. **Mental Capacity –** the new Liberty Protection Safeguards (LPS) are due to come into force in April 2022 via the Mental Capacity (Amendment) Act 2019. The LPS will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty when they lack capacity to consent to their care arrangements.

   The legislation will create Responsible Bodies to authorise an incapacitated person's deprivation of liberty. The identity of the Responsible Body will depend entirely upon the arrangements for the persons' care which could be:

   - An NHS Trust or Local Health Board if the person is being cared for in the hospital, or
   - A CCG or Local Health Board for arrangements under NHS CHC, or
   - A Local Authority in all other situations, such as care homes, supported living and private hospitals.

   Under LPS, deprivation of liberty will have to be authorised by the Responsible Body and will also apply to 16- and 17-year-olds, as well as adults.

   This places new legal obligations upon the Trust and has also associated resource implications

Impact on Care Quality Commission Registration and/or Clinical Quality

Safeguarding Children, Young People & Adults, Mental Capacity Act compliance and Deprivation of Liberty assessments are key quality indicators and are subject to external inspection. All Deprivation of Liberty outcomes are forwarded to CQC for notification.

Governance Implications (legal, clinical, equality and diversity or other):

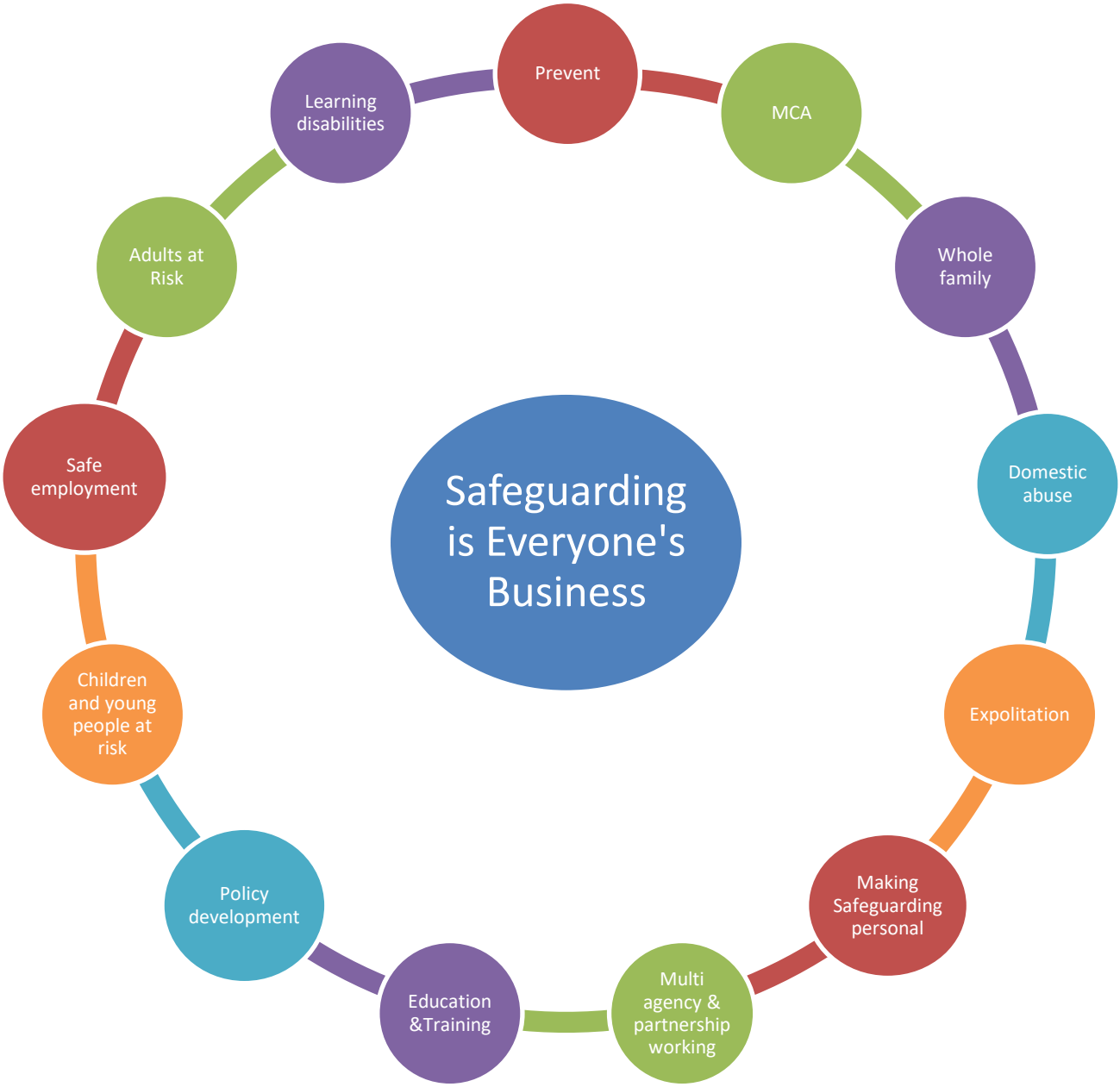
The trust has legal responsibilities as detailed within the strategic impact section. The reassurance of a robust service is measured through audit or assurance tools comparing practice against policy.

Electronic flagging of patients with learning disabilities and / or Autism is a recognized national system, however this does categorise individuals and therefore has an

acknowledged implication for equality and diversity. This is in line with our equality duty and supporting published papers on Equality in Health. This ensures pathways of care are reasonably adjusted and patients with disability are not disadvantaged by the service provided. National Flagging through CPIS (Child Protection Information Sharing) for children who are subject to a Child Protection Plan; or a cared for child or an unborn infant, who will be subject to a Child Protection at birth, is maintained by Social Care partners and is shared to Health Providers.	
Financial Implications: Failure to adhere to the standards can result in penalties and/or legal claims. Cost and resource implications for the introduction of the Liberty Protection Safeguards.	
Freedom of Information Implications – can the report be published?	Yes

Recommendations	The Committee are asked to a) To receive and review the report, recommending any areas for further improvement at Safeguarding Group b) Receive assurance of Safeguarding activity c) Support delegated responsibility to the Safeguarding Group for the development of the 2022–2024 work-plan, which the Lead for Safeguarding will focus on, in conjunction with the Safeguarding Team. d) Recommend the annual report Trust Board

Safeguarding Annual Report
Quality Committee
April 2022



A co-ordinated approach – safeguarding is everyone's responsibility

1.0 PURPOSE OF REPORT

1.1 This report provides a summary of the Safeguarding activity from 1st April 2021 – 31st March 2022. The purpose of this annual report is to provide assurance and inform members of the committee of how Dorset County Hospital meets its duties to safeguard adults by preventing and responding to concerns of abuse, harm or neglect.

2.0 INTRODUCTION

2.1

The purpose of this report is to provide an assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who encounter our services.

The Safeguarding Team provide expert advice, support, supervision and specialist training to support all Trust staff to fulfil their safeguarding responsibilities and duties. The safeguarding work is underpinned by DCHFT`S strategy 'outstanding care' for people in ways which matter to them, to ensure their voice is always heard.

The term 'Safeguarding' encompasses all activities to assist children, young people and adults at risk, to live a life that is free from abuse and neglect and to enable independence, wellbeing, dignity and choice. Safeguarding includes the early identification and/or prevention of harm, exploitation, and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' and promoting best practice from serious incidents to improve future services development for patients and staff.

The Safeguarding Annual Report 2021- 2022 provides a summary of the activities of the Adult, Children and Midwifery Safeguarding Teams across the Trust to demonstrate to the Trust Board, external agencies, and the wider community how the Trust discharges its statutory duties in relation to current safeguarding expected national standards and best practice guidelines challenges and future priority.

Definitions

Safeguarding:

The Care Quality Commission (CQC) state; 'Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care' (CQC, 2016).

Safeguarding Children; a child is defined within the Children Act 1989 as – "an individual who has not reached their 18th birthday".
Even when they:

- Live independently
- Are a parent themselves
- Are in custody
- Are a member of the armed forces

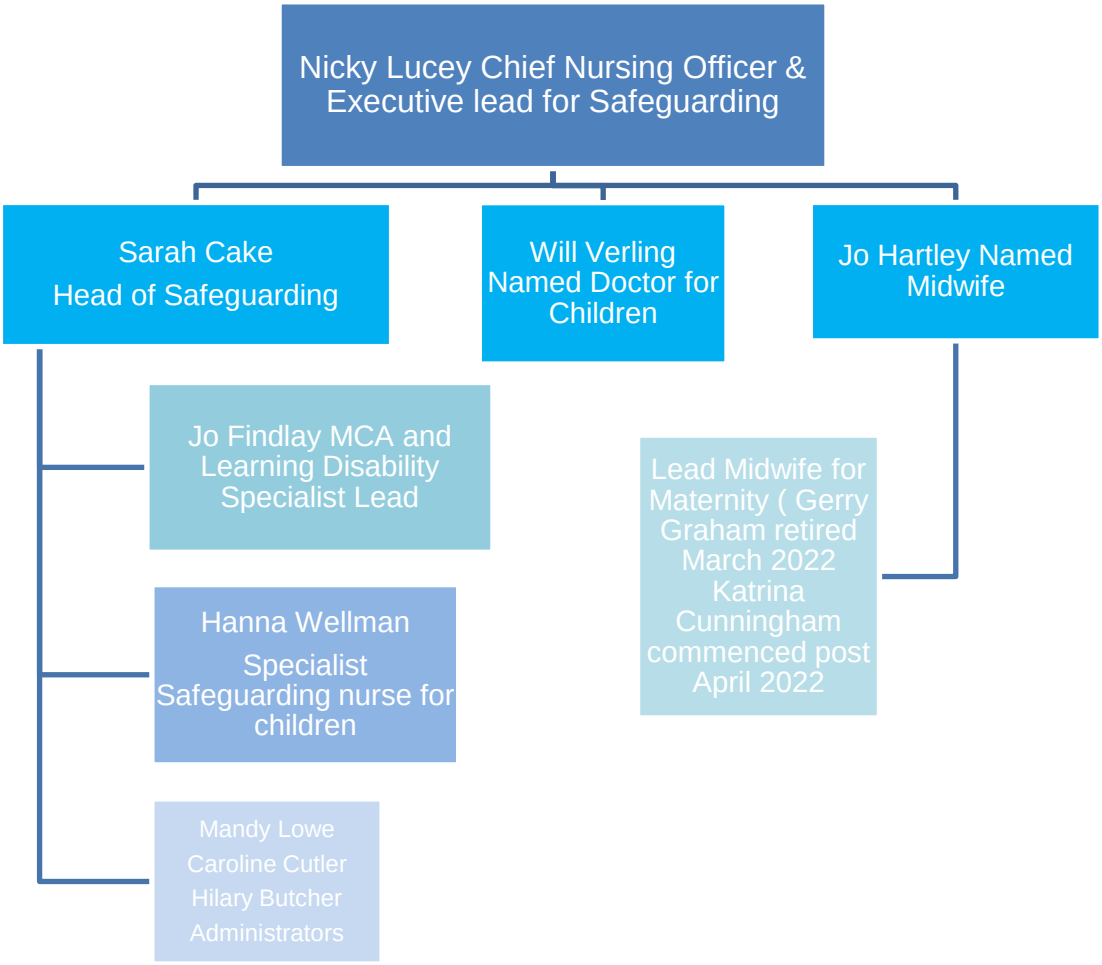
This does not change their entitlement to protection or Safeguarding.

Safeguarding Adults: An adult is an individual aged 18 years or over. The Care Act 2014 defines an 'adult at risk' as:

- an adult who has care and support needs (whether the needs are being met or not).
- is experiencing, or at risk of, abuse or neglect.
- And as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All DCHFT staff has a statutory responsibility to safeguard and protect those who access our care regardless of their position in the Trust. Though, some defined named safeguarding roles do exist. Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Intercollegiate Safeguarding Competencies Children (2019). Both are due to be updated in the next 12 months.

The Safeguarding Team hold quarterly meetings and report through the Quality Committee by exception reporting and submission of an annual report.


Nicky Lucey Chief Nursing Officer & Executive lead for Safeguarding
Sarah Cake Head of Safeguarding
Will Verling Named Doctor for Children
Jo Hartley Named Midwife
Jo Findlay MCA and Learning Disability Specialist Lead
Hanna Wellman Specialist Safeguarding nurse for children
Mandy Lowe
Caroline Cutler
Hilary Butcher
Administrators
Lead Midwife for Maternity (Gerry Graham retired March 2022 Katrina Cunningham commenced post April 2022

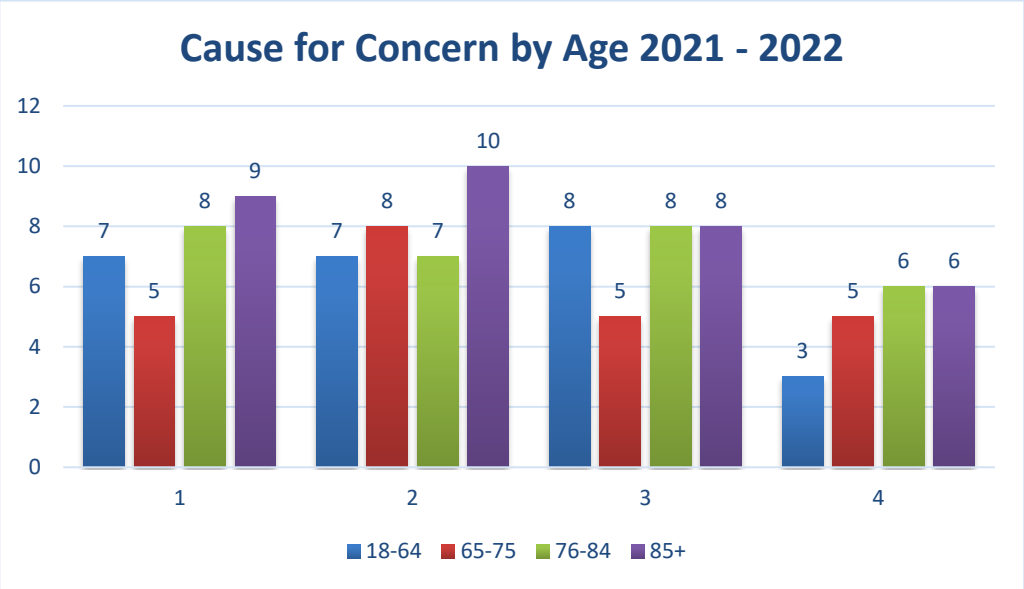
3.0 ADULT SAFEGUARDING ACTIVITY

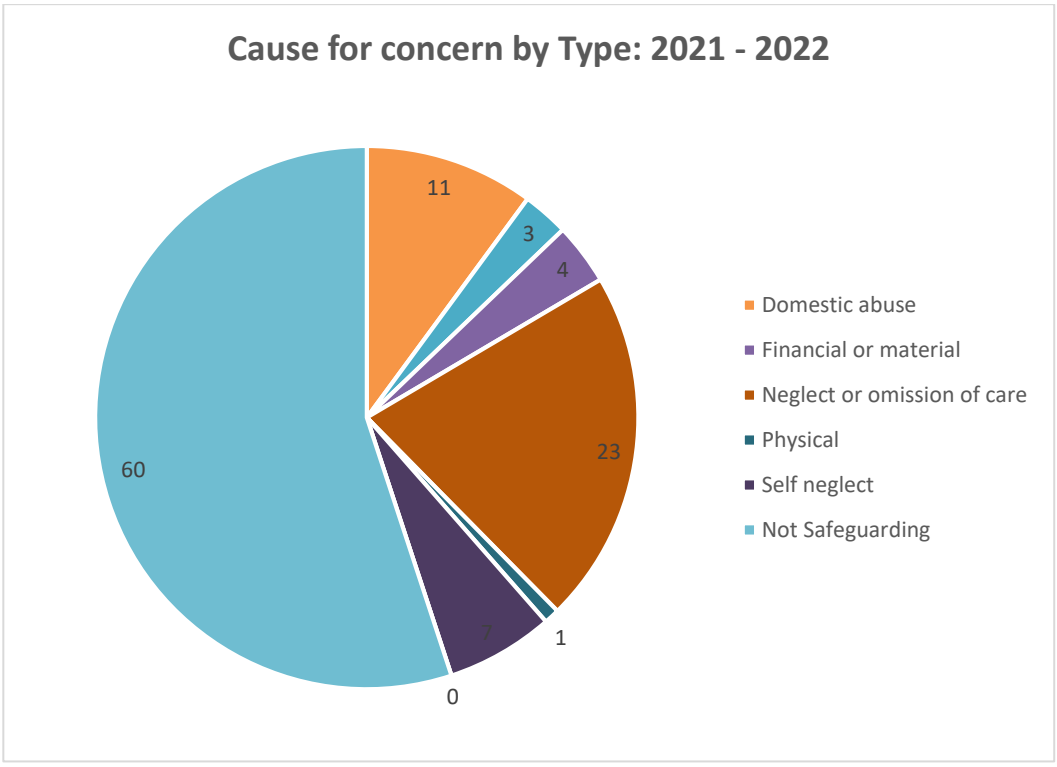
3.1 During the past 12 months staff have formally submitted concerns for 110 people using our service. The majority of these were not investigated through a Safeguarding investigation but were signposted to other services. The activity in relation to contact with the Safeguarding team has also intensified, common themes have been advice for employees / advice on discharge planning/ advice on mental capacity. In 2021- 2022 there were 8 concerns raised in relation to Dorset County Hospital Foundation Trust by external agencies. All of these were investigated through a nominated enquiry process and did not proceed on through to a full safeguarding investigation. The main issues related to communication and safe transfer into the community. The findings of the investigation are communicated to the department where the incident occurred for learning, they are informed that the issue is not being pursued through Safeguarding, but any changes to practice will need to be adopted through their quality-of-care agenda.

3.2 All concerns are discussed with the Head of Safeguarding or deputised to another member of the team to complete an initial review, in conjunction with Dorset Council a decision is formulated as to whether to proceed to a full investigation under Safeguarding Adult Procedure. The Care Act 2014, Section 42 (2) requires a local authority to make statutory enquiries, or cause others to do so, where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and as a result of those care and support needs is unable to protect him/herself against the abuse/neglect or the risk of it (see Care Act 2014, S42(1)). A S42(2) enquiry establishes whether any action needs to be taken to prevent or stop abuse or neglect, and if so, what and by whom. The local authority is responsible for this public law decision as to whether to carry out a statutory, s42(2) enquiry. It works alongside individuals and partner agencies in gathering information connected with S42(1) to support that decision and in carrying out S42(2) enquiries. Ultimately the decision is decided by the Dorset Council Safeguarding Triage Team manager.

3.3 There were **no** external investigations by Dorset County Council under Adult Safeguarding Procedures during 2021-2022.

3.4 The graph below demonstrates the age demographics of the referrals received in each quarter, review of the data has indicated that the age group with the highest reported concerns was 85+ which differs from the previous 12 months when the age category was 18-64 predominantly the vulnerability for this group was frailty and or dementia. Anecdotal evidence would indicate that older people were delaying presentation / just about managing at home, before crisis point required hospital attendance that then indicated unmet care and support needs.


Cause for Concern by Age 2021 - 2022
12
10
8
6
4
2
0
7
5
8
9
7
8
7
10
8
5
8
8
3
5
6
6
1
2
3
4
18-64
65-75
76-84
85+


Cause for concern by Type: 2021 - 2022
11
3
4
23
1
0
7
60
Domestic abuse
Financial or material
Neglect or omission of care
Physical
Self neglect
Not Safeguarding

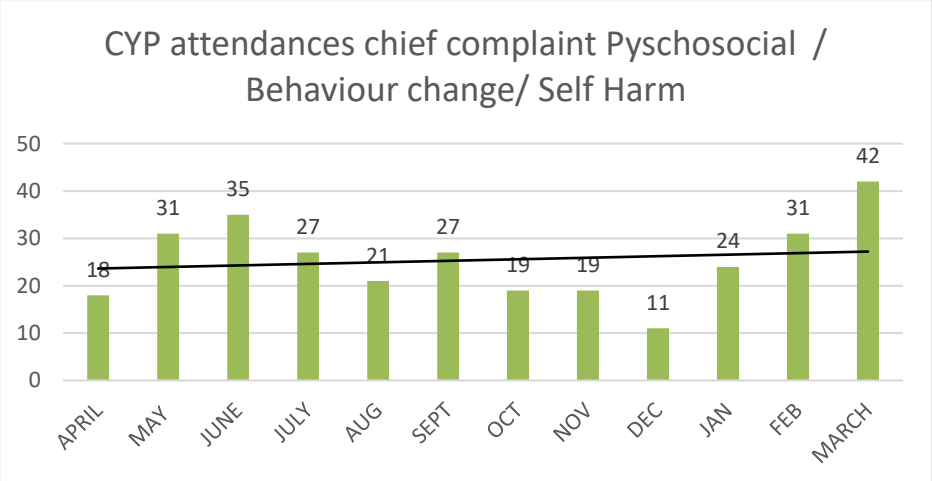
3.5 The highest category of abuse reported was not safeguarding, the majority of these were supported through a review of care and support needs / discharge to assess process.

4.0 CHILDREN SAFEGUARDING ACTIVITY

4.1 The Dorset Council approach to safeguarding is aligned with a strength-based approach to managing concerns. This methodology formulates part of the training and supervision offered to staff who are more used to a more protection or paternalistic approach. The professional who has concerns about a child can call the consultant social workers, who will talk through the concerns, and discuss actions, to make sure the child receives the right support at the right time.

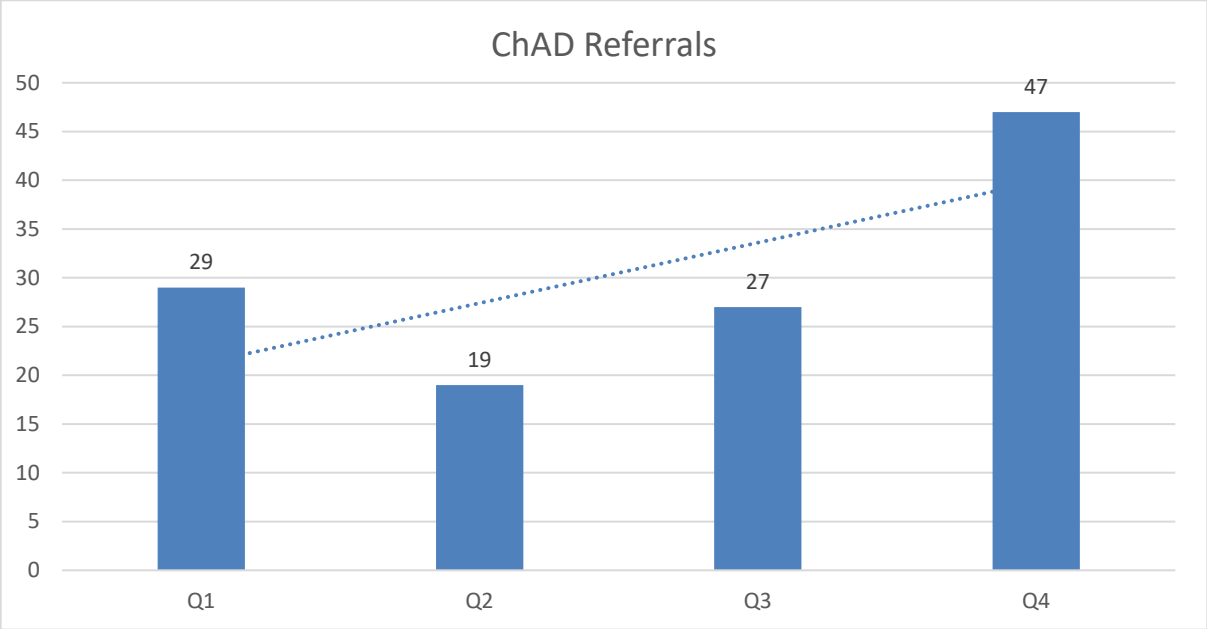
4.2 The Safeguarding Team continue to review the Emergency Department records for all 0–17-year-olds, The team have been fully involved in the creation of the safeguarding module for the new digital system (AGYLE) in the emergency department. This ensure that appropriate follow up is made to community teams

4.3 The Safeguarding Team in conjunction with Kingfisher Ward / liaison psychiatry / ED and Paediatricians review on a weekly basis any children that have a mental health diagnosis, presented with self-harm and or a safeguarding concern or a frequent attender to ensure all documentation, and processes have been completed. Any learning is escalated through the departments or to external agencies. The figures for children and young people with a presentation to DCHFT with self-harming behaviour and or mental health crisis/ intoxication have been collated, as it become an increasing concern for the Safeguarding Group members, with high incidents of deliberate self-harm (overdose/cutting etc.) in younger patients, the youngest being 10 years old. All children that present with self-harming behaviour have an assessment by psychiatric liaison /CAMHS (Child & Adolescent Mental Health services) provided by Dorset Healthcare



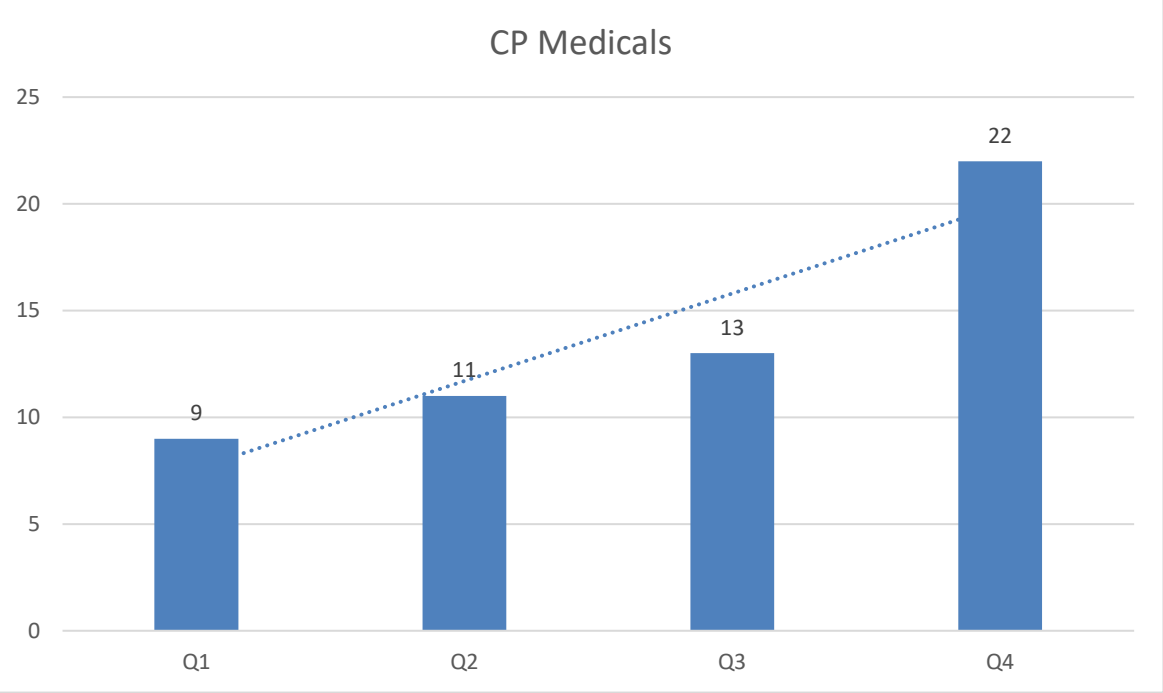
4.4 Children's and Advice Duty Service

ChAD is the Children's and Advice Duty Service, which is a 24-hour service/ priority line, in Dorset, which offers advice to professionals requiring immediate responses for safeguarding children/ young people and families. ChAD is a single point entry for contacts regarding safeguarding and promoting the well-being of children in Dorset. ChAD is not a referral; it is a contact/ conversation to determine the appropriate action for any Safeguarding or Social concern relating to a child/ young person or concerns relating to the adult who cares for a child/ young person. ChAD offers professionals the chance to speak to the most relevant person/ or team for the child/ family in question, discuss the actions that need to be take and helps to ensure the child receives the right support at the right time.



4.5 The above details only those contacts that we are made aware of, staff also contact directly for support through early help services, advice on whether as child is known to services, we are not always made aware of these, so the actual number of contacts is likely to be much higher. We also record contacts to out of area social work teams and contacts made directly to social workers to share information in regard to a child that may attend that is on a child protection plan or known to one of the specialist teams, for example the Children with a disability team if the present with a concerning attendance such as aggression /psychosocial issues.

Child Protection Medicals undertaken by Dorset County Hospital Paediatricians



	Q1	Q2	Q3	Q4
CP Medicals	9	11	13	22

4.6 For children and young people who may have experienced physical abuse or neglect, paediatricians undertake a medical assessment` of the child to identify any injuries or health need related to the abuse. DCHFT does not undertake sexual abuse medical assessments; these are referred to either University Hospitals Dorset (Poole hospital site or the Sexual assault referral centre). The paediatricians, clinical staff and a representative from social care review all these cases on a monthly basis, as part of their governance, supervision and learning process.

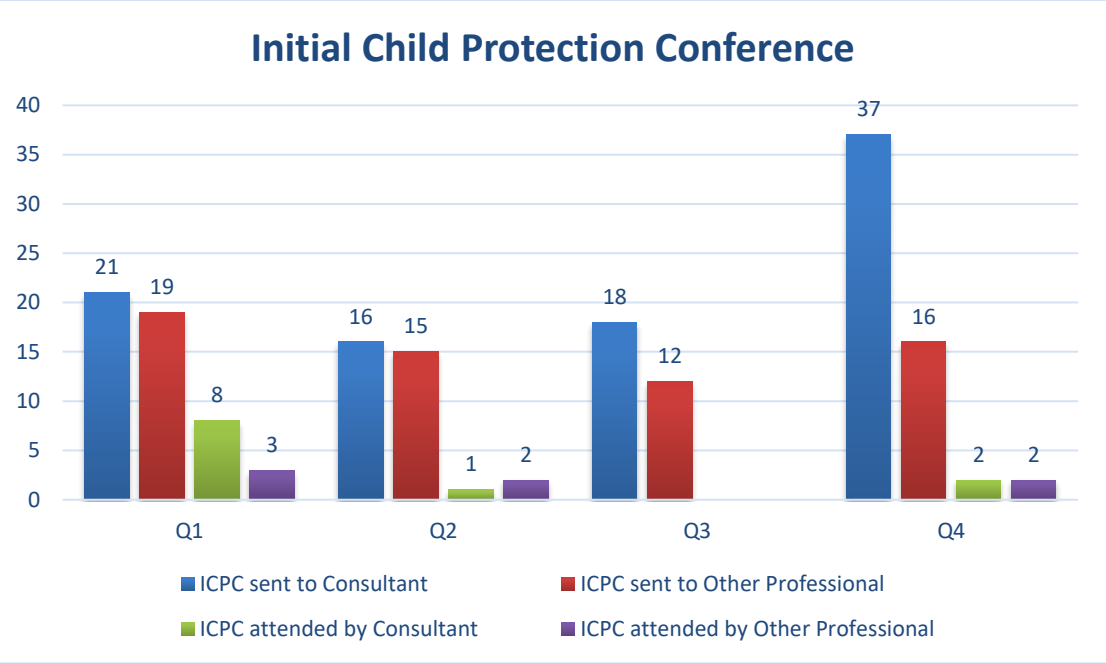
4.7 An Initial Child Protection Conference must be convened when it is believed that a child may continue to suffer or to be at risk of suffering significant harm

The conference must consider all the children in the household, even if concerns are only being expressed about one child. Where consideration is given to a child or children not being the subject of a conference, the reasons must be clearly stated in the social workers report.

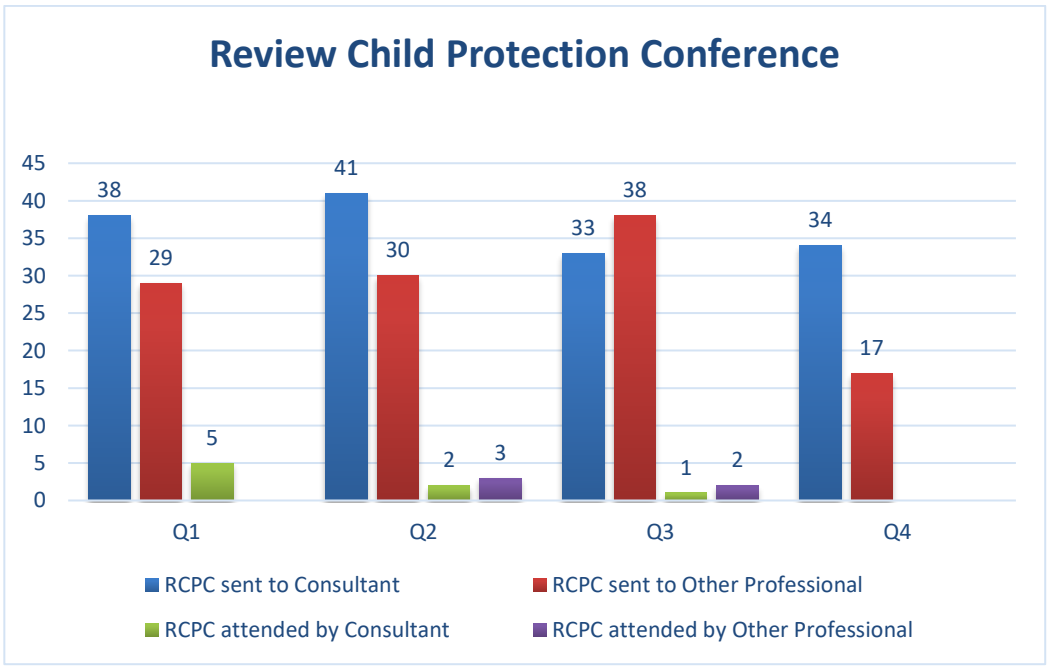
The Children's Social Care Manager is responsible for authorising the decision to convene an Initial Child Protection Conference and the reasons for calling the conference must be recorded.

Practitioners and Paediatricians that have either been involved with the Child protection process for that child or they are already on their case load will asked to contribute either in

person or by written report. The local authority`s children's social care service may well send through request were the child is not on a current caseload, or the Trust has not been directly involved in the child protection process, therefore attendance is not required.



The review process for child protection follows up to review how actions have progressed for that child and whether the level of risk has been mitigated or remains the same. Again, staff members may well be asked to contribute to this process.



5.0 Special Care Baby Unit (SCBU)

Since 2020 the Safeguarding paperwork for SCBU has been updated and a Safeguarding checklist for admissions has been introduced to ensure good multiagency communication. The "think child, think family" and "the invisible man" messages are addressed by an updated family page which staff are encouraged to complete for all admissions. There is also a family observation and liaison page for daily use with families with ongoing Safeguarding concerns. Staff are encouraged to document all liaison and interactions both positive and negative. A Network Safeguarding SBAR (Situation, Background, Assessment, Recommendation – a tool for succinct escalation) for use with out of area transfers of families of concern is also now in regular use.

The Safeguarding Lead for SCBU completed two Safeguarding Supervision study days in October 2021 and in January 2022 completed the Assessing Risk and Clinical Decision Making in Safeguarding module at Bournemouth University. There is now a system in place to address the supervision needs of SCBU staff. SCBU Skills Study Days will be utilised to undertake group supervision sessions. These take place four times yearly and all staff attend over the course of the year. There is also access for staff to the Safeguarding lead on an ad hoc basis regularly once a month and these dates will be emailed to staff. Two further study days will be attended by staff over the coming months. The first will be looking at how we better engage fathers of babies with Safeguarding concerns and the second will be looking at how we can better support those families who have Children's Services involvement throughout pregnancy and up to 2 years of age, including those parents who have baby's removed from their care at birth. Learning from these events will be shared with SCBU staff and the wider Safeguarding Team.

SCBU staff continues to have a close working relationship with the Lead Midwife for Safeguarding and we hope to forge greater links with the Safeguarding Team and Kingfisher in the future. Recent discussion with the Safeguarding Team has highlighted that Integrated Liaison Meetings would be an ideal opportunity to move forward with this. SCBU staff are invited to bring any safeguarding cases of patients admitted or discharged to SCBU.

At the time of writing Level 3 compliance stands at 60%, however all outstanding staff are enrolled on the system to do their updates, so the unit lead anticipates compliance to be 100% in the very near future. Dom Sheehy (Lead Nurse for SCBU and ANNP) and Lead Midwife are continuing to monitor this.

6.0 SERIOUS CASE REVIEWS

Both Adult and Children's Safeguarding Boards/ Partnerships are required to undertake When a child or adult dies or is seriously harmed as a result of abuse or neglect, a review may be conducted to identify ways that professionals and organisations can improve the way they work together to safeguard children and prevent similar incidents from occurring.

Bournemouth / Poole / Christchurch & Dorset Safeguarding Adult Board (BCPDSAB) `Katherine ` (Dorset review only)	DCH participated with this review, learning actions undertaken in respect of including consideration of older domestic violence in all training.
Bournemouth / Poole / Christchurch & Dorset Safeguarding Adult Board (BCPDSAB) LD	DCH participated in the first part of the review and progress event, await second part of the

	SAR post Coroner. (No learning actions identified at this point)
Pan Dorset Children Safeguarding Partnership Briefing Reports / Rapid Review	Three submitted during the last year / DCH have not been asked to participate in any full Child Safeguarding Practice reviews during 2021-2022

7.0 TRAINING

7.1 Adults

All Staff are required to undertake training in Safeguarding Adults, either level 1 or level 2 this is aligned with the competency framework and dependent on job role. The Intercollege document is due to be refreshed and published Spring 2022, it will be advising that more staff groups undertake level 3 safeguarding training for adults, however this will be for minimal staff within the acute setting.

The Safeguarding team have delivered face to face training on the preceptorship programme for newly qualified Allied health professional& nurses, the international nurses' programme, & junior doctor programme.

7.2 Children

Level 1 and 2 Safeguarding Children Training is provided internally to DCHFT staff. Level 1 training is initially provided at induction and then staff maintain their own competence via the e-learning platform.

All non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers utilise the on-line training at Level 2.

Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person are offered internal training at Level 3.

All training has been appraised and updated during 2021-2022 to ensure emerging themes, learning from case reviews is included. Level 3 during COVID19 has been offered via e-learning / PowerPoint presentations/ video`s and reading lists from May 2022, Kingfisher ward staff will be trialling yearly updates to mirror maternity`s training programme. The issue of recoding this within the ESR system remains a challenge.

The overall training figures when considering the intense pressure staff have been under in the past 12 months is satisfactory, however level 3 safeguarding for children training figures have remained stagnant, in Q3 both divisions head of nurses were requested to devise a plan with their Matrons of how they would ensure and increase compliance. In quarter 4 this was escalated to the divisional business managers to be added to the divisional performance log.

.

Trust Wide Results.	Quarter1 (average) scores includes all staff and volunteers	Quarter 2 (average) scores include all staff and volunteers	Quarter 3 (average) scores include all staff and volunteers	Quarter 4 (average) scores include all staff and volunteers
Adults				
SGA level 1 >90%	86%	88%	**89%**	89%
SGA level 2 >90%	90%	89%	**90%**	91%
MCA/ DoLS level 1 >90%	87%	87%	**89%**	89%
MCA/ DoLS level 2 >90%	87%	87%	**89%**	89%
BPAT	88%	90%	**90%**	91%
WRAP	94%	94%	**95%**	96%
Children				
Level 1 >90%	81%	84%	**86%**	87%
Level 2>90%	90%	90%	**91%**	92%
Level 3 >90%	76%	77%	**78%**	78%

8.0 Supervision

Supervision sessions have been undertaken throughout 2021-2022, although some sessions were cancelled due to the impact of the Pandemic. In October 2021, 10 members of staff undertook a 2-day course in safeguarding supervision to ensure adequate provision across all specialties to offer and deliver supervision. Supervision sessions are recorded / actions documented, although daily ad-hoc supervision is not unless action required. Below is the supervision paper submitted to the Safeguarding group. (See addendum pack)

9.0 MENTAL CAPACITY ACT

9.1 Throughout the pandemic the message to staff around the Mental Capacity Act, was very much 'business as usual'. The Safeguarding team continued to give advice and guidance to staff around their application of the Mental Capacity Act. The staff intranet pages were kept up to date with the latest advice and guidance notes. MCA flow chart for ward staff created within the system and shared. (See addendum pack)

10 DEPRIVATION OF LIBERTY SAFEGUARDS

10.1 Until the Mental Capacity Amendment Act (2019) Liberty Protection Safeguards come into force, the Deprivation of Liberty Safeguards continue to be the prescribed process by law for the authorisation of any deprivation of liberty within a hospital setting.

10.2 The Liberty Protection Safeguards did have a planned go live date of April 2022. However, the DHSC recognise that the aim to implement the LPS by April 2022 cannot be met and so implementation has been officially delayed. The LPS are a complicated set of reforms and DHSC expect that a wide range of stakeholders will submit detailed consultation responses about the plans. The Government will need time to consider those carefully once the consultation has closed, before making final decisions about the design of the LPS and plans for implementation, including future funding plans. DHSC think it would be premature to set a new implementation date or confirm any funding to support implementation before they have been able to consider responses to the consultation. DHSC will therefore update us on their plans, including any associated funding, after the consultation.

The government launched the consultation on 17 March 2022 and is consulting on a number of documents:

Code of Practice

The MCA was implemented alongside a Code of Practice which now requires updating for 2 key reasons:

- the existing Code guidance needs updating considering new legislation and case law, organisational and terminological changes, and developments in ways of working and good practice
- the new LPS system means that additional guidance needs to be added to the Code

LPS regulations

The LPS were introduced in the Mental Capacity (Amendment) Act 2019. The UK government is now consulting on 6 sets of draft regulations which will underpin the new system. When enacted, 4 of these sets of regulations would apply in England only. The remaining 2 sets of regulations would apply to both England and Wales. Separately, the Welsh Government has published 4 sets of regulations which would apply in Wales.

The Consultation has a closing date of 7 July 2022. The consultation will say more about the detailed proposals for the design and implementation of the LPS. The period for the consultation will be 16 weeks as opposed to the usual 12 weeks. This is to consider local government elections taking place in May. Although the consultation has been launched DHSC will not set a new target date for implementation.

DCH will give individual organisational feedback as part of the consultation as well as share concerns/ issues/ themes with the other Dorset LPS groups and the SW NHSEI LPS group to be escalated to the National Clinical Reference Group

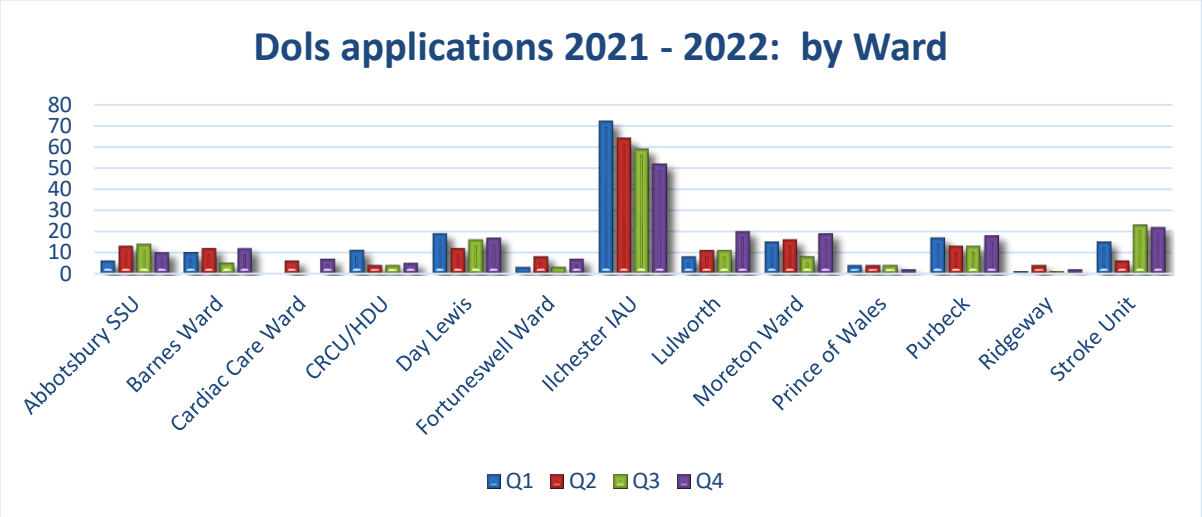
The LD and MCA Lead continues to represent Acute Trusts for the SW on NHS E I SW Liberty Protection Safeguards Group as well as Dorset County Hospital on the Pan Dorset Responsible Body Partnership group. A new group has also convened by the CCG at the request of NHSE– 'Dorset Health LPS group'. This acts as a subgroup of the Pan Dorset Responsible Body group to bring together key issues for health partners

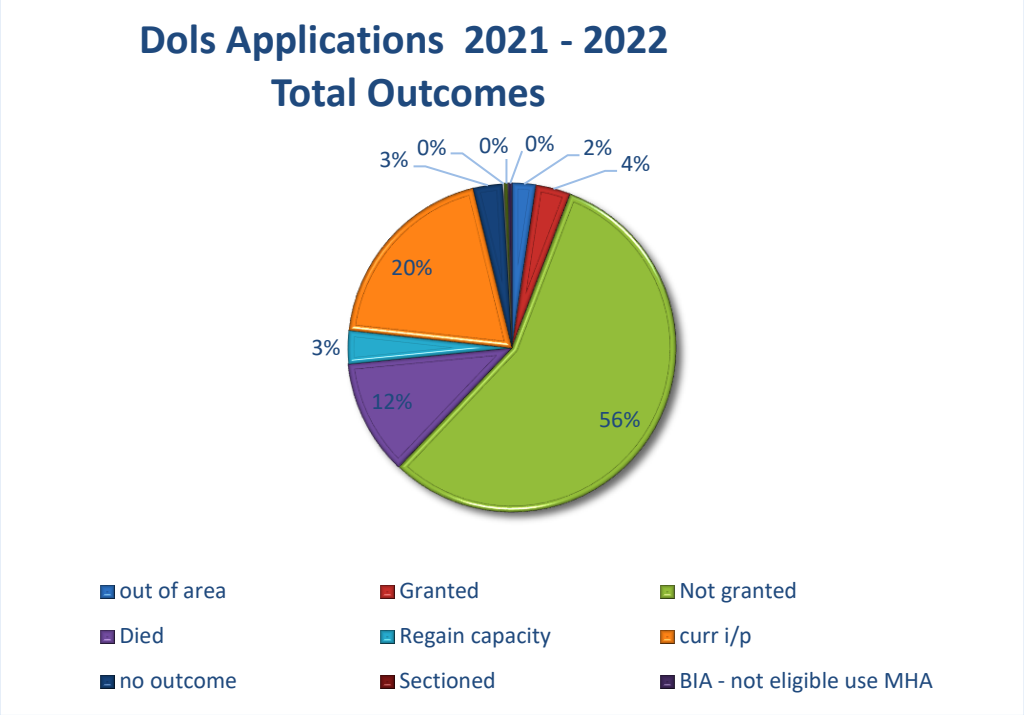
10.3 DCH- implementation of LPS

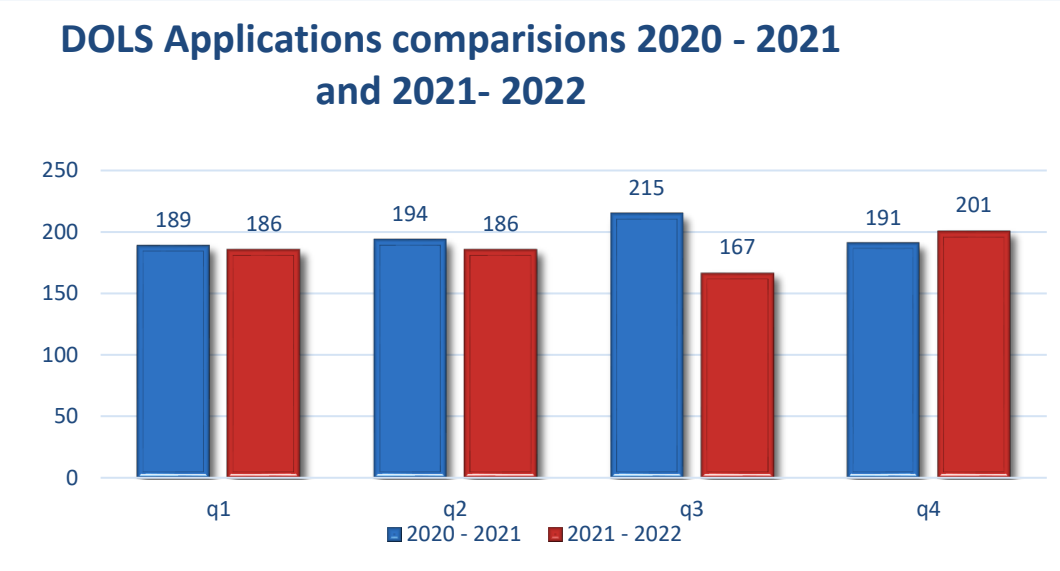
A scoping document has been updated highlighting timelines and identified work streams and LPS has now been placed on the corporate risk register (see addendum pack)

A Risk has been logged regarding LPS on the corporate risk register- Register Risk 1098 updated January 2022. See workplan for more information

10.4 There have been a total 741 Deprivation of Liberty Safeguards (DOLs) applications in the reporting period; this is a decrease from 789 in 2020- 2021







11.0 DOMESTIC ABUSE

11.1 The Domestic Abuse Bill 2019-2021 received Royal Assent in April 2021, the NHS is directly involved in treating victims & survivors of domestic abuse, therefore the introduction of a Health Domestic Violence advocate with Safeguarding team has already been invaluable. This is a funded role through Dorset Council and Paragon

The role of the DVA Health Advocate is to work closely with health colleagues to share knowledge and skills and improve their referral processes into existing commissioned services which will lead to increased referrals. The DVA Health Advocate will carry a case load and work directly with victims of domestic violence and abuse, receiving referrals across all risk categories with a focus on medium and high risk, utilising existing services and referral pathways for standard risk clients. DVA Health Advocate's work from the point of crisis to provide high quality advocacy and support and engaging with local partners ensuring each person has a co-produced support package.

Having a DVA Health Advocate based within a hospital can help:

- NHS staff to have the confidence to ask about domestic abuse and provide a response to disclosures
- Provide an immediate specialist response to the patient/client – clients are then more likely to engage in ongoing community support
- Increase the number of Health referrals to MARAC/HRDA and specialist support agencies
- Provide support to NHS Staff who are experiencing domestic abuse in their own lives
- Reduce the number of hospital attendances due to issues caused by domestic abuse – physical injuries, mental health concerns, substance, and alcohol misuse

11.2 Domestic Abuse is significant to the healthcare agenda due to:

a) *Patient Care:* Achieving high quality care for patients.

b) *Regulations*: Domestic Abuse is integral to Children and Adults. Safeguarding is a fundamental requirement for registration and complying with the Care Quality Commission.

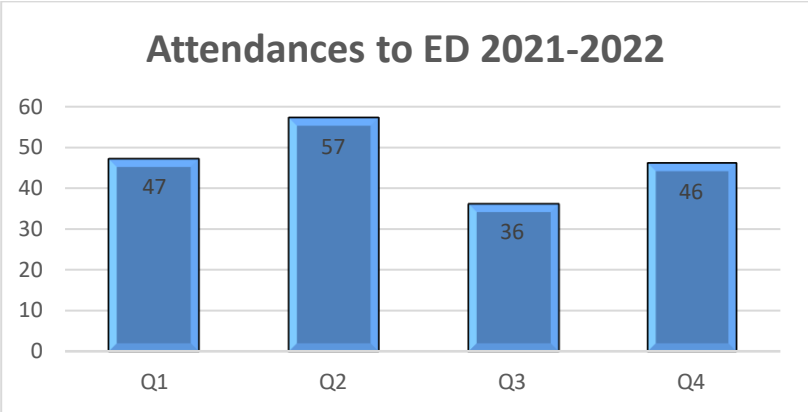
c) *Legislation*: Complying with legislation including the Children Act, Human Rights Act; Equality Act; Mental Capacity Act and Safeguarding Vulnerable Groups Act.

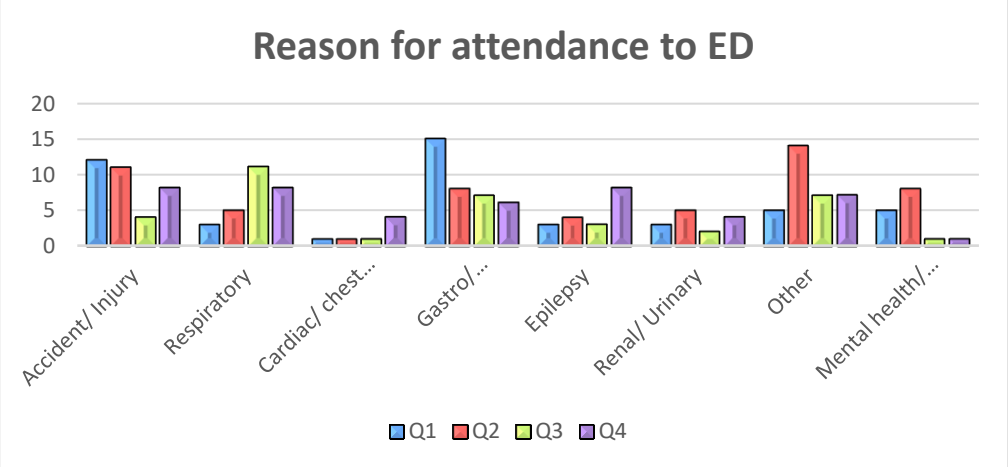
d) *Cost Effectiveness*: Harm, neglect and abuse cost the NHS millions each year in avoidable admissions and care.

11.3 All staff receive domestic abuse awareness as part of their mandatory training.

12 LEARNING DISABILITY

12.1 Attendances at ED for people with a learning disability 2021 -2022





12.2 DCH submitted data to the NHS I E Learning Disability Benchmarking exercise 2021-22. The report for the previous year (2020-21) has only recently been provided to the benchmarking platform
The report details the findings of the third NHS England NHS Improvement learning disability improvements standards collection. The standards focus on 4 areas:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce
4. Specialist learning Disability service

There is a 3-pronged approach of organisational level, staff level and service user level data collection

Key points for future consideration include:

- Providing a low stimulus waiting area

- Providing accessible appointment letters
- Providing changing places toilet facilities
- Providing home visits instead of outpatient appointments
- Triaging people with a learning disability and autism
  The report also focuses on the provision of learning disability liaison staff. DCHFT has a Learning Disability and Mental Capacity Act lead whose role is different to that of a liaison nurse but provides leadership around supporting people with a learning disability to Trust Staff. The report does not recognise this.
  There is an emphasis on employment of people with a learning disability or autism. DCHFT currently doesn't have any data around this
  The report also explores training around learning disabilities and autism, something that is not yet mandatory but with the development of the National Oliver McGowan training this will be mandated in the future following the completion and reviews of pilot training.

12.3 The Trust continues to notify the LeDeR programme of any deaths of people with a learning disability and is represented on the Dorset LeDeR Steering group by the LD and MCA Lead. Any learning from the reviews relevant to areas in the Trust is shared with the divisions

12.4 Dorset and Yeovil Acute Health Facilitation Network
The LD and MCA lead has pulled together a group of colleagues from United Hospitals Dorset, Dorset Health Care and Yeovil Hospital to meet regularly in order to share good practice to reduce barriers and health inequalities experienced across the area by people with a learning disability.

12.5 New easy read CPR/ DNACPR leaflet published

13.0 PREVENT

13.1 Prevent forms part of the Counter Terrorism and Security Act, 2015. Prevent is concerned with preventing children and vulnerable adults becoming radicalised into terrorism.

13.2 NHS Trusts are required to: -

- Train their staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised, and how to raise a concern.
- Train Workshop to Raise Awareness of Prevent Training (WRAP) facilitators to cascade more detailed Prevent training to staff.
- Report concerns of people becoming radicalised to the Prevent hotline.
- Attend the local authority Channel panel. This multiagency panel discusses the risk posed by vulnerable people who are referred for multiagency support.
- Report the training figures and number of people referred to Channel on a quarterly basis to NHS England.

13.5 The Training is completely e-learning and is a requirement for all staff.

13.6 PREVENT learning is required by all Trust staff and requires an update every 3 years. The e-learning package that has been developed by NHS England, will ensure a consistent approach to both training and competency, and will meet our contractual obligations in relation to safeguarding training as set out in the NHS Standard Contract.

13.7 The compliance and activity is monitored quarterly by NHS digital and Dorset Commissioning Group through submission of data.

13.8 There have been no PREVENT referrals or CHANNEL referrals in the past 12 months.

14.0 SAFEGUARDING INCIDENTS INVOLVING STAFF

14.1 Over the past 12 months the safeguarding team have worked in conjunction with HR and LADO (Dorset Council) when safeguarding concerns have been raised about employees. There have been 3 cases; all have been resolved from a Trust perspective.

15.0 AUDIT

Due to the COVID 18 pandemic the usual audit plan was suspended.

15.1 Overarching MCA/Safeguarding Assurance audit is completed 6 monthly. The format for this aligned with the CQC KLOES, however due to the inspection process changing it will need to reference the new key line of enquiry

15.2 Pan Dorset Safeguarding Children's Partnership (Dorset) initiated a Child Exploitation Audit which the team participated with, the results of this at time of report are not available.

16.0 OTHER ACTIVITIES / Compliments and Complaints

Development of a bespoke training package for level 3 Safeguarding children.

Both intranets' sites for Safeguarding have been updated and refreshed.

Six monthly Safeguarding newsletters shared with all employees at DCH. (See addendum pack)

External internet site updated to include more links to accessible information.

Improvements to recording Safeguarding with in the DPR system.

Change of flagging system for children at risk.

Assistance with AGYLE system development

Head of Safeguarding finalist for GEM leadership award

Collaborative work on 2 cases' that involved social care Domestic Abuse & Safeguarding Team.

Initiative commenced after discussion at Adult Safeguarding health and social care lead meeting, SWAST (southwest ambulance) alerts now shared with Safeguarding team, then they disseminate this information to wards, / discharge team as the majority are requiring review of care and support needs so should aid early discharge planning to commence.

Feedback from a family carer of a person with profound learning disability. 'My son has just been discharged from DCH after spending nearly 3 weeks "inside". He was in Intensive Care and Moreton Ward. I have to say we were treated royally in both places, and I cannot speak too highly of the service.' This was forwarded to the departments and PALs.

Safeguarding was contacted by a Research Nurse who had been concerned regarding a conversation with one of her patients. The lady was partially sighted, had stated that she could not attend her appointment as she was being visited by some people on that date who wanted to review her bank statements, but she did not know why.

Action taken: Safeguarding team gave details of fraud line, citizens advice, visit postponed until clarification of the reason for the visit and official letter explaining the need for the review, which her son was able to read for her. The `people` were in fact the Council, who did produce a letter on request.

Making Safeguarding Personal/ Human Rights approach was taken by several professionals regarding a very complex case that involved addiction / self-neglect and domestic abuse. Those involved included our addictions nurse, discharge lead, senior sister and the safeguarding team, who all shared the belief that this patient had the mental capacity to determine her place of residence. It was felt that she was being treated with disregard to her thoughts, feelings and wishes & that the mental capacity act was being weaponised against her. Subsequently after a professionals meeting called by Safeguarding, this lady`s wishes to return home were respected and she returned to her property safely.

On information shared we were able identify that several our frequent attenders at ED were potential victims of DV that were also homeless. Health DV advocate now attends the drop in at the Lantern weekly to try and offer support / guidance. We are hoping this may reduce attendance at ED but may mean that if they do attend, they may be more willing to disclose if they know they can speak directly.

17.0 SAFEGUARDING DORSET COUNTY HOSPITAL WORK PLAN 2022-2024 KEY OBJECTIVES

(See addendum pack)

Addendum pack


8.0 safeguarding supervision paper.p


9.0 Hospital MCA Flowchart for Ward


10.3 DCH LPS Implementation on


10.3 DCH LPS Option Paper March


16.0 newletter Spring 2022 v2.pdf


16.0 newletter Winter 2021.pdf


17.1 strategy and work plan 2022 -20

References

1. Care Act 2014
   http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

2. Deprivation of Liberty Safeguards
   https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards

3. Dorset Adult Safeguarding Board Policy
   https://www.dorsetforyou.gov.uk/dorsetsafeguardingadultsboard

4. Regulation 13: Safeguarding service users from abuse and improper treatment

5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13
   http://www.cqc.org.uk/content/regulation-13-safeguardingserviceusersabuse-and-improper-treatment

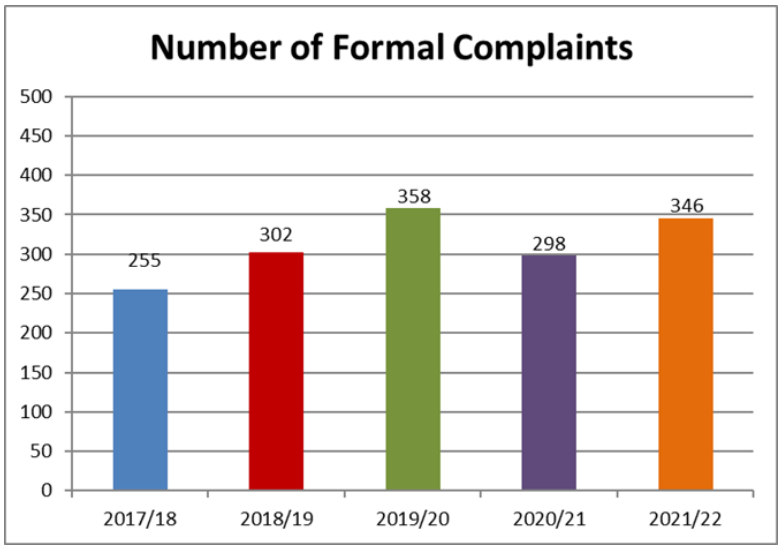
6. Mental Capacity Act 2005
   http://www.legislation.gov.uk/ukpga/2005/9/contents

Meeting Title:	Board of Directors Part 1
Date of Meeting:	27th July 2022
Document Title:	**Draft Annual Complaints Report 2021/22**
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Alison Male, Head of Patient Experience Emma Hoyle, Deputy Chief Nursing Officer

Confidentiality:	*No*
Publishable under FOI?	*Yes*

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Quality Committee	21 June 2022	

Purpose of the Paper	The annual complaints report complies with the Local Authority Social Services and National Health Service Complaints Regulations 2009, which requires each NHS trust to produce an annual report regarding complaints received.						
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	The paper covers the reporting period 1st April 2020 to 31st March 2021. The total number of formal complaints received by the Trust for this year was 346 which have increased by 16% from the previous year. There were also 728 recorded contacts for PALS informal issues resolved, also an increase of 62% on the previous year.						



During this year 38 complaints (5%) have been reopened. Complaints are normally reopened for the following reasons:

- Complainants contact us to seek further clarification about the complaint raised indicating that the complaint has not been fully addressed or they

	disagree with aspects of the response from their perspective. • Additional questions have been asked following receipt of their response. • Complainants take up the offer of a meeting with staff to discuss their complaint in more detail. Of the 38 reopened complaints 34 of those reopened were due to additional questions being asked, or ongoing concerns or requesting a meeting or telephone call with staff. The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints in order for the organisation to learn from what has happened to them. We will continue to ensure that we learn when our patients tell us they have not had a good experience with us. Learning from complaints assures our patients that the Trust has taken their complaint seriously and taken the opportunity to learn from their feedback. Examples of the learning points included in the complaint responses. We 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. Due to the continued demand on the hospital and clinical teams, this has occasionally not been met and this will continue to be monitored via the Patient Experience Group.
Action recommended	The Board is recommended to: 1. **NOTE** the Draft Annual Complaints Report 2021/22.

Governance and Compliance Obligations

Legal / Regulatory	Y	Complies with the Local Authority Social Services and National Health Service Complaints Regulations 2009
Financial	N	None currently identified
Impacts Strategic Objectives?	Y	NHS Foundation Trusts are required to produce an Annual Complaints Report. Using this feedback will help deliver further improvements to patient care. This relates to our strategic themes of **People** - Putting our people first to make DCH a great place to work and receive care; **Place** - Building a better and healthier place for our patients and population.
Risk?	Y	Failure to act on the feedback from complaints will have a negative impact on both staff wellbeing and patient care and strategic objectives
Decision to be made?	N	
Impacts CQC Standards?	Y	As feedback is designed to enhance and improve both patient safety and experience, non-delivery may result in a detrimental consequence to the quality and experience of our patients.
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Title of Meeting	**Quality Committee**
Date of Meeting	**21st June 2022**
Report Title	**Draft Annual Complaints Report 2021/22**
Author	Alison Male, Head of Patient Experience Emma Hoyle, Deputy Chief Nursing Officer

1.0 INTRODUCTION

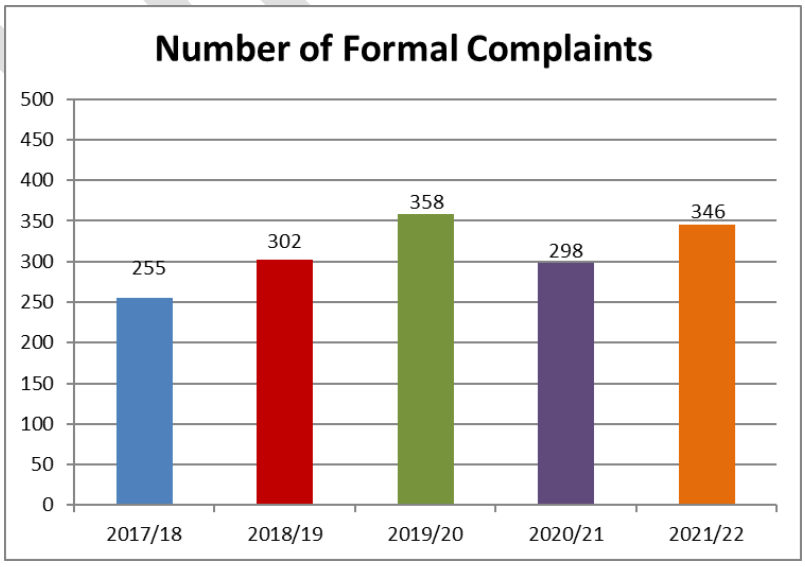
1.1 The annual complaints report complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which requires each NHS Trust to produce regular reports about complaints received, including an annual report.

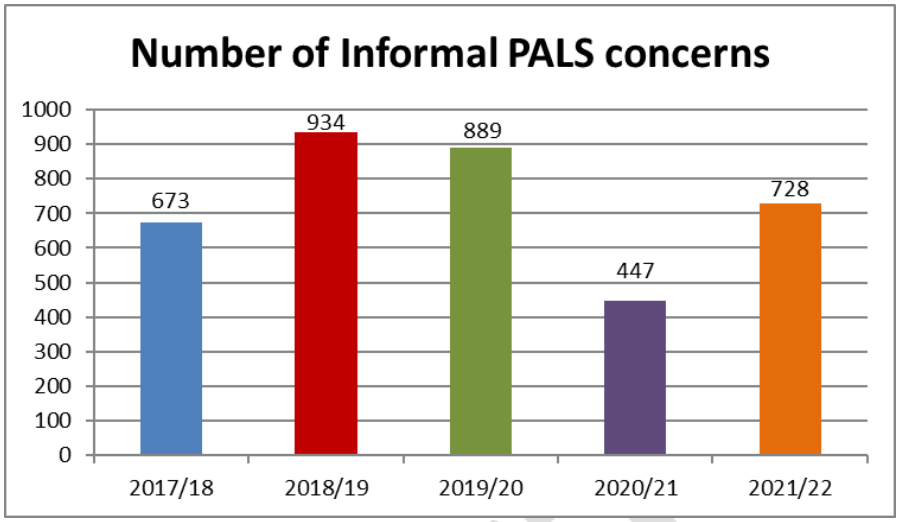
1.2 This annual report includes an overview of the number and nature of complaints received and how complaints are handled.

2.0 NUMBER OF COMPLAINTS RECEIVED

2.1 The total number of formal complaints received by the Trust for this year was 346 which have increased by 16% from the previous year. There were also 728 recorded contacts for PALS informal issues resolved, also an increase of 62% on the previous year.

2.2 The charts below shows a visual comparison of the number of formal complaints and informal PALS concerns over the last five years:





2.3 Each formal complaint is treated as well-founded in order to investigate and a response is provided to the complainant outlining the findings of the investigation.

2.4 During this year 38 complaints (5%) have been reopened. Complaints are normally reopened for the following reasons:

- Complainants contact us to seek further clarification about the complaint raised indicating that the complaint has not been fully addressed or they disagree with aspects of the response from their perspective.
- Additional questions have been asked following receipt of their response.
- Complainants take up the offer of a meeting with staff to discuss their complaint in more detail.

Of the 38 reopened complaints 34 of those reopened were due to additional questions being asked, or ongoing concerns or requesting a meeting or telephone call with staff.

3.0 PROCESS FOR COMPLAINTS HANDLING

3.1 The Trust informs patients and carers how to raise concerns in the bedside folders, on the Trust website and in the “How was your experience at Dorset County Hospital” leaflet which is found around the hospital. This leaflet promotes ways to give positive feedback as well as information about raising a complaint.

3.2 All feedback, concerns and complaints are co-ordinated centrally and upon receipt are screened and triaged according to the seriousness of the issues raised. The focus is to consider each complaint from the complainant’s perspective and complainants are offered the opportunity to discuss the way in which their complaint is handled.

3.3 Details of complaints are recorded on the Datix web-based system, this enables complaints and concerns to be managed in an open, central and accountable manner.

3.4 The responsibility for investigating complaints is devolved to the Divisions and their respective teams, who are required to provide a comprehensive response within an agreed timeframe. This outlines the response to the investigation with recommendations, learning or actions taken for improvement where appropriate. The final response to every formal complaint is agreed and signed by the Chief Executive or a nominated deputy.

3.5 The complaints process allows the Trust flexibility in arranging local resolution meetings with complainants. These meetings usually include the relevant healthcare professionals including the Consultant or Matron in order that questions can be answered by the clinicians delivering care and a personal apology given where appropriate. This has proved to be a very positive and helpful process with the openness of the meetings being well received by all participants. Prior to the COVID-19 (Coronavirus) pandemic, many of these discussions were face-to-face. During the COVID-19 (Coronavirus) pandemic, and due to the challenges around staff availability and social distancing, alternative methods to facilitate this option were explored via virtual meetings or telephone. As the COVID-19 (Coronavirus) pandemic eases, face to face meetings is now being offered to complainants.

4.0 RESPONSE TO COMPLAINTS

4.1 This year again our task was to continue to improve the timeliness of responses to complaints so that complainants are responded to within mutually agreed timescales.

We 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. Due to the continued demand on the hospital and clinical teams, this has occasionally not been met and this will continue to be monitored via the Patient Experience Group.

4.2 In order to support the Divisions during this difficult time we continued to:

4.2.1 Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, and complaints in need of urgent response.

4.2.2 Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions.

4.2.3 Provide adhoc training and support to clinicians and managers around complaint process and responses.

4.2.4 All complaints responses are reviewed by the Chief Nursing Officer or in her absence the Deputy Chief Nursing Officer for quality assurance before sent to the Chief Executive or nominated deputy to sign.

5.0 LEARNING FROM COMPLAINTS

5.1 The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints in order for the organisation to learn from what has happened to them.

5.2 Complaints are an important way for the management of an organisation to be accountable to the public, as well as providing valuable prompts to review organisational performance and the conduct of people that work within and for it.

5.3 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.

5.4 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.

5.5 The actions from learning points are allocated to individuals in the Divisions via the Datix system and are monitored at Divisional and Care Groups meetings.

5.6 Patients have continued assisted in making videos narrating their experience of the care that they received, and also their feelings about the complaints process. These videos are shown to the relevant divisional leads and are available for presentation at Board when required.

5.7 We will continue to ensure that we learn when our patients tell us they have not had a good experience with us. Learning from complaints assures our patients that the Trust has taken their complaint seriously and taken the opportunity to learn from their feedback. Examples of the learning points included in the complaint response are below.

Concern raised:	**Learning/Actions taken:**
Complication of treatment; discharged without any medication - Patient had a recurring cyst, which had difficulty healing, which the patient felt was down to treatment.	• Patient's case was discussed at the surgical clinical governance meeting and scrutinised by other surgeons who assessed that this was a recognised and unavoidable complication.
Cancelled treatment – patient attended for a cataract operation in the left eye, but was told on arrival that cataract operations in the left eye do not take place at the	• 18 Week Support medical and nursing staff operate and adhere to the local Trusts polices and standard operating procedures (SOP). The learning from any concerns identified will be collaboratively shared with the

weekend. Patient was later told when calling to rebook the appointment that the procedure was cancelled as they only had one eye, which is not the case.	Trust. • To ensure the Trust only refers patients to 18 Week Support who have vision in both eyes that require an operation. • To ensure communication between the Trust and their patients is timely.
Delay in treatment. Attitude of some staff – child with a history of virus induced wheezes attended ED prior to being transferred to Kingfisher. The parent felt that there was a delay in starting blast therapy treatment, despite the parent advising staff this had been the planned treatment on previous occasions. Parent felt they were patronised and not listened to.	• For the ED team to ensure full explanation of treatment and reasons why are given to the family as well as the patient (when appropriate) and to share any concerns with the paediatric team on transfer to the ward. • The nurse on Kingfisher Ward has reflected on your feedback and apologises if her attitude appeared rude or abrupt. • Dr has reflected on his communication and interaction with you for the future treatment of patients. • Dr has received further education on the Wheeze and Acute Asthma therapy. • Dr to ensure all documentation has been reviewed relating to his patient. • Dr and the nurse have agreed a professional working relationship for the future. • The VIW & Acute Asthma Treatment Pathway has been recirculated to the paediatric and ED teams. • A peer review meeting to review the discharge summaries with the junior staff.

5.8 To enhance the learning there is triangulation of Risk Management information on incidents alongside complaints and PALS enquiries. Where a complaint raises a clinical concern or falls within the realm of an incident the Risk Management and Patient Experience Team will link and ensure thorough investigation and engagement with the complainant. This is made easier with Complaints being on the same system as incidents and enables proactive analysis of any trends in certain services.

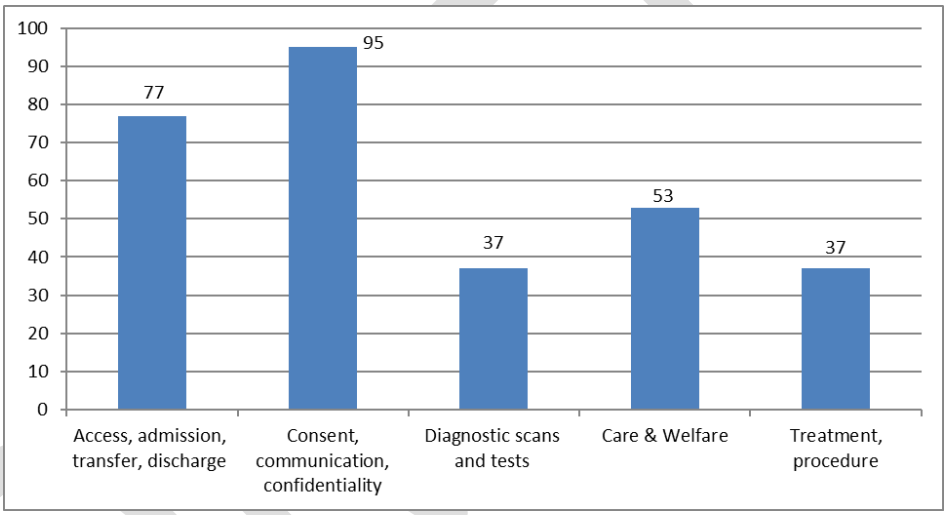
6.0 REPORTING & MONITORING

6.1 The Trust Board receives a monthly summary of the number of complaints received and the issues raised as part of the Integrated Operational Report. A further report which contains a more in depth analysis of the issues raised in complaints is provided quarterly to the Patient Experience Group and Quality Committee.

6.2 Complaints are coded on the Datix system under a variety of categories. Although the subject matter may vary, the root causes which result in a complaint being raised can be associated to three main themes: communication, staff attitude and delays.

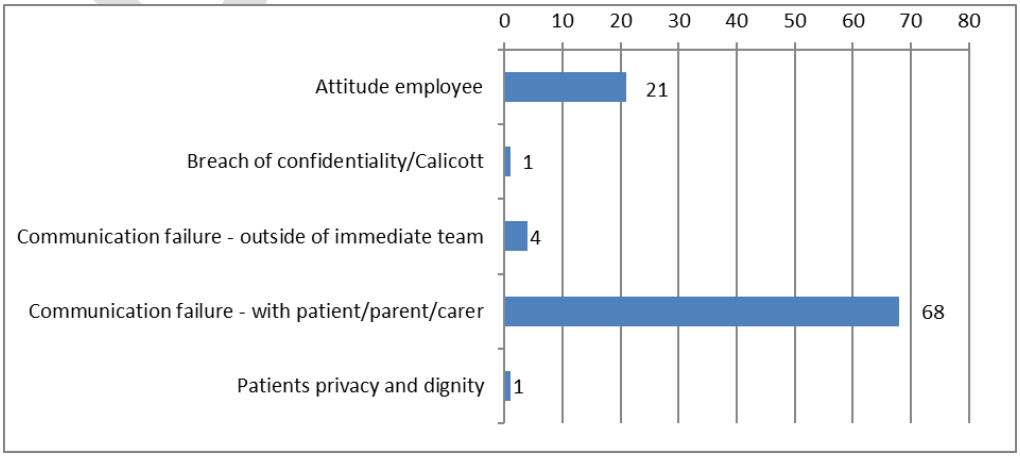
6.3 Complaints related to Consultants are shared with the Medical Director for professional conversations as required.

6.4 The five main themes are shown in the chart below.

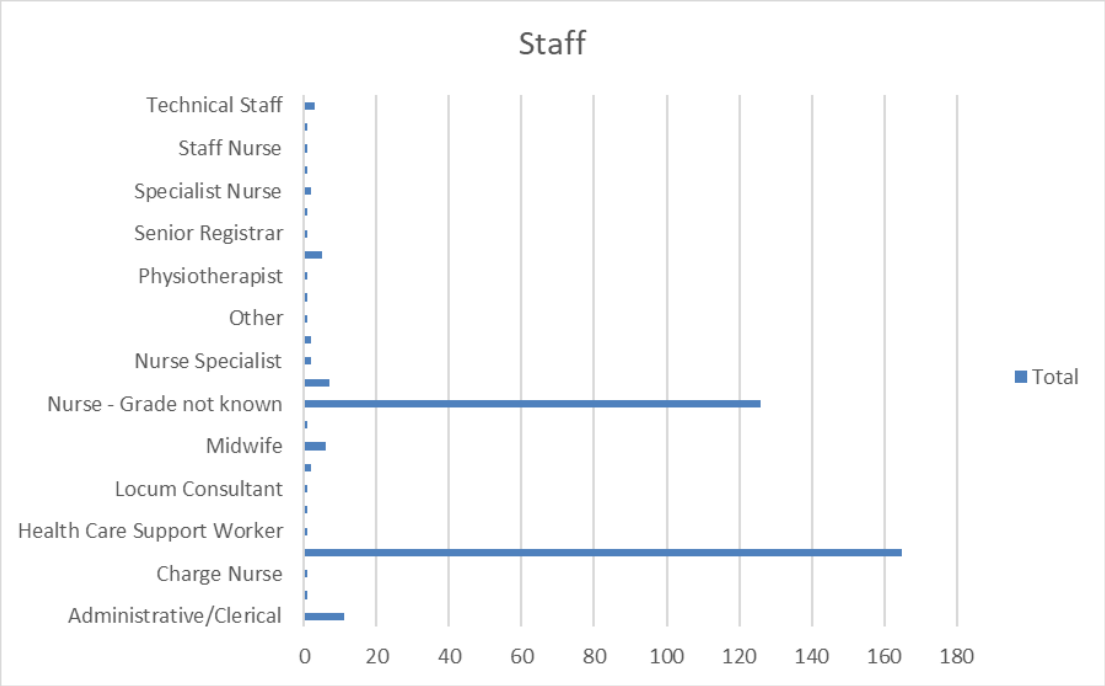


NOTE: SOME COMPLAINTS ARE LOGGED TO MORE THAN ONE SUBJECT

6.5 The chart below shows a breakdown of the largest theme of **consent, communication and confidentiality** in more detail.



7.0 COMPLAINTS BY STAFF GROUPS



8.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

8.1 Contact information for the Parliamentary and Health Service Ombudsman (PHSO) is provided to all complainants should they remain unhappy with the outcome of the Trust's investigation and response. During the last year we have been contacted by the PHSO once. This complaint related to an initial contact from the family in 2021. This related to visiting regulations, which the family felt were not in line with other hospitals. Following an initial review of the complaint and relevant documentation, the PHSO did not uphold the complaint. The family were unhappy with this and asked for a further review around visiting for end-of-life patients. The PHSO is currently reviewing this aspect.

9.0 NEW NHS COMPLAINTS STANDARDS

9.1 Led by the Parliamentary Health Service Ombudsman (PHSO) these standards were tested in pilot sites in 2021 and will be refined and introduced across the NHS later in 2022.

The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff. They also place a strong emphasis on senior leaders regularly reviewing what learning can be taken from complaints, and how this learning should be used to improve services.

"My Expectations" will help the Complainant raising the concerns having a clear measured progress so that the organisations can determine the action they need to take to improve & learn. This will demonstrate the powerful contribution that people who use this service can make when they have the opportunity to seek out "What good looks like & learn".

The Standards are the first step towards recognising complaint handling as a professional skill. They will set a clear path for all services to harness the rich learning that comes from feedback and complaints to help improve services for the benefit of all. For staff to understand it is good to talk and be proactive by recognising a potential situation that could be prevented from escalating by having the right conversation in the right manner.

By adopting the Standards, NHS staff will be able to address and resolve at first point of contact. Embracing this approach will give our staff the opportunity to learn & improve using feedback as a tool to strengthen their abilities in key roles and moments in a patient's journey.

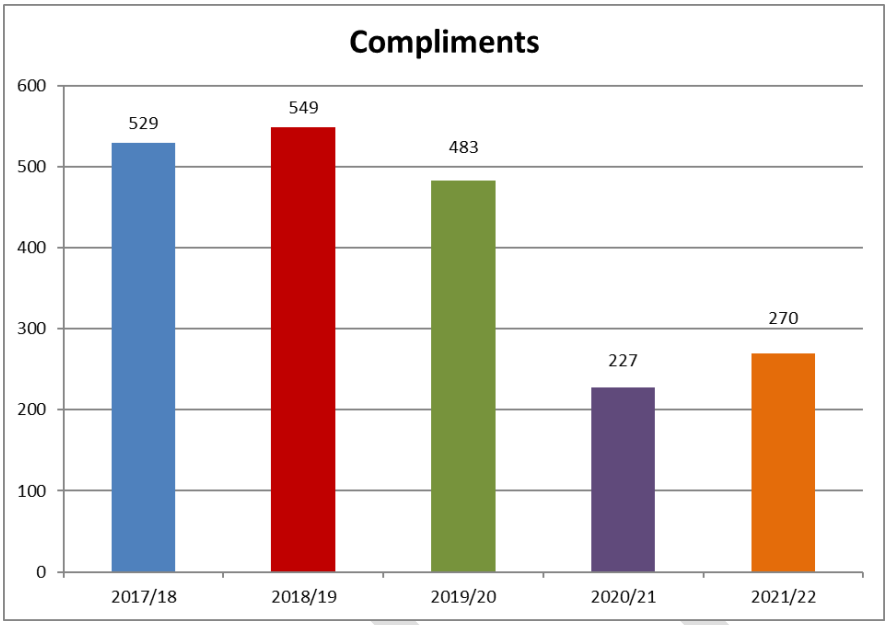
Earlier resolution of complaints will also reduce the possibility of complaints becoming legal claims or being referred to the Ombudsman. This can save financial and emotional costs for everyone.

When the new standards are launched, we are hoping to engage senior leaders across the Trust to help and support the introduction of the new standards and learn together to look at complaints differently and how this can be placed more in our control than before.

The Standards and the guidance modules describe how staff can meet those expectations. Guidance modules to implement the standards can be downloaded from the PHSO website.

10.0 COMPLIMENTS

10.1 The graph below shows the number of compliments collected by the Patient Experience team in recent years, with the number of compliments received this year being 270. The Hospital Hero award ceremony was suspended during the Covid-19 (Coronavirus) pandemic and now those staff who are nominated received their certificate in the post and a voucher for tea/coffee & cake from Damers Restaurant. The 'Celebrating Success' weekly email is circulated to the organisation which highlights those staff who have been complimented about their work during the past week.



11.0 CONCLUSION

The Trust continues to meet the regulatory requirements on managing complaints, identifying learning from complaints. The focus for next year as part of our continuous improvement in managing complaints will be:

- To continue to respond to complaints in a timely manner with compassionate responses to include learning from complaints to enhance quality improvement.
- The Patient Experience Team with the Divisions will continue to work closely to monitor complaint responses provided within the agreed timescales and improve the process where necessary.
- To develop complaints training for staff in relation to the new NHS Complaints standards.
- The action plan implemented last year has been updated below:

	ACTION:	**Timescale/Update**
1	Monitor the number of extensions granted and the reasons for needing the extension.	Process in place - completed
2	Meet with Divisions (as per Division capacity /resource) on a weekly basis to highlight complaints response times, and complaints in need or urgent response.	Process in place - completed
3	Send out a weekly report highlighting which complaints and concerns are outstanding and complaint timeframes to Divisions and senior management team and Deputy Director of Nursing & Quality	Process in place - completed

4	On-going monthly monitoring of response timeliness. A monthly report is provided to reflect progress and numbers received. To be continually monitored to maintain target of 95%.	Process in place - completed
5	Review the complaint journey from receipt of complaints for further development of the Complaints web-based module on Datix	Monthly with Risk Management Team - ongoing
6	Review the complaints training & complaint process information offered to staff in response to the new Complaint Standards in 2022.	September 2020 - ongoing
7	Provide adhoc training and support to clinicians and managers around complaint responses.	Process in place
8	Plan quarterly meetings with Patient Experience & Engagement Lead and Divisional Managers to review progress and track improvement made.	Process in place - completed
9	Send out the complaint process survey regularly throughout the next year to gain feedback on the complaint process and monitor the impact of improvements made.	Process in place – ongoing
10	Theme the learning from complaints identified in complaint response letters - to be included in the Patient Experience Quarterly report.	Process in place - completed
11	Identify and record if complaints are upheld, partially upheld or not upheld. Information to be recorded on Datix	Process in place – completed.
12	Review the process of collating and recording compliments	September 2020 - completed

12.0 RECOMMENDATIONS

12.1 The Quality Committee is requested:

- to note the contents of this report
- receive assurance of improvements in complaints management and learning

Meeting Title:	Trust Board of Directors
Date of Meeting:	27 July 2022
Document Title:	**Infection Prevention & Control Annual Report 2021-2022**
Responsible Director:	Nicky Lucey, Chief Nursing Officer, Director Infection Prevention & Control
Author:	Emma Hoyle, Deputy Chief Nursing Officer, Associate Director Infection Prevention & Control

Confidentiality:	*No*
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	As part of the assurance required for Trust Board an annual Infection Prevention and Control report is required. This meets the national requirements set via NICE, NHSE/I The Board of Directors is asked to accept the report from Quality Committee (19 July 2022). For noting: • The Trust met the trajectories set for MRSA bacteraemia, Gram Negative Organisms and *Clostridium difficile* infections for 2021-2022 • The Trust continued to develop and adjust in the global pandemic of COVID-19 in response to the local and national requirements • Hand hygiene compliance has remained high and sustained at 97% • No outbreaks of Norovirus • The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards. • Mitigation and enhanced monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high risk areas • Trust remains key national benchmark for use of data management system in infection prevention & control (ICNET).							
Action recommended	The Board of Directors is recommended to: 1. **NOTE** the report 2. **RECEIVE** assurance on actions to address any performance issues							

Governance and Compliance Obligations

Legal / Regulatory	Y	Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.
Financial	Y	Undetermined, but could incur penalty if unable to achieve agreed standards/targets.
Impacts Strategic Objectives?	Y	The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives
Risk?	Y	*Links to Board assurance Framework*
Decision to be made?	N	*For assurance*
Impacts CQC Standards?	Y	As this report incorporates standards outlined by 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	

Infection Prevention and Control Annual Report 2021-22

Nicola Lucey – Chief Nursing Officer/Director of Infection Prevention and Control

Emma Hoyle - Deputy Chief Nursing Officer**/**Associate Director Infection Prevention and Control

INDEX

EXECUTIVE SUMMARY

The annual report provides a summary of the infection prevention and control activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust.

The Chief Nursing Officer is the accountable board member responsible for infection prevention and control and undertakes the role of the Director of Infection Prevention and Control.

The Infection Prevention and Control Group function in order to fulfil the requirements of the statutory Infection Prevention and Control committee. It formally reports to the sub-board Quality Committee, providing assurance and progress exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – part 3 Code of Practice for the Prevention and Control of HCAIs), which was reviewed and updated in 2015.

The work plan, led and supported by the Infection Prevention and Control Team (IPCT), sets clear objectives for the organisation to achieve with clear strategies in place to meet the overall Trust strategy of Outstanding.

Overall 2021- 2022 was a challenging but successful year, meeting key standards and regulatory requirements for infection prevention and control. Below is the highlight of those:-

- The Trust met the trajectories set for MRSA bacteraemia, Gram Negative Organisms and *Clostridium difficile* infections for 2021-2022
- The Trust continued to develop and adjust in the global pandemic of COVID-19 in response to the local and national requirements
- Hand hygiene compliance has remained high and sustained at 97%
- No outbreaks of Norovirus
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high risk areas
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNET).

1. INTRODUCTION

This is my sixth year as Chief Nursing Officer, with the responsibility of Director for Infection Prevention and Control (DIPC) and this report summarises the work undertaken in the Trust for the period 1st April 2021– 31st March 2022. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

The pandemic has continued to remain challenging for the Trust and Infection Prevention and Control over the reporting year as the world-wide pandemic of COVID-19 maintained its dominance particularly in healthcare. The Infection Prevention and Control team have been vital in developing and supporting the Trust. They have continued to provide expert counsel to others across the system and southwest region, sharing best practice and challenge to ensure COVID-19 secure environments for patients and staff.

The Trust met the target for zero cases of preventable MRSA bacteraemia. The Trust reported 20 trajectory cases of *Clostridium difficile* against a target of 22 cases and was under trajectory for gram negative organisms. The Infection Prevention and Control Team has seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

These lower rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases. I am incredibly proud of the teamwork that has enabled this positive track record of patient safety.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team epitomizes this quality improvement ethos, and they significantly contribute to achieving our strategic mission: "Outstanding care for people in ways which matter to them". Their support for training and engaging with the clinical teams has been at the highest standard, reflective of the care provided and experience by our visiting public.

I am never complacent and have ongoing high ambitions for patient safety. I look forward to another year ahead of delivering outstanding services every day through effective, efficient, and joined up infection prevention and control.

Nicola Lucey
Chief Nursing Officer
Director of Infection Prevention and Control

2 INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 5 times during 2021- 2022. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPCG was chaired by the Chief Executive Officer, Patricia Miller, Chief Nursing Officer, Nicola Lucey, who also is the Director of Infection Prevention and Control (DIPC), is in attendance and acts as deputy Chair, with the responsibility for reporting to the sub-board Quality Committee for assurance.

2.2 DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2021-2022:

- Monthly MRSA Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- Monthly hand hygiene rates.
- Outbreak and incident reports.
- IPC risk assessments relating to COVID-19

2.3 INFECTION PREVENTION and CONTROL TEAM

The IPCT has welcomed new members in the year and the team consists of:

- Nicola Lucey, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer
- Dr Cathy Jeppesen, Infection Control Doctor and Consultant Microbiologist
- Dr Lucy Cottle and Dr Amy Bond, Consultant Microbiologists
- Abigail Warne, Specialist Nurse- secondment to Matron IPC role from March 2021- Maternity Leave until September 2022
- Julie Park, IPC Nurse
- Christopher Gover, IPC Nurse
- Emma Karamadoukis, IPC Specialist Nurse
- Helen Hindley, IPC Nurse
- Sophie Lloyd, IPC Nurse (Secondment - Joined October 2021)
- Tina Arnold, As and When IPC Nurse (Joined September 2021)
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Rhian Pearce, Antimicrobial Pharmacist

3. HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectories for C*lostridium Difficile* and Gram-negative blood stream infections. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).* This was from one definition of a case – sample taken over 72 hours after admission was deemed a HCAI requiring review. This year the definition is as follows:

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients has been an inpatient in the Trust reporting the case in the previous 4 weeks
- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks
- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust ion the previous 12 weeks

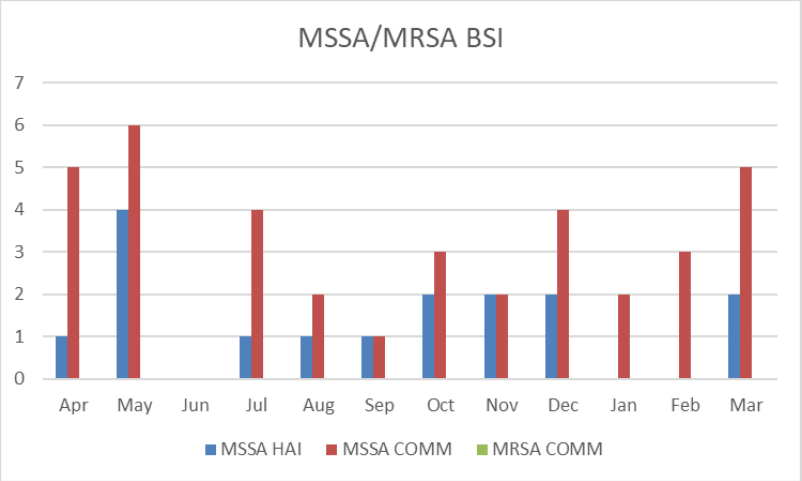
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

3.1 METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2021-2022 assigned to the Trust. The last case of preventable MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA (blood samples taken ≥48hours post admission) have significantly reduced.

3.2 *STAPHYLOCOCCUS AUREUS* BACTERAEMIA (MSSA)

In 2020-2021 there were a total of 54 cases of MSSA bacteraemia, of these 38 cases were identified <48 hours of admission and 16 identified >48 hours after admission. No national trajectories have been set for these organisms. At DCHFT this is a reduction in cases to the previous year.



To manage MSSA blood stream infections we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices via audit.

3.3 GRAM NEGATIVE BLOOD STREAM INFECTIONS

3.3.1 Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving this reduction has been changed to 2023. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).* National update awaited in reference to the change in reporting 2021-2022.

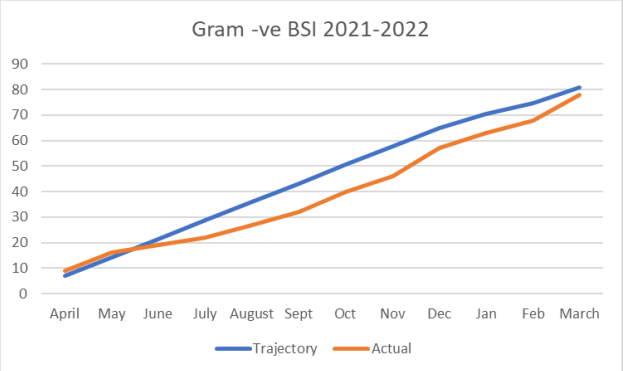
3.3.2 Mandatory data collection has been in place for several years for E. coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella app. and Pseudomonas *aeruginosa.* 2021-2022 formal trajectories for gram-negative blood stream infections were set by NHSE/I at 81 cases (55 *Escherichia coli* 3 Pseudomonas *aeruginosa* and 23 Klebsiella sps). Noted this trajectory was HOHA and COHA combined for the first time.

3.3.3 In 2021-2022 there were a total of 148 positive BSI samples for E. coli. 49 of these cases were attributed to the Trust – HOHA & COHA. All cases of E. coli that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with Public Health England guidance; this includes all mandatory and optional data.

3.3.4 In 2021-2022 there were a total of 50 positive BSI samples for Klebsiella sps. 20 of these cases were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in

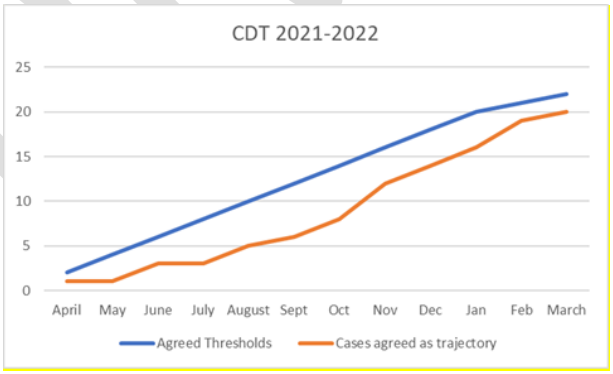
accordance with Public Health England guidance; this includes all mandatory and optional data.

3.3.5 In 2020-2021 there were a total of 24 positive BSI samples for Pseudomonas *aeruginosa*, 9 of these cases were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with Public Health England guidance; this includes all mandatory and optional data.



3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

In 2020-2021 COVID-19 pandemic trajectories were not nationally set. However, formal trajectories set for 2021-2022 by NHSE/I at 22 cases. In total the Trust reported 55 cases detected HOHA/COHA; of these cases 35 were appealed as non-preventable with no lapses in care; this resulted in 20 cases reported as hospital acquired. The Trust identified 55 cases in total (2 less than last year).



All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Patricia Miller, Chief Executive Officer, or Nicola Lucey (Chief Nursing Officer/Director of Infection and Control) and scrutinised to identify any relevant learning from the cases. The learning actions when completed are then presented and signed off by the Divisional Matron at the IPCG.

4. OUTBREAKS OF INFECTION

4.1 NOROVIRUS

There have been no outbreaks or cases of Norovirus in the reporting year 2021-2022. This could be attributed to the national and local lockdowns implemented because of the COVID pandemic and measures put in place to manage social contact, plus the enhanced personal protection equipment for staff and visitors. However, it is noted that norovirus outbreaks occurred throughout the South West region in the 2021-2022 period.

4.2 INFLUENZA

There has been a national reduction in cases of Influenza A & B during the Winter 2021-2022 in comparison to the previous years. The impact of social distancing, mask wearing in the community and local lockdowns reduced the infectivity to zero at DCHFT and we had no inpatients with influenza.

In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine. 59.9% of front line staff were immunised and 50.3% of all staff, a decrease from 91% the previous year. Additional vaccination sessions were arranged to support.

5 CLINICAL AUDIT

5.1 SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections that affect the superficial tissues (skin and subcutaneous layer) of the incision and those that affected the deeper tissues (deep incisional or organ space).

Preventing surgical site infections is an important component of Infection Prevention and Control programmes. There is a Mandatory requirement by the Department of Health for all Trusts' undertaking orthopaedic surgical procedures to undertake a minimum of three months' surveillance in each financial year.

SSI for all surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay
Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure
Stage 3- review of patients readmitted within 365 with SSI

During 2021-2022 the IPC team have supported 2 modules for surveillance. The IPCT can facilitate a less time-consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

The two audits completed were Oct-Dec 2021 (Knees) and Jan- March 2022 (Breast). Only one infection was identified in Oct-Dec Post Op Knee surgery 2021 data collection and the surgical and microbiology team reviewed and managed the

case. This is reflected in the UKHSA report. There were no breast infections recorded for the final surveillance quarter Jan-Mar 2022.

5.2 PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVCs are devices commonly used in acute hospitals, for the administration of intravenous fluids and medication. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular monthly auditing to check that all PVC's are having visual infusion phlebitis (VIP) score checks completed has continued this year and remains ongoing. The annual average compliance for this year's audits has been 92% up from 79% last year.

Should compliance fall below 90% additional weekly/monthly audits are carried out. Divisional leads are invited to IPCG on a bi-monthly basis to discuss their areas results.

5.5 ISOLATION AUDIT

This year's side room isolation audit took place in February and looked at all inpatient areas (excluding Kingfisher Ward and ITU) with results as follows; Out of 43 rooms in use for infection control purposes 56% had correct signage, 44% incorrect signage and a total of 100% overall side rooms in use across the trust. At the time of audit being carried out staff were educated on the importance of using correct signage to protect not only the patient but also themselves and visitors and thus reducing the transmission of infection.

5.6 COMPLIANCE WITH URINARY CATHETER POLICY

Over the past year the following audit has been carried out monthly in relation to Urinary Catheter Care.

- Indwelling Urinary Catheter Recording on Vital Pac

Compliance with the requirement to accurately document indwelling urinary catheter insertion on VitalPac has been good with an overall trust compliance of 94% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 91% compliance and Urgent and Integrated Care 95% compliance. These percentages are an average. Urinary tract infections are the second largest single group of healthcare associated infections in the UK. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered and considered prior to insertion of urinary catheter and there is a continuous process for review.

5.7 Carbapenemase producing enterobacteriaceae audit (CPE)

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. Although UKHSA advice on this changed in December 2019 we now have a dedicated policy for CPE and it remains that all patients admitted to the Trust must have a screening risk assessment carried out on admission.

This audit, which was carried out between April 2021 and March 2022, aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Results show that the overall compliance with undertaking the admission screening risk assessment was 76.3%. This has increased by 2.3% on the previous year's 74% result. This audit will be repeated next year and, it is anticipated that compliance will improve. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated for 2022-23. In conjunction with the role out of a new CPE policy ward and unit leads have also had the opportunity to discuss changes in guidance with the IPC Team and it is hoped that this will have a positive impact upon future audit results.

6 EDUCATION

Despite the COVID pandemic the Infection Prevention & Control Team continued to provide formal face to face education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and all of the nursing team were involved in delivering the sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Overseas Recruitment Training
- Intravenous Training
- Volunteers Training

Mandatory Training for clinical and non-clinical staff has been also offered via an online workbook.

Overall compliance with mandatory IPC training over the year was 84% for clinical staff and 79% for non-clinical staff. The Divisions are responsible to release staff to access their training. During the pandemic some release of staff for mandatory training was reduced due to the safety pressures, as pressure reduced staff were able to move forward with the mandatory training.

IPCT recognised that additional support and training was required and now provides face to face mandatory training in addition to the online package.

Throughout the pandemic the infection control team also promoted the use of PPE, revisited hand hygiene and supported good IPC clinical practice trust wide, this included educating and demonstrating to staff how to effectively apply the fundamentals of donning and doffing to further protect themselves in their working environment.

7 POLICY DEVELOPMENT/REVIEW

The following policies have been developed / reviewed during the year:

Clostridioides difficile Diarrhoea Policy	295
Microbiological Specimens - Collection of	323
Hand Hygiene Policy	386
Pandemic Influenza Plan	802
Viral Haemorrhagic Fever - Patients with Suspected - Policy for the Management of	856
Haematology/ Cancer Ward - Infection Prevention and Control Operational Policy for	1,174
Patient Discharge with a Urinary Catheter (Urethral and Supra-Pubic)	1,446
Avian Influenza - Infection Prevention and Control Advice for Management of Patients with Suspected	2,042
Good Infection Prevention Practice: using ultrasound gel	2,058
Carbapenemase Producing Enterobacteriaceae (CPE) - Policy for the Assessment and Management of Patients with	2,075

8. COVID-19

The global pandemic of Covid-19 remains ongoing and at the forefront of providing healthcare services that are safe for both patients and staff. The trust response continues to be led by the Incident Management Team.

The hospital environment has been adapted to suit the needs for this new virus and the complexities that it creates. Over the past 2 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England and expert response to emerging situations. The IPCT have also worked closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

At DCHFT the IPCT have continued to manage the routine swabbing of inpatients to ensure patients are swabbed for Covid-19 on admission, day 3 and day 5-7 as per national guidance. This has helped to ensure any potential cases or outbreaks are identified in a timely manner and have ultimately helped to achieve a low rate of nosocomial transmission.

However, due to the extremely transmissible nature of Covid-19 and increased prevalence in the community we did have 6 wards with identified outbreaks between September 2021 and March 2022. Comparatively this was a low number of outbreaks for an inpatient setting in the South West region. No outbreaks were reported between January 2021 and September 2021.

No reported staff outbreaks of COVID-19 but due to the reduction in national COVID-19 preventative measures, the community rise in infections rose steadily between January and March 2022 leading to multiple staff absences due to requirement to self-isolate as infected with COVID-19 or a close contact of COVID-19 outside of work.

The Trust followed national IPC guidance throughout the pandemic, and this is supported by the board assurance framework. On investigation due to the nature of the virus and its transmissibility it was hard to identify the root cause of outbreaks. However, the outbreaks were during a period when visiting was not completely restricted and community rates were rising.

The response from the ward teams, matrons, CSM, microbiologists and IPCT was prompt enabling actions required following positive results to be taken quickly. Personal Protective Equipment (PPE) supplies have remained good and there have been no shortages.

9 Infection Prevention and Control Surveillance System (ICNet)

Last year we updated on the joint procurement and implementation of a County Wide instance of ICNet, an infection prevention and control surveillance system supplied by Baxter Healthcare Ltd.

a. The status of the Dorset partners varied at the inception of this Programme:

- Dorset County Hospital (DCHFT)
- Poole Hospital (UHD)
- Dorset Health Care (DHC)
- Royal Bournemouth and Christchurch Foundation Trusts (UHD)

b. The IPC Programme is divided into three phases:

Phase 1 – DCH migration to hosting by DHC – completed July 2020
Phase 2 – UHD (both sites) implementation – completed 2021
Phase 3 – DHC implementation – scheduled September 2022

There have been several delays due to the pandemic which consisted of staff availability in testing, pathology lab issues and new pathology systems due to be installed. It is hoped that by the end of this current year the system will be running smoothly across the trusts.

10 Infection Prevention & Control Week - October 2021

To celebrate 'International Infection Prevention week' on the 18th – 22nd October 2021. The IPCT requested wards produce a poster presentation with an open IPC theme (in View of the current workloads, Covid-19 pandemic and ongoing staffing issues). '*Every action counts - Supporting excellence in infection prevention and control behaviours'.*

The poster presentation could encompass any area of IPC that as a ward, they felt improvements in practice could be made, whether this be hand hygiene, PPE, Glove use etc. The overall aim is to persuade everyone – staff, patients, and visitors to follow good practice in infection prevention and control keeping healthcare settings as safe as possible. Many wards within the trust produced beautiful poster displays encompassing many different IPC topics and the judging was carried out by the IPCT and N Lucey and N Johnson (Interim Chief Executive). Prizes were awarded to **Barnes and Day Lewis combined display (first), Evershot (second) and Lulworth ward (third).**

11 FACILITIES REPORT - CLEANING SERVICES Sarah Jenkins
HOTEL SERVICES REPORT- CLEANING SERVICES Sarah Jenkins

INFECTION PREVENTION CONTROL & CLEANLINESS ANNUAL REPORT 2020/21

Throughout the past year the Housekeeping Team have continued to work hard to maintain the cleanliness of the hospital, coping, as all services, with the fast-changing nature of the service due to the continuing challenges of the covid 19 pandemic and the restarting of services following their cessation in the last two years.

We have continued to work in collaboration with the teams throughout the hospital and our outside contractors, particularly with our colleagues in infection prevention control and the wider nursing teams, to ensure our continued focus on providing and maintaining a hygienically clean and appropriate environment for our patients, visitors and colleagues. With the introduction of the Standards of Healthcare Cleanliness 2021, the emphasis on cleanliness being everyone's responsibility will hopefully further enhance these relationships.

Cleanliness

Cleaning services throughout the buildings occupied by the Trust, both on and off the main hospital site, in both clinical and non-clinical areas, are provided by an in-house team of staff supervised through a 24/7 rota by a team of supervisors. This team is augmented by external contractors, managed by the Hotel management team, who undertake the window cleaning and pest control aspects of cleanliness.

The expansion of the number of off-site buildings has led to changes in the service provision, with the expansion of the clinical offering provided by the acquisition of the lease on a floor of South Walks House being of particular note. The extension of this lease, both in terms of time and the area being utilised, will lead us to further review the offering to all external areas, with the appointment of a new supervisor responsible for the staff on these areas supporting this.

As far as is practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness and by input from the clinical and housekeeping teams. We continue to review these considering changes to IPC guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness.

We continually review the cleaning needs of the hospital and in particular this year we have had to look at the provision in the emergency department due to ongoing

building works. The new Standards of Healthcare cleanliness have necessitated changes in the frequency of cleans and consequently changes in the cleaning schedules. We are about to become a pilot site for a new software system which will enable us ensure compliance with the new standards and ensure that the cleaning schedules remain fit for purpose.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the new national standards. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE and PLACE lite. Feedback is given to staff on the areas from these audits.

Despite the difficulties of the past 12 months, cleaning standards have been maintained with highlighted issues being remedied in reasonable timescales.

Deep Cleaning

The pressures of the pandemic and the number of patients visiting the hospital have severely limited our ability to carry out our deep clean programme in the way that we would have wished. We have taken every opportunity to carry out such cleans as and when we have been able.

Many cubicles continue to be deep cleaned on a regular basis following the discharge of patients and bays have been cleaned following infection outbreaks. As alluded to above, the pressures on flow have limited our ability to carry out the bay cleans as we would have liked but we continue to work with the clinical teams to ensure that these are carried out where possible.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. We have replaced the HPV machines in the course of the past few months and the staff are currently receiving training on their use for the roll out across the Trust. These machines provide far greater assurance in terms of reporting and are safer for the operatives in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.

Internal Monitoring

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the new functional risk categories to which the area is assigned, and these vary between weekly and annually. The timescale for rectification of failures is also dictated by this categorisation.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard.

In spite of all the difficulties, audit scoring has remained consistently high which is a credit to the dedication and hard work of the housekeeping team.

We have recently purchased new auditing software which is currently being rolled out across the Trust. The reporting that this will offer will lead to greater accountability of the cleaning and the audit process. This will also assist with the new aspect of auditing required which looks at the process of cleaning, efficacy audits, which are required annually in each area.

Whilst we have carried out weekly environmental audits from time to time during the last twelve months, we have not been able to hold them as frequently as we have liked, nor have the patient assessors been able to accompany us. This program has recently restarted and so in the fullness of time it is hoped that these will once again see our patient assessors accompany us to the wards.

The pandemic also mean that we have not been able to carry out full PLACE assessments, Patient Led Assessment of the Care Environment, in the last year. However, we have carried out two sessions of PLACE lite, with a smaller team carrying out a limited number of PLACE assessments and we were pleased to welcome our patient assessors to these. In these the cleanliness and condition of the areas are looked at from a patient's perspective and the results were very pleasing, showing the hard work done by all teams to maintain the cleanliness and condition of the hospital.

12 ESTATES REPORT (DON TAYLOR – Head of Estates and Facilities)

12.1 WATER QUALITY

The Estates Team are responsible for maintaining the majority of the Trust's potable water systems, reporting to the Water Quality Management Group (WQMG) and Infection Prevention and Control Group. Provisions for water safety are independently audited by experts from the Water Hygiene Centre.

The Estate
Changes and additions to the property portfolio, through reorganisation, capital works and acquisition, have presented technical challenges requiring significant change in terms of capability and resource.

Several major unit repairs and replacements have been carried out including the main water softening plant, borehole pump and supply pipe, and hydrotherapy pool chlorine dosing system.

Policy & Governance
Some appointments required by the Water Safety Policy have been made and funding now supports the engagement of an Authorising Engineer (Water). The policy itself and its accompanying Operational and Maintenance Procedure require review and update to be brought in line with changes to regulation and DCHFT practice.

Risks
HCWS (Hot and Cold-Water Systems) are managed within capability and availability and, in general, the main site systems need investment to mitigate age related and maintenance issues. Over the period the MECH team attended approximately 500 leaks and, of the systems monitored, roughly half have displayed temperature or biological control issues. Some legacy issues with non-compliant installations have been resolved. The acquisition of additional properties and capital projects have presented some challenges. Measures to mitigate the various problems have been identified.

The table below shows the routine samples and raised counts.

	Outlets	Samples Taken	Raised Counts
Legionella	21	161	1
Pseudo. A	209	630	89

The table below shows the samples and raised counts following concerns for water safety. Measures to ensure immediate user safety are communicated as required.

	Outlets	Samples Taken	Raised Counts
Legionella	43	429	135
Pseudo. A	83	463	3
Coliforms	42	463	162
E. coli	42	463	3

12.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME
A Deep Cleaning programme has been produced.

12.3 REPLACEMENT FLOOR COVERINGS
Approximately 200 separate flooring jobs of various types, from minor repairs to complete replacement, have been carried out by directly employed labour.

12.4 DECORATION AND ENVIRONMENT
The Estates team continue to deliver high quality decoration on request, through the environmental auditing process and routine inspections of high and public use areas. The pandemic has affected access in some high-risk areas.

12.5 VENTILATION
The Estates team continue to carry out routine inspection and maintenance on all ventilation systems and formal validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B carrying out remedial works as required. During Covid the Estates team worked tirelessly with Consultants and Heads of Department in making changes to our ventilation systems both to aid Covid treatment and to respond to the multiple reorganisations. An AP(V) under the auspices of an AE(V) maintain the Permit to Work system and ensure all statutory and regulatory records are validated. Following changes to the HTM 03-01 all ventilation issues are discussed at the newly formed Ventilation Safety Group which meets every 3 months

12.6 WARD AUDITS
The Estates Dept. continue to support weekly environmental audits in association with Infection Control, and Housekeeping although these have been limited due to the pandemic.

12.7 CAPITAL WORKS

Renal POD unit – modular unit quickly procured and installed outside pharmacy and the Renal unit. This was in response to the pandemic and allowed Renal to treat Patients with or without Covid-19 symptoms outside of the normal Renal department. The unit had increased ventilation installed to meet the trusts hybrid VSG requirements which exceed HTM requirements, the unit also has appropriate water services and wash hand basin provision, all parts deigned to meet HTM standards.

ded Lift car linings on 3 & 4 in the north wing, and south wing lifts C & D, apart from the technical upgrades the shortly prior to the lift cars were refurbished and relined with easier to clean with new surfaces.

h Walks House temporary arrangement for clinic use with the installation of vinyl flooring, internal sub room division and air scrubbers to reduce risk of airborne infections. The E&F team have supported the maintenance of temporary hand wash units and deliver mitigation of the HCWS.

Installation of new Oxygen storage tank for greater capacity along with enhanced pipework arrangements for an improved resilience of clinical services.

Changes to pathology labs with enabling works for new equipment digital services to increase capacity and deliverable support of clinical teams. This incorporated additional wash hand basins, changes to machinery layouts to aid staff space and help improve process flow. The works were necessary to support infrastructure changes to incorporate combined service changes and improvements including support to the digital service team.

Water systems remedials have been covered under water quality above.

Roof and Gutter works have been carried out across the estate, reducing locations of known water ingress by around 80%, as well as preventative treatment on trial locations to mitigate the root causes and potential infection hazards.

AHAH- Refurbished admin space in Damer`s house for clinic use, this included wash hand basins, flooring, benching, and storage space for Pharmaceuticals including waste to current standards.

Therapies off-site which led to the purchase of Redwood house at Charlton down. Due to the previous standard of the property which was being used as a charities office there was a need to refurbishment the property including the management of a substantial asbestos hazard. The extent of the refurb included enhancements of the admin/clinic spaces, to ensure we met current standards the team upgraded the water system to facilitate the supply for new wash hand basins. Toilets refurbished for staff and patients in addition to increasing the size of the reception waiting area.

Scanning bureau works to include an additional office space born from space saved by reducing paper storage.

Fortuneswell bay that was previously used as an admin space returned to clinic use with new floors, lighting, and the addition of a wash hand basin.

Maternity Bereavement room was created from space previously used as a kitchenette, this to improve patients' facilities with the need for a forget me not suite.

Critical care relative's room – this involved the conversion of a vacated office space to create a new relative's room to provide patient privacy.

Neurophysiology department changes which mainly involved the division of an existing large room, then converting it into two clinical spaces. This required new independent ventilations systems within both spaces to meet current compliance requirements, in addition to wash hand basins, new flooring and an upgraded nurse call system.

Ilchester ward nurse base, alterations to the nurse station to include greater visibility of patients and ward in general.

Abbotsbury ward sisters' office was converted into a staff rest area and a small quiet room reconfiguration for staff carried out.

Site wide replacement of the fire alarm system is still ongoing, much of the works are now completed as we approach the final change over stages. The works had

been particularly difficult to manage as these started at the beginning of the pandemic and continued throughout. This requires the management of access for contractors into all areas of the site including clinical and potentially high-risk areas. The need for Drewlec to maintain and adopting to meet ever changing DCH IPC procedures and processes has been paramount, thus ensuring the safety of patients, staff, visitors, and the contractors themselves carrying out the works.

Orthopaedic outpatients' refurbishment – This area has been extensively refurbished with the enhancement of consulting, clinic, staff, and treatment spaces. These works required upgrades to ventilation, nurse call, water systems and facilities in general to meet current HBN and HTM standards.

13 DECONTAMINATION SERVICES REPORT
(Phillip Barton-Young – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination)

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended) our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent authority.

The Notified Body will be undertaking a two-day surveillance audit in July 2022. The Accreditation held by the service continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service.

Environmental Monitoring

The Clean Room Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on five washed but unsterile items – Quarterly
- Water Endotoxin - Annual

Latest testing of all areas occurred in February 2022 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are trended, and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern currently.

For compliance with HTM 01-01 ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfector is effective.

Tracking and Traceability

Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and one Outpatient Department at the moment.
Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf-Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis or when a new wrap is introduced. Previous testing still showed 100% sterility which gives assurance that the decontamination process is effective.

A new double-bonded wrap was introduced in 2020 and sets wrapped in this will be sent for testing once they have expired their 365-day shelf life.

Staff Training

All Managers and Supervisors have achieved qualifications relevant to their role. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day-to-day basis.

All members of staff receive training appropriate to the area of production they are working in and are observation assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

ENDOSCOPY DECONTAMINATION UNIT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016 as an extension to scope of the existing certification in the Sterile Services Department.

This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customers.

Environmental Monitoring

Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Quarterly
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually

Latest testing of all areas occurred in May 2022.

The department is awaiting formal results from the testing for reporting and trending.

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and more recently in the outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4936 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Hospital Technical Memorandum) 01-01:2016 that full traceability of reusable items can be evidenced. In relation to invasive probes, used in the Outpatient or Theatre setting, this requires the completion of the Tristel Wipe audit book and the insertion of the Tristel Wipe decontamination sticker being placed in the patient's health care record.

The only exception was in Ultrasound; the Radiology Patient System is audited for the same information as patient's health care records are not accessed during this diagnostic process.

This annual audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The 2021 audit results have yet been reviewed.

Audit #5010 Decontamination and Single Use Instruments

This annual audit is used to measure compliance with requirements for the management of sterile instruments and single use instruments as per HTM 01-01:2016 and the sample involves each department that is supplied by Decontamination Services and also uses single use surgical instruments.

This observation audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The outcome of the 2021/22 audit has not yet been reviewed due to awaiting one final submission. This will be followed up and submitted once return is received.

14 ANTIMICROBIAL REPORT - RHIAN PEARCE (Antimicrobial pharmacist)
Antimicrobials: Summary report for financial year 2021/22

1. Overview – national context

Antibiotic misuse has profound adverse consequences, most notably the development of antimicrobial resistance. Judicious antimicrobial prescribing is a critical component in slowing the development of antimicrobial resistance (AMR).

Antimicrobial stewardship (AMS) refers to an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Addressing AMR through improving stewardship is a national medicines optimisation priority, led by NHS England and supported by PHE.

2. Summary of AMS activity at DCHFT (2021/22)

<table>
<tr><th colspan="2">2.1 Achievements 2021/22</th></tr>
<tr><td>1. Antimicrobial Stewardship Committee</td><td>• The Antimicrobial Stewardship Committee (ASC) has struggled to convene over the last year. Re-invigorating the ASC will be a priority for the coming year.</td></tr>
<tr><td rowspan="3">2. Surveillance

• Effective surveillance of antibiotic prescribing, resistance patterns, HCAIs and infection related outcomes is the foundation of any stewardship program, but sustained progress in this area can only be delivered through continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship Team.</td><td>Antibiotics Consumption:

❖ EPMA reporting capacity has continued to improve. Several reports have been developed to allow targeted intervention and improve data capture to support a wide range of stewardship activities.
❖ We have also introduced a powerful reporting database (REFINE/DEFINE), which has greatly improved our ability to monitor antibiotic prescribing trends across the Trust. It also allows us to compare our prescribing trends against other hospitals.</td></tr>
<tr><td>Local antimicrobial resistance monitoring:

• We looked at resistance data for Enterobacteriaceae in urines Q1 2019-2021 and changed our empirical antibiotic regimens for UTI in response to this piece of work.</td></tr>
<tr><td>Patient outcomes for infection syndromes:

Draft data spec. produced for business intelligence.

National AMR dashboard in development – plan to include infection related outcomes.</td></tr>
<tr><td>3. Trust Policies (includes guidelines, PGDs, PSDs, clinical pathways)</td><td>Antimicrobial prescribing guidelines:

Continued work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. In total, eight new/rewritten guideline were published, thirteen updated</td></tr>
</table>

	and six new guidelines are near completion
	Patient Group directions and clinical pathways: We developed a clinical pathway for neutropenic sepsis patients admitted to the emergency department, along with two supporting PGDs to allow nursing staff to initiate antibiotics without a prescription. We also updated a further ten PGDs.
4. Formulary additions:	**Ceftazidime/avibactam** Ceftazidime/avibactam was a welcome addition to the local formulary, improving the range of antibiotics available locally to treat increasingly complex cases involving resistant bacteria.
	Fidaxomicin The formulary status of fidaxomicin was updated to reflect its new position in the management of C.difficile, allowing GPs to prescribe it in accordance with NICE criteria.
5. RCAs	• Continued participation in *Clostridium difficile (c-diff)* RCA meetings where we provide a formal review of antibiotic prescribing, feeding back to clinical teams directly. This also gives us the opportunity to capture any emergent themes related to antimicrobial prescribing and c-diff trends. • Continued contributions to RCAs and datix involving antimicrobials.
6. laboratory-based diagnostic testing Improving the range of laboratory-based diagnostic testing for infection is recognised as an essential tool for tackling resistance and optimising patient outcomes	• Procalcitonin was introduced to steward early discontinuation of antimicrobials in COVID patients admitted to ICU. We are currently exploring the utility of procalcitonin outside of ICU.
7. Education	**Mandatory training** Implemented a 3 yearly mandatory training programme, delivered via e-learning, for all prescribers on AMS, using the ARK toolkit. Anticipated roll-out in September, to coincide with our EPMA upgrade which has new functionality to support the ARK tool.
	Face-face teaching sessions: o Gentamicin/Teicoplanin/Vancomycin prescribing (F1s) o Introduction to the Antibiotic review toolkit with case studies. (F1s) o Management and treatment of cellulitis (Clinical Pharmacists)

	○ Antifungal stewardship (Band 7 Clinical Pharmacists**)** ○ Training day for regional foundation pharmacists on AMS
8. Audits/QI projects:	• Review of antimicrobial prescribing in surgical patients (Lulworth C-diff PII) • Review of antimicrobial prescribing in stroke patients (Stroke C-diff PII • Prevalence of missed doxycycline –polyvalent cation interactions at DCH • Review of inpatient carbapenem prescribing (PPS performed weekly over a 3-month period) • Review of inpatient antifungal prescribing in IFI (PPS performed weekly over a 3-month period) • Introduced a 30-45 min daily short intervention project to stop or de-escalate antibiotics in 2-3 patients per day (started Apr 2022).
9. AMS ward rounds:	Full ward rounds looking at prescribing in detail (AB & RP): – Ilchester, Apr 2021 – Barnes May 2021 – Day-Lewis, Jun 2021 – Fortuneswell, Aug 2021 – Purbeck, Nov 2021 – Lulworth, Dec/Jan 2022 (c-diff PII) – Stroke, March/Apr 2022 (c-diff PII) Summary: General improvement across prescribing standards compared to historical baseline. Findings were minor and not indicative of major or systemic problems with prescribing.

2.2 National targets/regional benchmarking.

- **CQUINs:** Suspended due to COVID for 2021/22. However, we anticipate their re-introduction for 2022/23
- **Antibiotic consumption trends - NHS standard contract:** Typically, antibiotic consumption targets form part of the standard NHS contract. However, the COVID pandemic has had a significant impact on antimicrobial consumption both regionally and nationally; for this reason, no specific targets were agreed for the financial year 2021-22.

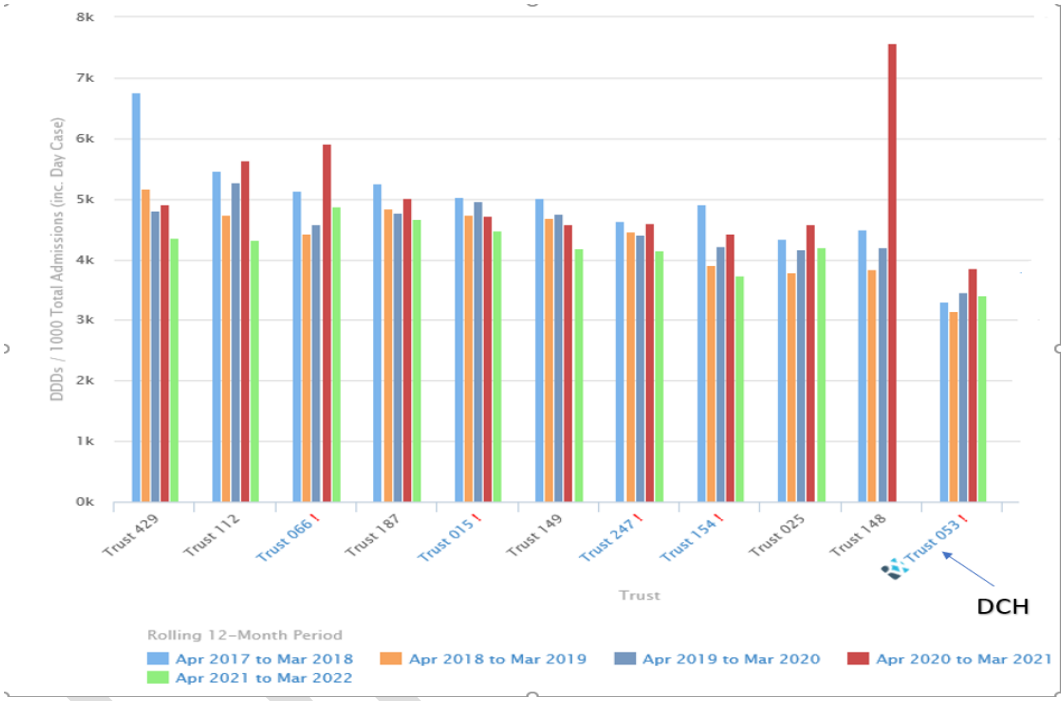
2.3 Antimicrobial consumption for DCH 2021/22

Total antibiotic consumption, adjusted for admission is down 11% from the previous financial year (see fig 1), comparable to pre-pandemic levels. Like other trusts, we observed an upswing in antimicrobial use during the first and second wave of the pandemic, increasing the total consumption, adjusted for admissions, for the financial year 2020-21.

DCHFT continues to have the lowest total antibiotic prescribing rates regionally, measured as total antibiotic use adjusted for activity (total DDDS/1000 total admission inc day case).

Fig. 1

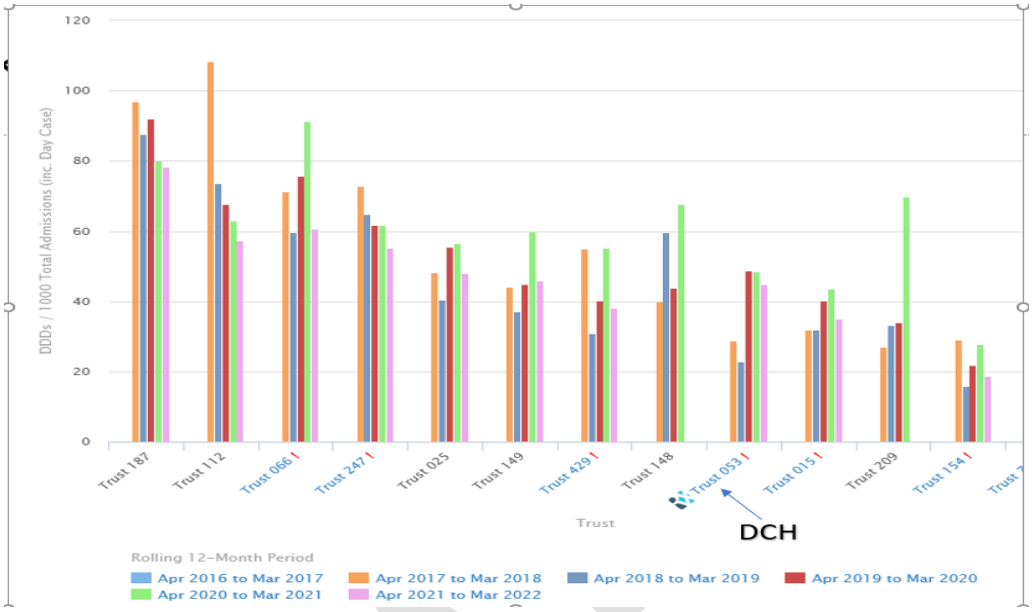
Total antibiotic consumption (DDDs/ 1000 admissions) by financial year – in region comparison.



2.2.2. Carbapenems

Carbapenem prescribing is down 8% on the previous financial year (Fig. 2). However, this still represents a significant increase compared with the 2018/19 financial year, equating to an approxamate doubling (96%) in consumption (Fig. 2). We perform regular audits of inpatient carbapenem use, which indicate that carbapenem use is generally appropriate, with the vast majority being recommended by the microbiology team. Resource permitting, we also plan to implement a regular review of local resistance data, to include monitoring of ESBLs, which may be driving carbapenem use locally.

Carbapenem consumption (DDDs/ 1000 admissions) by financial year – in region comparison.

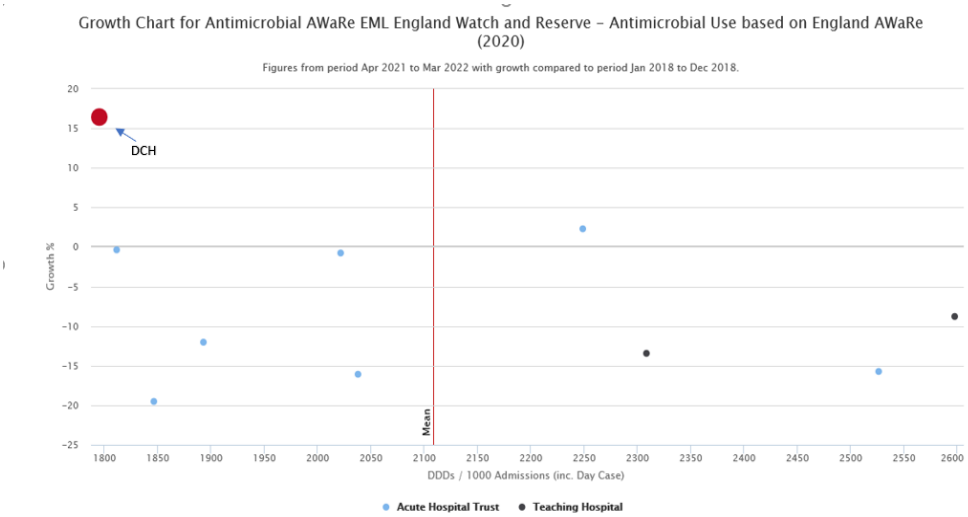


2.2.3. Proportion of total antibiotics by AWaRe category

The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee. It was recently adapted by NHSE as a tool to support antibiotic stewardship efforts nationally. Antibiotics are classified into three groups, Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms and their use should be limited.

Using consumption data alone, measured by DDDs, is a poor surrogate for overall antibiotic stewardship performance; a trust would meet the consumption targets by using a larger proportion of broad-spectrum antibiotics instead of narrow-spectrum agents. Using AWaRe categorisation alongside total consumption, is a more balanced approach to measuring performance when using top-line consumption trends.

Fig 3.



As part of the NHS standard contract for the coming financial year (2022/23), NHS trusts are required to reduce 'watch-reserve' antibiotics by 4.5% compared to their 2018 baseline. Compared to other trusts in the South-Central region, DCH are outliers for growth in watch-reserve antibiotics from their 2018 baseline, seeing the largest growth regionally over this period (equating to a 16% increase), see FIG 3. However, despite this growth, DCHFT are the lowest prescribers of antibiotics from the watch and reserve category, measured as DDDs per 1000 admissions, compared with regional peer hospitals (See Fig 3).

At present, the exact drivers/reasons for this sustained increase in watch and reserve antibiotic use are undetermined.

2.3. Limitations

Data are unadjusted for the confounding effects of case mix, age, and sex. As such, direct comparison between DCHFT and the national or regional picture is limited. In addition, patient outcome data and resistance trends are not routinely collected or published alongside consumption data, raising concerns over the potential unintended consequences of targeting consumption targets in isolation.

3. Summary of future work

- Continued work on developing a set of metrics for monitoring stewardship activity, focusing on process and outcome measures to better illustrate the value of our programme. We also intend to develop a clear work-plan for AMS, to better illustrate the need for future investment and improve resource allocation.

We must continue to make progress, and as a team, we are pushing ourselves with a new set of challenging ambitions for next year. However, we are unlikely to meet

these goals without increased engagement from the organisation, recognising that AMR is a threat to patient outcomes across all clinical divisions and is a shared responsibility. There is also a potential financial loss for the Trust if insufficient resources are allocated to meet CQUIN targets when they are re-introduced.

15 Conclusion

The last year continued to be dominated by COVID-19 and the IPCT workload remained high as a result. Keeping the Trust staff and patients safe is priority during this time and the working day of the IPCN remains unpredictable. I personally would like to thank my team for their dedication and maintenance of their positive spirit particularly as the pandemic has continued with new challenges.

2021-2022 has been a very successful year with significant reductions in healthcare acquired infections reported i.e., gram negative blood stream infections. Trajectories for both MRSA and *CLOSTRIDIUM DIFFICILE (CDI)* were achieved demonstrating excellent practice and engagement with infection prevention and control by Trust staff.

The higher numbers of *CDI* over the pandemic time have been reviewed via a deep dive. A root cause has not been agreed but the Trust is confident that the national guidance is met in relation to management of CDI and continues to work within the southwest IPC team to explore possible reasons.

This report demonstrates the continued commitment of the Trust and shows evidence of success and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all DCHFT staff dedicated in keeping IPC high on everyone's agenda.

The annual work plan for 2021-2022 reflects a continuation of support and promotion of infection prevention & control. Looking forward to the year ahead the staff at DCHFT will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

2022-2023 will be a progressive year as DCHFT the final stages of the Dorset-Wide implementation of ICNET as a single instance is achieved.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Hoyle

Deputy Chief Nursing Officer

Associate Director Infection Prevention and Control

Appendix 1

Infection Prevention & Control Work Plan 2

Infection Prevention & Control Work Plan 2022-2023 V1

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Director of Infection Prevention & Control (DIPC)	Bi-Monthly	Bi-monthly IPCG meetings in place.
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet. Support of the Dorset wide project to be clinically lead by DCHFT	Contract renewal	Associate Director Infection Prevention & Control (ADIPC)	October 2022	May 2022 Dorset wide ICNet roll-out in progress-
		The Trust will maintain a high standard of Infection Prevention & Control	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings IPC performance standard dashboard to be achieved Learning from performance data to be disseminated and evidenced via Divisional performance	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Divisional Heads of Nursing / Quality	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			reports				
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	DCHFT will maintain a clean and safe environment for patient care	Dorset County Hospital to support PLACE assessment	The environment is safe and clean. Cross infection rates low	Facilities Manager	Sept 2023	
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	March 2023	
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	Facilities Manager (Lead) Estates Manager Patient representatives Pharmacy IPC Team	March 2023	
		All clinical equipment is clean and ready for use at point of care	Daily/Weekly Nursing Cleaning regimes in place in all clinical areas	Evidence via weekly audits – report compliance to IPCG	Divisional Heads of Nursing / Quality	Bi-Monthly	
		DCHFT will maintain a clean and safe water system	Policy in place and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy. Water Safety is a standing item at IPCG. Additional	Head of Estates	March 2023	May 2023 – Post COVID recovery meetings in place

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				meetings to be arranged and reported on for individual locations.			
		DCHFT will maintain a clean, safe and effective ventilation system	Establish ventilation safety group the reports to IPCG on a bi-monthly basis. Develop Ventilation Policy to measure compliance with HTM-03 and reduce risk of airborne infections in the healthcare settings	Compliance with refurbishment with HTM – 03 a/b	Head of Estates	March 2023	
		DCHFT will adhere to NHS Cleaning Standards 2021	Facilities and Housekeeping to enure standards are maintiand and auditted vi monthly audit process	DCHFT will maintain high standards for cleaning within new framework – Bi monthly feedback to IPCG	Head of Facilities	March 2023	
3	Provide suitable accurate information on infections to service users and their visitors	Patients will be fully informed about their presenting infections. All new cases of *CDifficile,* MRSA and ESBL will be counselled by an IPCN	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and contact details	Positive patient feedback	IPCT	March 2023	May 2022 – IPCT continue to visit patients with newly acquired infections and established infections to provide information and reassurance.
		The Trust will have up to date patient	Review of all IPC patient information.	Positive patient	IPCT	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		information relating to infection control	Check meets standards and revise accordingly. Apply Equality and Diversity policy to all IPC information leaflets	feedback			
4	Provide suitable accurate information on infections to any person concerned with providing further information support nursing/ medical care in a timely information	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and staff	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department, providing clinical support to staff and patients. Off site support available e.g. South Walks House, Redwood House, Weymouth OPD	Minimum cross infection, reduced prolonged outbreaks of infection, reduced HCAIs	IPCT	March 2023	May 2022 - Daily IPCT ward rounds in place.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate	Achieve trajectory for *Clostridium difficile* infection (CDI) TBC cases 2022-2023 (does not include cases whereby no lapses of care were	Divisions to undertake Root Cause Analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset-Healthcare Acquired and Community Onset	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be	Divisional Heads of Nursing / Quality / Matrons	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	treatment and care to reduce the risk of passing on the infection to other people	identified)	Healthcare Acquired. IPCT to support. Antimicobial Pharmacist and IPC Doctor to support pharmacy and medical element. This must be completed within 14 days of infection.	discussed by IPCT and any trends reported to Infection Prevention Group (IPG). Delays in RCA progress will be reported at IPCG on the Divisional Dashboards. Face to Face RCA meetings to be re-established with Executive Lead.			
		Achieve trajectory for Gram-negative blood stream infections (BSI) TBC cases 2022-2023	Undertake IPC led data analysis of all hospital acquired cases of gram negative BSI – escalate to full RCA if lapses in care identified	All cases of Gram negative BSI will have investigation and relevant action plan if deficits identified.	ADIPC	March 2023	
		Ensure the Trust is robustly prepared for Seasonal variations in IPC.	Support staff vaccination programme for seasonal influenza/COVID-19 Reinforce Respiratory Guidance/Seasonal	The Trust will be able to function effectively during the variance in season IPC activity and Infection Control	ADIPC	October 2022	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Influenza Policy and Pandemic Influenza Policy Ensure staff are familiarised with the Outbreak/Noro/COVID -19 policy	standards are maintained			
		Ensure Trust remains aligned to United Kingdom HSAgency (UKSHA) COVID-19 Infection Control Guidance.	Maintain COVID-19 Board Assurance Framework and report bi-monthly to IPCG , Quality Committee and Trust Board	The Trust will be able to support the demands of the COVID-19 pandemic	ADIPC	Ongoing	
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	High standards of hand hygiene practice throughout the Trust.	Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve<90% to present action plan to IPG.	Hand hygiene results >95% and sustained at this level for all wards/departments Departmental Managers to report to IPG with action plan when hand hygiene results <90%.	Divisional Heads of Nursing / Quality / Matrons	Monthly	
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand	IPCT/ External auditors	Bi-Monthly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				hygiene standards.			
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2022	
		Education	Support DCHFT mandatory training programme and other IPC training within educational packages Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2023	
7	Provide or secure adequate isolation facilities	Ensure the risk of cross infection is reduced Trust wide	Undertake annual audit of isolation precautions to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation. Undertake quarterly PPE audit to confirm compliance with policy	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2022	
		Ensure adequate isolation facilities in new build and any	IPCT to be involved in: • ED15	New build is fit for purpose for isolation	ADIPC	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		new build has the pandemic planning as part of process	• New build Critical Care • New build ED • Southwalks	requirements and pandemic preparedness			
8	Secure adequate access to laboratory support as appropriate	IPCT to support and be involved in the county wide pathology project ensuring delivery of safe patient care is not affected	IPCT at DCHFT to continue to support development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project. IPCT to continue to monitor efficacy of data since transfer to single instance laboratory system Dorset Healthcare to go live Summer 2022	One ICNet system across Dorset	ADIPC	October 2022	
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and	Audit programme- to audit compliance with Key IPC policies	PVC audits undertaken to ensure compliance with observation standard	PVC observations will be observed every shift and recorded on Vital Pac	IPCT	Quarterly	
			Urinary catheter documentation audits undertaken to ensure	Urinary catheters will be reviewed on a	IPCT	Monthly	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	control infections		compliance with observation standard	daily basis and care documented on Vitalpac			
			Audit compliance with CPE screening recommendations. Divisional Matrons to review results with wards and develop action plans dependant on results of audits	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust	IPCT Divisional Matrons	Biannually	
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan to be developed and implemented Results to be presented at Divisional	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads Divisional Matrons	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Governance Meetings and IPCG				
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	Audit identifies compliance with safe management of storage and disposal of sharps	IPCT	Sept 2022 (IPCT) Oct 2022 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask testers in place to support evolving needs created continuous change of suppliers of masks influenced by COVID-	All clinical staff will have access to FFP3 training and able to care for patients using airborne	Lead Fit Mask Tester	Bi-monthly feedback via IPCG/H&SG	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	the provision of health and social care		19 pandemic	precautions			
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious patients	Ensure all 'IPC Emergency Boxes' are maintained and in date Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	All clinical staff are aware and able to support the emergency preparedness of the trust for IPC issues	IPCT/ Lead Emergency Planner	October 2022	
		Environmental controls are in place to ensure ventilation meets standard for respiratory pandemic precautions	Estates to ensure clinical and non-clinical areas have documented assessment and controls in place to support pandemic guidance	DCHFT can demonstrate compliance	Estates Lead	September 2022	

There are 10 criteria set out by the *Health and Social Care Act 2012* which are used to judge how we comply with its requirements for cleanliness and infection control. This is reflected in the *Care Quality Commission Fundamental Standards Outcome 8* and detailed above in the annual work plan which is monitored by the Trust's Infection Prevention and Control Group.

Emma Hoyle Deputy Chief Nursing Officer /Associate Director Infection Prevention & Control May 2022 V1

Meeting Title:	Board of Directors Part 1
Date of Meeting:	27th July 2022
Document Title:	Action plan in response to serious concerns raised during the National Diabetes Quality Programme peer review visit
Responsible Director:	Anita Thomas, Chief Operating Officer
Author:	Dr Will Ward, Consultant Paediatrician James Male, Care Group Manager

Confidentiality:	None
Publishable under FOI?	Yes

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
Trust-wide Diabetes Management Team Meeting	5 May 2022	Progress noted, actions in next period agreed
Quality Committee	21 June 2022	

Purpose of the Paper								
	Note (✓)	✓	*Discuss (✓)*		*Recommend (✓)*		*Approve (✓)*	
Summary of Key Issues	National Diabetes Quality Programme (NDQP) undertook a peer review of Paediatric Diabetes service at DCH on 26 November 2020 to determine compliance against the NDQP standards and to identify areas of good practice as well as recommendations to improve outcomes for children and young people with diabetes. Whilst the peer review team noted several important achievements, the team also raised a number of Serious Concerns which were detailed in a letter to the Trust dated 02 December 2020 requiring the Trust to prioritise action to address the serious concerns identified and to submit a templated action plan by 04 January 2021. As detailed in the Programme Manual, a serious concern is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality outcome of patient care and requires prompt action to resolve. The attached document is the updated action plan that was originally submitted to Quality Committee and NDQP in January 2021 and brought to Quality Committee in February 2022. Appointments have been made in both Paediatric and Adult Services in the preceding period. Psychology support is proving difficult to secure but both services continue enquiries and advertisements. Joint Clinic setup to start on 5th July PM and will run weekly changing from AM to PM, commitment for 12 clinics to be converted from Youth People to Transition Clinics for 16 – 18 Year Olds.							

Action recommended	The Board is recommended to: 1. **NOTE** the remedial actions outlined in the action plan. 2. **AGREE** to receive an update on the progress made in three months time.

Governance and Compliance Obligations

Legal / Regulatory	Y/N	Y – potential for quality or outcome of patient care to be seriously compromised
Financial	Y/N	Y – additional financial resources will be required to address the insufficient staffing levels. Business case to be progressed through the Trust's Business Planning process
Impacts Strategic Objectives?	Y/N	Y - Significant impact on patient experience; also reputational risk
Risk?	Y/N	Y – Service level risk
Decision to be made?	Y/N	N
Impacts CQC Standards?	Y/N	Y – Safe and Responsive
Impacts Social Value ambitions?	Y/N	Y
Equality Impact Assessment?	Y/N	N
Quality Impact Assessment?	Y/N	N

Serious Concern summary	Action number	Action	Ref. / link to internal risk mgt systems (if appropriate, e.g. Datix)	Lead responsibility	Target Date	Current status (including RAG)	Action taken to date **(including date of update)**	Comments	Date Completed
No formal out of hours service currently in place	1	Network Coordinator to arrange meeting with appropriate network members to negotiate a joint approach. Single unit approach not thought to be viable.	Risk ID 840	Lead Consultant	Jul-22	A	Initial meeting set up via Network Coordinator. August 21 Network Coordinator obtaining information on approach in East Anglian Network	Following discussion with East Anglian service, not all units taking part. Explored within Wessex and a similar model is not favoured in Wessex. Current proposal to link with 2-3 other units in clusters to provide the on call service, discussion taken place with Lead consultants at UHD and Salisbury, in principle keen to progress discussion, UHD provide OOH service currently until 10pm, nurses are reluctant to become part of OOH rota. Currently looking at alignment of policies for out of hours advice, modelling has not happened at this stage. Unable to begin on-call until service until 2022/2023 awaiting recruitment to vacant posts and agreement from all organisations involved in join on call service, Mapping underway for possible out of hours rota arrangments and potential to link with urgent care provider to host the service. Plan to meet and discuss with WW in May 2022	
Insufficient staffing to offer 24/7 service currently	2	Develop business case to cover on-call staffing requirement to cover out-of-hours service		Service Manager	Mar-21	G	Business Case approved 2020, finance agreed 2021 and recruitment preocesses started (see blow)	Business Case Approved	Completed
	3	Recruit additional staffing as required		Matron	From Apr 2021	A / G	29/12/20 - Preparing adverts and reviewing job descriptions prior to recruitment May 2021 - funding agreed for model Space concerns required resolution prior to recruitment completion As at January 2022 - all but one role recruited - see comments	Recruitment underway – Increased hours of currently employees for Band 7 dietician, and Band 6 / 7 PDSN's. All remaining Nursing & dietetic posts now recruited with final post due to start on 1/8/22. Dietician Maternity Leave covered. Within recruitment, developmental Staff Nurse posts to allow for succession planning, development within service. Clinical Psychology post unfilled. Temporary medical cover arranged through speciality Doctor cover, pending consultant recruitment. Specialty Doctor completing Diabetes Module. This last post represents the 'amber' element of the action. Included in Business Plannning for **22/23** to recruit additional substantive consultant posts following reveiw of service needs	
	4	Implement new arrangements		Lead PDSN	Jul-21	A		Outstanding post to be recruited, plan to review once at establishment	
Psychology questionnaires distributed but not reviewed promptly – risk. Insufficient Psychological support for patients and staff	5	Develop business case to cover increased clinical psychology provision, providing support to patients and staff, including the transition service element		Service Manager	Mar-21	G	10/12/20 Draft business case developed	Business Case Approved	Completed
	6	Recruit lead psychologist		Matron	31/12/2021	A	29/12/2020 Preparing job description for Lead Psychologist. Offered 3/11/2021	Clinical Psychology post advertised and recruited, Candidate has withdrawn, Converted to 8b and readvertised unsuccessfully x2. Interim cover provided for 1 session/week from another psychologist in the trust. Discussions between Diabetes Service and Paediatric Matron to take place.. Initial action completed in 2021 - new actions now in place following loss of first appointee.	
	7	Implement new arrangements		Lead PDSN	31/12/2021	A	Contingent on successful appointment	Outstanding post to be recruited, plan to review once at establishment (see above). Short term support (0.2wte) identified whilst awaiting recruitment for a period of 6 months.	
Insufficient staffing resource to provide required number of MDT consultations.	8	Develop business case to cover permitting the service to offer the Best Practice Tariff delivery model.	Risk ID 840	Service Manager	Jan-21	G	10/12/20 Draft business case developed, staffing approved from 1/10/21,	Business Case Approved	Completed
	9	Recruit additional staffing as required		Matron	Oct-21	G	01/08/21 - Preparing adverts and reviewing job descriptions prior to recruitment Additional posts partially filled 1/10/21 - Psychology post is the remaining concern, however both posts currently mitigated through Specialty Doctor and Physocology Provision provided	Appointed 0.5wte B7 dietician, and increasing hours for nursing posts already recovered, final nursing vacancy recruited due to start 1/8/22. Clinical Psychology post unfilled. Interim medical cover arranged for period of 12 months through speciality Doctor cover (supported and trained), pending consultant recruitment. Included in Business Plannning for **22/23** to recruit additional substantive consultant posts to provide additional consultant following review of service needs	
	10	Implement new arrangements		Lead PDSN	Jul-21	G		Additional paediatric clinics commenced with speciality doctor and new team members. Initially with reduced numbers during training period but full clinic provision from March 2022	
No agreed pathway for access to CGM in line with NICE guidance. Some eligible families are self-funding	11	Contribute to identification and specification for CCG funding stream for continuous glucose monitoring	Risk ID 840	Senior Programme Lead (CCG)	Jan-21	G	Business case developed for presentation to Dorset Integrated Care System Transformation Group. Implemented 1/10/21 with multiple children starting in October/November. Dorset ICS second best in country for CGM in pregnancy	Business case approved by CCG with funding from October 2021. Now 25% of patients using NHS funded Dexcom	Completed
	12	Develop business case to cover return of pump service to DCH from UHD		Service Manager	Mar-21	A	Medical Director level discussions about service changes and resolve transfer completed. January 21 - CCG and UHD approached for agreement to alter service from 1 April 2022	Chief Executive & Medical Director approved plan to return pump service and instructed the management team to action this. Current discussions with UHD / CCG for service to return supported by SRO Chief Operating Officer. Initial patients booked for pump starts in June 2022	
Key issues escalated but no proactive management. Two risks on risk register for 5 years+ and business case not reviewed.	13	Action to be defined at senior meeting to include Clinical Lead, MDT colleagues, Medical Director, CEO and other stakeholders.		Senior Programme Lead (CCG)	Feb-21	G	Dorset Diabetes Steering Group in place with Paediatric representation agreed.Process to be agreed regarding escalation of issues as part of system approach. Quarterly meetings established with SRO COO to review risks, actions and escalations from the service. Concerns. celebrations escalated via Division Governance	Dorset CCG are committed to working with DCH to develop a clear and trusted relationship within our Dorset ICS to improve the areas identified by the review team. Dorset CCG will put in place regular arrangements and opportunities for both good practice as well as areas of concern to be highlighted and discussed with joint planning processes in place to support it.	Completed
	14	Review of Risk Register, scoring system and escalation measures to ensure governance working effectively in future		Head of Risk Management and Quality Assurance	Mar-21	G	SRO and Head of Risk Management met in March 2022 with a view to signing off this action	Follow up audit review planned for June 2022	Completed
	15	Diabetes MDT to take a patient story to the Board to discuss what happens		Lead Consultant	Mar-21	G	17/12/2020 Suitable patient identified and Company Secretary contacted to identify a date for presentation	Case presented to Trust Board on 29 September 2021 with discussion about departmental issues following.	Completed 29/9/21
	16	Diabetes MDT to resume provision of Best Practice Tariff data to CCG for them to monitor service provision going forwards		Lead Consultant	Apr-21	G	To be discussed with CCG Senior Programme Lead to confirm	Now providing Best Practise Tariff Data and plan to send data directly to CCG Programme Lead	Completed
GIRFT recommendation for transition service. No compliant transition service.	17	Continue meetings between Paediatric and Adult diabetes teams to develop the service according to the service specification and delivering Ready Steady Go		Lead consultants	Jan-21	G	Twice monthly meetings planned for delivery to continue Transition MDT and service development planning 4/11/21 meetings ongoing	Meetings established and ongoing	Completed
	18	Develop business case to cover paediatric staffing resource required to provide Transition service		Service Managers (adult and paediatric	Mar-21	G	10/12/20 Original BC approved As at January 2022 - further business case submitted 4/11/21 Business case approved with funding from 1/10/21	Business Case Approved, Included in Business Plannning for **22/23** to recruit additional substantive consultant posts to provide additional consultant to service / need	Completed
	19	Recruit additional staffing as required		Matrons (adult and paediatric)	Apr 2021	A	Diabetes transition nurse successfully appointed and started on the 04.01.22 Dietician post – Successfully appointed and due to start in April. Psychologist - no successful appointment. February 2022 potential candidate identified.		
	20	Implement new arrangements including joint clinic, MDT and ongoing patient feedback and audit, admissions and attendance reviews		Team Leaders (adult and paediatric)	Jul-Aug 2021	G	4/11/21 awaiting recruitment – planning for April 2022 first iteration of service	Transition meetings are to discuss patients, not planning meetings. Trust wide Diabetes planning meeting arranged for discussion around setting up of joint clinics and associated pathways. Clinic to start on 5th July 2022 PM and will run weekly changing from AM to PM, commitment for 12 clinics to be converted from Young People Clinics to Transition Clinics for 16 - 18 year olds.	
	21	Review recruitment strategy to ensure stable plan for staff development for the long term		Service Managers and Matrons	Aug-21	G	Including liaison with education and staffing teams	Sarah Collinson providing expertese, NHSE reviewing strategy for long term development / recruitment - reporting into Quarterly Steering Group meetings	

Meeting Title:	Board of Directors Part 1
Date of Meeting:	27 July 2022
Document Title:	Nutritional Strategy Implementation Update
Responsible Director:	Nicky Lucey, Chief Nursing Officer
Author:	Kathryn Cockerell, Chief Dietitian

Confidentiality:	*No*
Publishable under FOI?	Yes

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	• In February 2020, the Trust's Food and Drink Strategy for 2020-2023 was approved and ratified by the Trust's board. Over the past two years, attention and focus on the Food and Drink Programme has been limited by the competing demands brought by the pandemic and its aftermath. • Nutritional Screening and the nutritional care of our patients at ward level continues to be challenging • Responding to the demands of the pandemic in the context of staff shortages has made it challenging to get the right people to attend steering groups • Despite the challenges, areas of progress provide a basis for continued improvements as we settle into new ways of working • In the post-pandemic period, it will be important to recognize the role that good nutritional care can play in not only improving patient care and outcomes, but also in the wellness of our staff and the wider community. The Board is asked to accept the report, and to use the report to highlight concerns and areas for quality improvement to the Trust Board. Positive quality Improvement: • Progress on the evaluation of our nutritional offer to patients Challenges to Quality Improvement: • Nutritional screening remains resistant to improvement • Slow progress toward a digital menu is hampering opportunities to improve patient care • Visibility to nutritional issues at trust, ward and individual patient level remains low							
Action recommended	The Board is recommended to: 1. **NOTE** the report							

	2. **CONSIDER** recommendations and request assurances toward improvement 3. **AGREE** the key points, risks & concerns to be reported to the Board

Governance and Compliance Obligations

Legal / Regulatory	Y	Inability to achieve progress or sustain set standards could lead to a negative reputational impact and inability to improve patient safety, effectiveness and experience.
Financial	Y	Undetermined, but could incur penalty if unable to achieve agreed standards/targets.
Impacts Strategic Objectives?	Y	The quality of our services in providing safe, effective, compassionate, and responsive care links directly with strategic objectives
Risk?	Y	Links to Board assurance Framework
Decision to be made?	Y	On recommendations
Impacts CQC Standards?	Y	As this report refers 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	

Quality Committee Paper
Nutritional Strategy Implementation Update

- **Executive Summary** *In February 2020, the Trust's Food and Drink Strategy for 2020-2023 was approved and ratified by the Trust's board. The strategy set out a series of aspiration for our food and drink offer to patients, staff and visitors to be realised over a three-year period. In March 2020, the World Health Organisation declared the COVID-19 virus to be a global pandemic leading to unprecedented demands on the health service. Over the past two years, attention and focus on the Food and Drink Programme has been limited by the competing demands brought by the pandemic and its aftermath. The table that follows provides an status against the timeline set out in the strategy document as well as a set of recommendations for consideration.*

1. Update on timeline (taken from Food and Drink Strategy 2020-2023)

Phase (Year)	Ref	Plan	Status
2020-2021 (1)	1.1	Embed Nutritional Screening into every ward's culture	Recent MUST audit suggests ongoing challenges with embedding nutrition screening. The problems pre-date the pandemic and have been resistant to series of focused management efforts and as well as to the implementation of a digital screening tool on VitalPac. **Recommendation 1.1: Senior management to review the governance structures around nutrition screening and nutrition provision including a robust pathway for raising and resolving complex nutritional issues for individual patients.**
	1.2	Develop closer links between dietetics, nursing, catering and ensuring robust processes and indicators from bedside to kitchen and back	Progress has been hampered due to staff shortages across all disciplines and the demands of the pandemic. Catering, dietetics and Speech Therapy hold a bi-monthly operational meeting to review issues and complaints that arise. Dietetics developing BI intelligence to improve surveillance of patient nutritional status. **Recommendation 1.2: Improve visibility of dietetics into ward leader and patient safety forums.**
	1.3	In conjunction with catering, continue to develop and innovate the food and drink offering to improve options for special dietary requirements	Catering published their HAACP which established the capabilities and safe working practices for our catering operation. As a result, some meals were deemed unsafe to produce in house and

		including increased energy and protein needs, therapeutic diet for the management of disease and special diets for religious, ethical or moral observations	are now purchased. This has improved patient safety and allows a wider range of choice for patients. A full vegan menu has been introduced and work is ongoing to complete full nutritional analysis of our food and drink offer with an anticipated completion of Autumn 2022.
	1.4	Establish a strong dietetic presence through the recruitment of a specialist post to work directly with catering to ensure our food and drink service is providing the appropriate nutrition for our patients, staff and visitors	Recruitment to a specialist catering post was unsuccessful and we've opted instead to employ an assistant working under the direction of the Chief Dietitian. Work is progressing with dietetics and catering collaborating to ensure a consistent high quality catering offer.
	1.5	Understand our requirements for a digital menu ordering system, rationalise and document all f the relevant processes from patient admission to discharge. Begin the tendering process with the development of a requirements document.	Clinical requirements have been to procurement but delays due to competing priorities have stalled progress on this effort. **Recommend 1.5: Dietetics to take the lead on market evaluation; re-engaging procurement for the formal tendering process.**
	1.6	Look to create a stronger, more robust process for gathering and responding to patient and other service user feedback on the food and drink offering	The absence of visitors during the pandemic has limited the opportunity to further this objective. PLACE assessments are due to restart this year. At the catering steering group the topic of surveillance over the food and drink offer was discussed however the group has not met since before the pandemic. **Recommendation 1.6: Re-establish the catering steering group to include our patient liaison, volunteers, dietetics, nursing, finance, procurement, and catering and set a clear programme of project and surveillance work.**
2021-2022 (2)	2.1	Assess the nutritional content of our food and drink offering to ensure our menus meet the nutritional guidance set out by national bodies appropriate for our service users.	Work has commenced and continues with an expected first draft expected in August of this year. We expect a revised Nutrition and Hydration Digest in November of this year and will set out an auditable nutrition standard for our food and drink offer. **Recommendation 2.1: Annual report to Quality Committee of nutrition and**

			hydration offer against national standards (by dietetics supported by catering).
	2.2	Select and implement a digital menu ordering system to improve patient safety, increase the efficiency of the food and drink services, provide a more responsive service to patients including those with additional communication needs	This item is dependent on the market evaluation work set out above. Successful implementation of bedside ordering provides tremendous opportunities to reduce the waste of resources, save staff time, improve patient care, and improve the patient experience. Due to our situation of having a completely manual menu process, we now have an opportunity to jump generations ahead to become an example of good practice within the Dorset ICS. **Recommendation 2.2: Prioritise the selection and implementation of a next generation digital menu system**
	2.3	Further develop service user involvement in improving the food and drink offering through focus groups and targeted consultations with current and previous service users	Due to the pandemic this has not progressed. **Recommendation: See recommendation 1.6**
2022-2023 (3)	3.1	Use our outstanding food and drink offering as springboard to improving nutritional care in the community by using our food and drink offering to promote positive and realistic messages about the importance of good food to wellbeing throughout the life course	As the ICS begins to take shape we must look for opportunities to contribute to its work in this way. **Recommendation: Board to consider support for a Pan-Dorset nutrition steering group to include acute and community dietetics, institutional catering, public health, primary care, social care, education. To set a nutrition agenda for the ICS.**

2. Conclusion

The nutrition and hydration of our patients is a key aspect of their care including their ability to respond to treatment and have the best chance of recovery and rehabilitation. Our dietitians have nutrition and hydration as a focus and are in a good position to advocate on behalf of patients and their families (as well as staff and visitors) but small numbers and insufficient visibility of the profession within MDTs hampers our impact. Conflicting demands on our medical and nursing professionals combined with our limited dietetic presence means that nutrition and hydration are often overlooked or delayed. The recommendations above are intended to improve the Trust's focus and performance with regard to the nutrition and hydration of our patients.

3. Recommendation

The Quality Committee is recommended to:

1. **NOTE** the report
2. **CONSIDER** recommendations and request assurances toward improvement
3. **AGREE** the key points, risks & concerns to be reported to the Board

Name and Title of Author: Kathryn Cockerell
Date: 9/5/2022

Meeting Title:	Board of Directors Part 1
Date of Meeting:	27th July 2022
Document Title:	Fortuneswell Pharmacy Quarterly Report 2021/22 (Q4)
Responsible Director:	Stephen Tilton - DCH SubCo, Chairman
Author:	Andrew Harris – DCH SubCo, Superintendent Pharmacist

Confidentiality:	No
Publishable under FOI?	No – commercially sensitive

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH SubCo board meeting	11th July 2022	Noted
Finance and Performance Committee	18th July 2022	

Purpose of the Paper	To provide a quarterly report (Q4) of the activities and financial performance of the Trusts subsidiary company, DCH SubCo, Ltd.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	In April 2018, DCH SubCo Ltd, under the trading name of Fortuneswell Pharmacy, commenced trading. Fortuneswell Pharmacy has dispensed all medicines for chemotherapy outpatients for DCHFT during this period. Fortuneswell Pharmacy continues to perform well both operationally and financially with no complaints in Q4. No dispensing errors were reported this quarter. The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the three year period and is now 1,500 per month, double the anticipated level of activity in the original business case. Additional space is required for Fortuneswell Pharmacy to be sustainable and to continue trading. Space was identified as part of the Fortuneswell unit redevelopment but due to additional space requirements following the pandemic, this space may no longer be available. The designs for the Fortuneswell unit were being redrafted and a decision on the space for the Pharmacy will be known by the end of January. If the additional space in the Fortuneswell unit for the extended outpatient Pharmacy is not available, then an alternative space will need to be identified otherwise the outpatient pharmacy will need to cease trading as the premises are no longer fit for purpose.							
Action recommended	Note the activities and financial performance of DCH SubCo Ltd. Note the risk to continued trading if additional space is not identified.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Due to the increasing activity, there is a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
Financial	Y	The company made a profit of £62,000 which was ahead of plan by £15,000, this overachievement is due to the over activity charge being ahead of the plan by £3,000, an underspend of £1,000 on pay/non-pay budgets and an underspend on Corporation Tax of £11,000 due to the decision to donate a £100,000 of its profit to Charity this financial year.
Impacts Strategic Objectives?	Y	This development supports the Dorset County Hospital NHS Foundation Trust's strategy to improve the patient experience, integrate

		its services, diversify income streams and adopt a more commercial and flexible approach to delivery of its support services.
Risk?	Y	Additional space is required for Fortuneswell Pharmacy to be sustainable and to continue trading. Also see legal/regulatory compliance obligations
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Fortuneswell Pharmacy Quarterly Quality Performance Report 2021/22 (Quarter 4)

Andrew Harris
Superintendent Pharmacist
June 2022

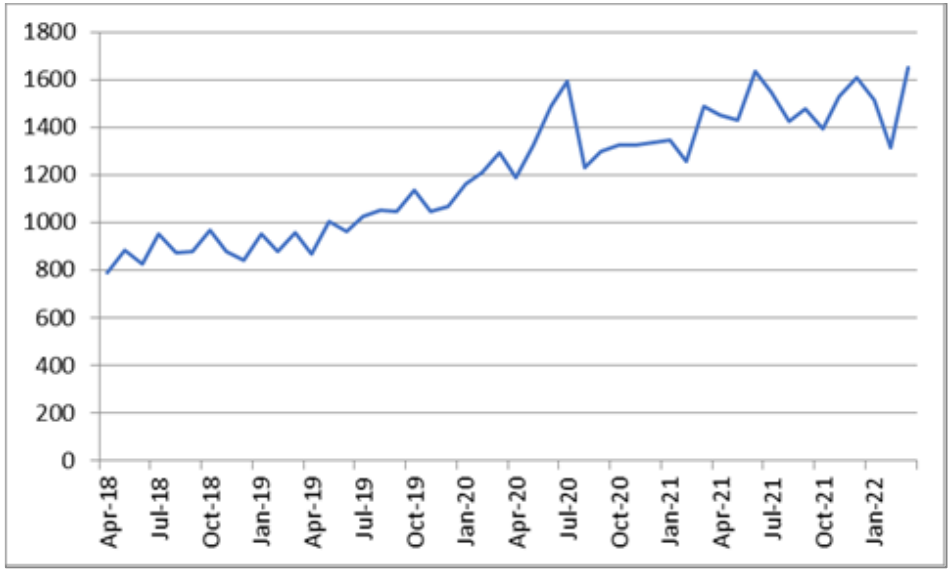
INTRODUCTION

DCHFT established a wholly owned subsidiary company, DCH SubCo Ltd, and in April 2018 commenced trading as Fortuneswell Pharmacy. The Pharmacy is located within the Fortuneswell Unit and provides a Pharmacy service for all Cancer patients. This paper provides a review of the performance for quarter 2 of 2021/22.

ACTIVITY

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total Number of Customers per Month	147	163	176	146	123	155	147	163	176	168	149	185
Total Items Dispensed	1450	1431	1635	1548	1423	1475	1392	1530	1610	1512	1314	1653
Average Items/day	72.5	75.3	74.3	70.4	67.8	67.0	66.3	69.5	76.7	75.6	65.7	71.9
No. of same day Prescriptions	294	306	336	316	299	346	319	338	373	373	289	372
No. of Advance Prescriptions	351	372	437	411	370	371	334	415	394	366	346	387

Activity levels from April 2018 to current:



Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

INCIDENTS

No dispensing errors have left Fortuneswell Pharmacy in financial year 2021/22

KEY RISKS

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,500 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.

- Additional space is required for Fortuneswell Pharmacy to be sustainable and to continue trading. Space was identified as part of the Fortuneswell unit redevelopment but due to additional space requirements following the pandemic, this space may no longer be available. The designs for the Fortuneswell unit were being redrafted and a decision on the space for the Pharmacy will be known by the end of January. If the additional space in the Fortuneswell unit for the extended outpatient Pharmacy is not available, then an alternative space will need to be identified otherwise the outpatient pharmacy will need to cease trading as the premises are no longer fit for purpose.
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). The consultation finished on 19th November 2020 and if approved HM Treasury is suggesting implementation in 2-3 years. This represents a significant risk to the long term sustainability of the subsidiary company.

PATIENT COMPLIANTS

There have been no patient complaints during this time period

FINANCIAL PERFORMANCE

- The company made a profit of £62,000 which was ahead of plan by £15,000, this overachievement is due to the over activity charge being ahead of the plan by £3,000, underspend of £1,000 on pay/non-pay budgets and an underspend on Corporation Tax of £11,000 due to the decision to donate £100,000 of this year's profit to charity.
- The cash balance at 30 September was £223,000 against a plan of £258,000, this position is behind plan due to the activity volumes, associated drug charges and timing of payments to suppliers. There was an additional invoice of £234,900 for performance in quarter 2.

Fortuneswell Pharmacy

Outpatient Pharmacy Dispensary Services						
Statement of Profit or loss	2021/22 Sep-21			2021/22 Year to date		
	Actual	Plan	Variance	Actual	Plan	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Operating Revenue						
Revenue	528	460	68	3,184	2,762	423
Total Operating Revenue	528	460	68	3,184	2,762	423
Operating Expenses						
Drugs/Raw materials and consumables	(502)	(435)	(67)	(3,030)	(2,610)	(420)
Employee benefit expenses	(6)	(7)	1	(38)	(40)	2
Other operating expenses	(9)	(9)	0	(54)	(54)	0
Total Operating Expenses	(517)	(451)	(66)	(3,122)	(2,704)	(418)
Investment Revenue	0	0	0	0	0	0
Profit/(Loss) before tax	11	10	1	62	58	5
Corporation Tax	0	(2)	2	0	(11)	11
Profit/(Loss) for the year	11	8	3	62	47	15

Fortuneswell Pharmacy

QUALITY SCORECARD

All contractual KPIs year to date are green:

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep–21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.53%	0.11%	0.11%	0.13%	0.15%	0.14%	0.25%	0.21%	0.23%	0.30%	0.29%	0.35%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	0	0	0	0	0	0	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9%	99.6%	99.5%	99.2%	99.4%	99.4%	99.4%	99.1%	99.5%	99.4%	99.4%	99.5%	99.40%

Fortuneswell Pharmacy

MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80 %	95.2%	95.7%	97.0%	94.9%	94.6%	95.4%	96.7%	95.4%	91.9%	94.1%	91.1%	92.2%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80 % For (ii) Less than 65 %	(i) 100% (ii) 96.6%	(i) 100% (ii) 97.0%	(i) 100% (ii) 99.2%	(i) 99.1% (ii) 97.8%	(i) 100% (ii) 96.1%	(i) 100% (ii) 97.4%	(i) 98.4% (ii) 95.3%	(i) 99.2% (ii) 96.4%	(i) 99.6%) (ii) 96.8%	(i) 100% (ii) 98.4%	(i) 99.5% (ii) 96.3%	(i) 99.2% (ii) 96.7%
Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Completion / Uptake Rate (%)														
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0	0	0	0	0	0	0	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049 %	0.05% - 0.099%	> 0.1 %	0	0	0	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Waste/Expiry management*	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£0.27	£0.09	£0.00	£0.00	£0.00	£0.00	£28.89	£23.44	£0.00	£0.16	£14.03	£50.22

Meeting Title:	Board of Directors part 1
Date of Meeting:	27th July 2022
Document Title:	Fortuneswell Pharmacy Quarterly Report 2022/23 (Q1)
Responsible Director:	Stephen Tilton - DCH SubCo, Chairman
Author:	Andrew Harris – DCH SubCo, Superintendent Pharmacist

Confidentiality:	No
Publishable under FOI?	No – commercially sensitive

Prior Discussion		
Job Title or Meeting Title	**Date**	**Recommendations/Comments**
DCH SubCo board meeting	11th July 2022	Noted
Finance and Performance Committee	18th July 2022	

Purpose of the Paper	To provide a quarterly report (Q1) of the activities and financial performance of the Trusts subsidiary company, DCH SubCo, Ltd.							
	Note	✓	*Discuss*		*Recommend*		*Approve*	
Summary of Key Issues	In April 2018, DCH SubCo Ltd, under the trading name of Fortuneswell Pharmacy, commenced trading. Fortuneswell Pharmacy has dispensed all medicines for chemotherapy outpatients for DCHFT during this period. This has led to a significant improvement in patient experience with waiting times significantly reducing compared to the previous service provided through the Hospital Pharmacy. Clinical risk has also been reduced with all chemotherapy prescriptions being clinically verified by a specialist trained Pharmacist in accordance with national (BOPA) standards. Fortuneswell Pharmacy continues to perform well both operationally and financially with complaints in Q1. No dispensing errors were reported this quarter. The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the three year period and is now 1,600 per month, double the anticipated level of activity in the original business case. Additional space is required for Fortuneswell Pharmacy to be sustainable and to continue trading.							
Action recommended	Note the activities and financial performance of DCH SubCo Ltd. Note the risk to continued trading if additional space is not identified.							

Governance and Compliance Obligations

Legal / Regulatory	Y	Due to the increasing activity, there is a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
Financial	Y	The company made a profit of £100.000 which was ahead of plan by £19,000, this overachievement is due to the over activity charge being ahead of the plan by £8,000 and underspend of £15,000 on pay/non-pay budgets offset by Corporation Tax increase due to the increased profit of £4,000.
Impacts Strategic Objectives?	Y	This development supports the Dorset County Hospital NHS Foundation Trust's strategy to improve the patient experience, integrate its services, diversify income streams and adopt a more commercial and flexible approach to delivery of its support services.

Risk?	Y	Additional space is required for Fortuneswell Pharmacy to be sustainable and to continue trading. Also see legal/regulatory compliance obligations
Decision to be made?	N	
Impacts CQC Standards?	N	
Impacts Social Value ambitions?	N	
Equality Impact Assessment?	N	
Quality Impact Assessment?	N	

Fortuneswell Pharmacy Quarterly Quality Performance Report 2022/23 (Quarter 1)

Andrew Harris
Pharmacy Director
July 2022

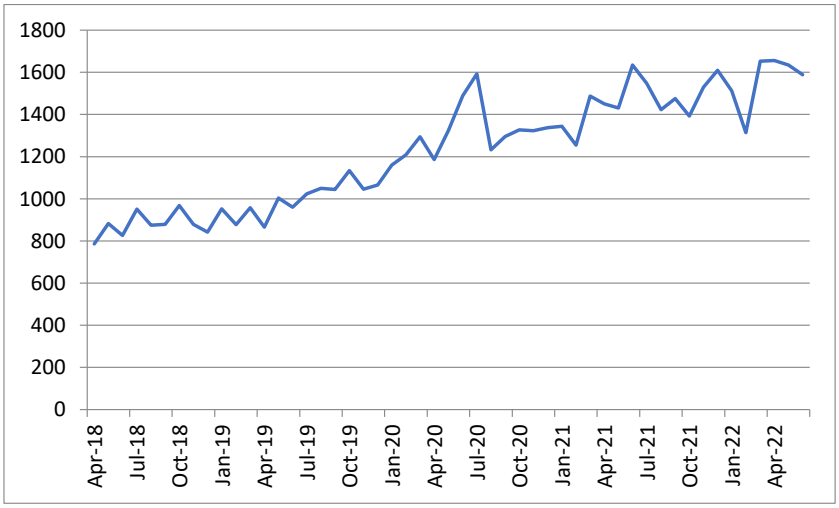
INTRODUCTION

DCHFT established a wholly owned subsidiary company, DCH SubCo Ltd, and in April 2018 commenced trading as Fortuneswell Pharmacy. The Pharmacy is located within the Fortuneswell Unit and provides a Pharmacy service for all Cancer patients. This paper provides a review of the performance for quarter 1 of 2021/22.

ACTIVITY

	Apr-22	May-22	Jun-22
Total Number of Customers per Month	151	211	178
Total Items Dispensed	1656	1635	1588
Average Items/day	87.2	77.9	79.4
No. of same day Prescriptions	442	364	376
No. of Advance Prescriptions	330	401	390

Activity levels from April 2018 to current:



Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

INCIDENTS

No dispensing errors have left Fortuneswell Pharmacy in financial year 2022/23

KEY RISKS

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,600 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected.
- Additional space is required for Fortuneswell Pharmacy to be sustainable and to continue trading. Space was identified as part of the Fortuneswell unit redevelopment but due to additional space requirements following the pandemic, this space may no longer be available. The designs for the Fortuneswell unit were being redrafted and a decision on the space for the Pharmacy will be known by the end of January. If the additional space in the Fortuneswell unit for the extended outpatient Pharmacy is not available, then an alternative space will need to be identified otherwise the outpatient pharmacy will need to cease trading as the premises are no longer fit for purpose.
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). The consultation finished on 19th November 2020 and if approved HM Treasury is suggesting implementation in 2-3 years. This represents a significant risk to the long term sustainability of the subsidiary company.

PATIENT COMPLIANTS

There have been no patient complaints during this time period

FINANCIAL PERFORMANCE

- The company made a profit of £100,000 which was ahead of plan by £19,000, this overachievement is due to the over activity charge being ahead of the plan by £8,000 and underspend of £15,000 on pay/non-pay budgets offset by Corporation Tax increase due to the increased profit of £4,000.
- The cash balance at 31 March 2021 was £50,000 against a plan of £238,000, this position is behind plan due to the activity volumes, associated drug charges and timing of payments to suppliers. There was an additional invoice of £299,500 for performance in quarter 4.

Fortuneswell Pharmacy

Outpatient Pharmacy Dispensary Services						
Statement of Profit or loss	2020/21 Mar-21			2020/21 Year to date		
	Actual	Plan	Variance	Actual	Plan	Variance
Operating Revenue						
Revenue	532	308	225	5,286	3,690	1,596
Total Operating Revenue	532	308	225	5,286	3,690	1,596
Operating Expenses						
Drugs/Raw materials and consumables	(504)	(283)	(221)	(4,988)	(3,400)	(1,588)
Employee benefit expenses	(6)	(6)	0	(65)	(75)	10
Other operating expenses	(18)	(23)	5	(110)	(115)	5
Total Operating Expenses	(528)	(313)	(215)	(5,163)	(3,590)	(1,573)
Investment Revenue	0	0	0	0	1	(1)
Profit/(Loss) before tax	4	(5)	9	123	101	23
Corporation Tax	(1)	(2)	1	(23)	(19)	(4)
Profit/(Loss) for the year	3	(7)	10	100	82	19

Fortuneswell Pharmacy

QUALITY SCORECARD

All contractual KPIs year to date are green:

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-22	May-22	Jun-22
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.91%	0.92%	0.88%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% -96%	< 95.9%	99.64%	99.20%	99.43%
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%

All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	90.1%	96.3%	91.8%

The waiting time for dispensing prescriptions, during a monthly period shall be:
 	
(i) 30 minutes or less in respect of 95% of all prescriptions; and
 	
(ii) 20 minutes or less in respect of 80% of all prescriptions
	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions
		
		(ii) 20 minutes or less in respect of 80% of all prescriptions
			For (i) Greater than or equal to 95%
			
			For (ii) Greater than or equal to 80%
				For (i) 80% - 94.9%
				
				For (ii) 65% - 79.9%
					For (i) Less than 80%
					
					For (ii) Less than 65%
						(i) 99.6%
						
						(ii) 95.6%
							(i) 99.2%
							
							(ii) 96.2%
								(i) 99.1%
								
								(ii) 97.3%

Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100%	100%	100%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049 %	0.05% - 0.099 %	> 0.1%	0	0	0

Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% -97.5%	< 97.5%	100%	100%	100%
Waste/Expiry management*	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£0.00	£14.36	£0.00

4.

NHS DORSET INTEGRATED CARE BOARD

ICB BOARD

1 JULY 2022

MINUTES

A meeting of the ICB Board was held at 9.30am on Friday 1 July 2022 in the Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TG

Present:

Jenni Douglas-Todd, ICB Chair (JDT)
Neil Bacon, ICB Chief Strategy and Information Officer (NB)
John Beswick, ICB Non-Executive Member (JB)
Cecilia Bufton, ICB Non-Executive Member (CB)
Jonathon Carr- Brown, ICB Non-Executive Member (JCB)
Dawn Dawson, Director of Nursing, Therapies and Quality – Dorset Healthcare and ICB Mental Health Partner member (DD)
Siobhan Harrington, Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member (SH)
Spencer Flower, Leader Dorset Council and ICB Local Authority Partner Member (West) (SF)
Paul Johnson, ICB Chief Medical Officer (PJ)
Drew Mellor, Leader Bournemouth, Christchurch and Poole Council and ICB Local Authority Partner Member (East)
Patricia Miller, ICB Chief Executive Officer (PM)
Rob Morgan, ICB Chief Finance Officer (RM)
Ben Sharland GP and Primary Care Partner Member (virtual attendance) (BS)
Dean Spencer, ICB Chief Operating Officer (DS)
Kay Taylor, ICB Non-Executive Member (KT)
Forbes Watson, ICB Non-Executive Member (FW)
Dan Worsley, ICB Non-Executive Member (DW)
Simone Yule, GP and ICB Primary Care Partner Member (virtual attendance) (SY)

Invited Participants:

Louise Bate, Manager, Dorset Healthwatch (LB)
Sam Crowe, Director of Public Health (SC)
David Freeman, ICB Chief Commissioning Officer (DF)
Tim Goodson, ICB Programme Director (TG)
Leesa Harwood, Associate ICB Non-Executive Member (LH)
Dawn Harvey, ICB Chief People Officer (DH)
Nick Johnson, Interim CEO Dorset County Hospital NHS Foundation Trust and ICB NHS Provider Trust Partner Member (virtual attendance) (NJ)

Fiona King, Governance and Committee Officer, Dorset CCG (minute taker) (FK)
Pamela O'Shea, Deputy Director Nursing and Quality (PoS)
Matt Prosser, Chief Executive, Dorset Council (MP)
Phil Richardson, ICB Programme Director (PR)
Andrew Rosser, Chief Finance Officer, SWAST (virtual attendance) (AR)
Nikki Rowland, ICB Programme Director (NRo)
Sally Sandcraft, ICB Programme Director (SSa)
Stephen Slough, ICB Chief Digital Information Officer (SS)
Charles Summers, ICB Programme Director (CS)
Natalie Violet, Business Manager to the ICB Chief Executive (NV)

Action

1. Welcome, Introductions and Apologies

Dr Manish Tayal, Associate ICB Non-Executive Member
Vanessa Read, Interim Chief Nursing Officer
Spencer Flower, not available until 10.00am
Forbes Watson, not available until 10.30am

1.1 **ICB Constitution**

1.2 The Chair introduced the Constitution and advised that it had been approved by NHS England and was now available on-line.

1.3 The Chief Executive advised the Board of one correction that had been made since the meeting of the Shadow Board on 20 May 2022. This related to the identification of local authority members as executives and not as elected members. This had now been amended.

1.4 The Board formally accepted the ICB Constitution as their primary governance document.

2. Quorum

2.1 It was agreed that the meeting could proceed as there was a quorum of members present.

3. Declarations of Interest, Gifts or Hospitality

3.1 There were no Declarations of Interest made at the meeting.

3.2 Members were reminded of the need to ensure Declarations of Interest were up to date and to notify the Corporate Office of any new declarations.

4. Staff Story

4.1 The Board were advised that the aim was to have a staff/patient story at the start of all Board meetings in the future. The patient story for this meeting related to a member of staff at Dorset County Hospital and her daughter and highlighted what the impact was when families were listened to and the impact on those families when they were not.

4.2 A number of participants in the meeting were aware of the story and offered their reflections.

4.3 The Chief People Officer shared her experience of spending time with the family and highlighted that the workforce across the system was 'our' population and how those with caring responsibilities were supported was fundamental to providing wellbeing for 'our' population.

4.4 The story highlighted the importance of thinking about the holistic person and the need to amplify the voices of not just the child but also those of our communities.

4.5 In terms of lessons learned the Chief Executive advised that she had shared the film with the mental health commissioning team and this and other stories would be put into the wider governance framework to enable clinicians to learn from them. She confirmed that the development of a strategy for children and young people would be a key priority for the ICS and its development delivery would be founded in our agreed approach to co-production with our communities.

4.6 Board members felt this had been a powerful way to start the meeting but considered how it would have been different for someone who was not part of the system and was not familiar with the structures. It was recognised there was a lot of assumed knowledge in public services.

4.7 The Chief Executive University Hospitals Dorset NHS Foundation Trust suggested a mechanism to share the stories from the different organisations within the system could be helpful. Stephen Sough agreed to take this forward. SS

5. Items for Decision

5.1 Establish the Committees, appoint the Chairs/membership of the Committees and approve their Terms of Reference

5.1.1 The Chair introduced the report on the Establishment of Committees – Functions and Decision Map.

5.1.2 The Board was advised that further work was needed on redesigning the system decision making framework to ensure the structure was as flat as possible to enable more agile decision making at the lowest level.

5.1.3 The Board **approved** the functions and decision map, committee structure, committee Chairs and terms of reference.

5.2 ICB Standing Financial Instructions (SFIs) and ICB Scheme of Reservation and Delegation

5.2.1 The Chief Finance Officer introduced the report on the scheme of reservation and delegation and standing financial instructions.

5.2.2 Amendments that had been requested had now been incorporated. The Chief Executive advised that in respect of the SFIs authorisation of bank and agency staff an interim arrangement had been put in place until the Chief People Officer took up her post in September.

5.2.3 The Board **approved** the scheme of reservation and delegation and standing financial instructions.

5.3 Appoint to Specialist/lead roles e.g. Conflicts of Interest Guardian Freedom to Speak up Guardian

5.3.1 The Chair introduced the report on the non-executive champion appointments to specialist and lead roles.

5.3.2 Prior to the circulation of the report there had been discussions with the non-executive members to ensure their understanding and agreement to the roles.

5.3.3 The Chair highlighted the positive engagement that had taken place which reflected the importance of agile working and working at pace.

5.3.4 The Board **approved** the recommendations in the appointment of non-executive champion roles report.

5.4 Governance Handbook and Suite of Core Policies

5.4.1 The Business Manager to the CEO introduced the Governance Handbook along with the suite of core policies which included the Standards of Business Conduct Policy and the Conflicts of Interest policy.

5.4.2 The Handbook described how the ICB would make their decisions and consideration was given that there might need to be a handy guide version of the Handbook for staff as it was a rather substantial document. The Chief Executive's Business Manager undertook to confirm with NHSE the level of detail required to be published in the Handbook. NV

5.4.3 Following a discussion about the Handbook the Board were advised that there was a requirement from NHS England for it to be published on the website from day one of the ICB.

5.4.4 Following a question about committee meetings being held in public, the Chair advised that Part One of the meetings of the Board would be held in public whilst the committee meetings would not.

5.4.5 It was anticipated that minutes from the committee meetings would appear as part of the Board minutes for transparency, although Part 2 minutes from the Board would not be published as they regularly contained commercially sensitive information.

5.4.6 The Board **approved** the ICB Governance Handbook and the suite of Core Policies.

5.5 Appoint the ICB founder member of the Integrated Care Partnership (ICP)

5.5.1 The Board considered the appointment of an ICB founder member for the Integrated Care Partnership.

5.5.2 The Board was advised that ICBs across the south-west were nominating their ICB chairs to this role.

5.5.3 The Chief Executive proposed, and Dr Forbes Watson seconded the proposal to appoint the ICB Chair to the Integrated Care Partnership.

5.5.4 The Board **approved** the appointment of Jenni Douglas-Todd as the founding member with the local authorities in terms of creating the ICP Board.

6. Items for Noting

6.1 There were no items for noting.

7. Items for Consent

7.1 There were no items for consent.

8. Questions from the Public

8.1 There were no written questions from members of the public but the Chair invited those members of the public online if they had any questions.

8.2 It was recognised that some people had encountered difficulties in initially joining the meeting and to try and avoid this for future meetings it was suggested that members of the public joined the meeting a little earlier in order to try and resolve any connectivity issues.

8.3 One person expressed concern about the process for residents being consulted before decisions were made.

9. Any Other Business

9.1 There was no further business discussed.

10. Date and Time of Next Meeting

10.1 The next meeting of the ICB Board would be held on Wednesday 20 July 2022 at 8.30am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TG

11. Exclusion of the Public

To resolve that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.